IMPLICATIONS OF CONTROLS ON ACCESS TO MEDICARE BILLING FOR GPS

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Until 1996 almost all attempts to control the growth in the General Practice workforce billing under Medicare in Australia have failed. The Coalition Government's recent initiatives are likely to succeed in this endeavour, but at the expense of further maldistribution of the GP workforce.

In previous articles on the medical workforce I have explored the former Labor Government's difficulties in controlling the rapid growth in the supply of doctors both from local and overseas sources.[1] The former Labor Government, like the current Coalition government, believed that there were too many general practitioners (GPs) billing on Medicare in Australia, especially in metropolitan areas.

Labor initially focussed on reducing the inflow of overseas trained doctors (OTDs). In 1992 it imposed a ten point penalty on doctors applying for permanent residence under the Independent and Concessional Categories (subsequently increased to 25 points in 1995). Also in 1992, the Australian Medical Council (AMC), introduced a quota of 200 on the number of overseas-trained doctors who were permitted to pass the Council's medical knowledge (or Multiple Choice Question test — MCQ). This quota reduced the numbers proceeding to the clinical test (after which those successful could gain provisional medical registration to practice in Australia). Finally, in 1993, the Labor Government signed a Labour Market Agreement with the Queensland and Northern territory (NT) Governments aimed at sharply reducing the number of temporary medical visas issued to Overseas Trained Doctors (OTDs) in these two jurisdictions.

Little was achieved. The 200 quota was removed unilaterally by the AMC in 1995 following challenges to the Human Rights and Equal Opportunity Commission (HREOC). This removal occurred despite subsequent Federal Court rejection of the original HREOC ruling against the AMC. Partly as a consequence, the number of overseas doctors passing the MCQ test in 1996 nearly doubled to 392 (out of 858 candidates). Meanwhile the number of doctors arriving in Australia as permanent residents continued to rise, from 445 in 1993-94 to 558 in 1994-95 and 626 in 1995-96. The penalties instituted under the skilled categories worked, but the number of immigrant doctors continued to grow because of a dramatic increase in the numbers entering as spouses sponsored by Australian residents. Meanwhile the 'Agreement' with Queensland and the NT collapsed and the Department of Immigration and Multicultural Affairs (DIMA) simply issued visas without restriction according to the requirements of the states. The number of visas granted for OTDs on temporary medical appointments increased from 664 in 1993-94 to 728 in 1994-95, 875 in 1995-96, and 611 in the first six months of 1996-97. The latter figures are a key indicator of Australia's maldistribution problem. The Queensland Government in particular, simply cannot fill its hospital workforce need from locally-registered doctors.

Perhaps because of concerns about alienating the ethnic lobby (which embraced the cause of OTDs wishing to practise unimpeded in Australia) Labor did not pursue tougher options like prohibiting OTDs from billing on Medicare. Instead, in 1995, the Labor Government turned on local aspirants to medical careers and announced a firm policy commitment (which the Department of Employment, Education, Training and Youth Affairs [DEETYA] was required

to implement) to reduce medical school enrolments from around 1,200 to 1,000. But this measure was not implemented either, because of resistance from the universities. New enrolments in 1997 will approximate the past level of 1,200 per annum..

With the advent of the Coalition Government in 1996 we have seen a sudden willingness to take radical action to limit access to Medicare billing rights and to limit OTDs from competing with local graduates for such rights. In opposition, Labor, too, has changed its position. Though Labor voted against the measures described below, it did so on the grounds that it was improper to retrospectively change the rules for interns and medical students who began their courses expecting open ended access to Medicare billing rights. Furthermore the Labor shadow minister for Health, Mr Lee, berated the Government for not implementing even tougher rules limiting the rights of OTDs to practice in Australia.[2]

This article explores the implications of the Coalition's legislation in the light of recent unpublished evidence on the distribution of GPs which confirms concerns about the excessive numbers located in metropolitan areas. The Government's main aim has been to reduce the budgetary costs of Medicare by limiting the supply of GPs. It appears likely to succeed in this endeavour. But, in doing so, it may exacerbate the already serious under-representation of GPs in rural and remote areas of Australia.

COALITION INITIATIVES

The Coalition has simply side-stepped the difficulties of reducing medical enrolments and stemming the inflow of OTDs. The Government can do this unilaterally since it controls the issue of Medicare Provider rights through the Commonwealth Health Insurance Commission. New access rules were passed by the Senate, with Democrat support, in December 1996 in the form of amendments to the Health Insurance Act 1973. The rules affect both overseas-trained and Australian-trained doctors.

ACTIONS AFFECTING OVERSEAS TRAINED DOCTORS

1. The December 1996 legislation prohibits overseas-trained doctors who enter Australia as permanent residents after 1 January 1997 from billing under Medicare for 10 years after gaining registration. Given that most take at least two years to gain AMC accreditation, such doctors will have to wait 12 or more years before potentially being able to bill under Medicare.

2. The legislation similarly prohibits such billing to OTDs holding permanent residence status before 1997, but who had not lodged a formal application with the AMC to initiate the accreditation process by 31 December 1996. This first stage simply requires OTDs to establish that they hold a medical degree (on payment of a $40 fee). They do not need to have begun the examination process. In defending himself against criticism from Mr Lee that these rules are excessively generous, the Minister, Dr Wooldridge stated that there were only 1,200 persons registered with the AMC, of whom just 400 would eventually gain accreditation.[3] In fact, according to unpublished AMC figures, there were 3,119 registrants by 7 November 1996 and several hundred more applied just before the December 30 cut-off date. The AMC believes that up to 2,000 of these registrants are 'inactive' on account of years of delay in taking their applications further, or because they reside overseas and do not hold permanent residence visas. The implication is that around 1,500 are still 'active' and thus potentially eligible to receive Medicare provider numbers if they pass the AMC examinations. Another 1,492 have taken the MCQ test but have not yet passed and a further 786 have passed the MCQ test and are still eligible to complete the final clinical test. For the next few years the prospect is that over 200 OTDs will pass the AMC accreditation process each year and thereby become eligible to tackle the next hurdle before becoming a Medicare provider. In the case of those wanting to become GPs, this is the competition to gain a Royal

Australian College of General Practitioners (RACGP) training place — to be discussed below.

How many OTDs are there in Australia who did not register with the AMC by the end of 1996? Probably not many serious candidates, since all OTDs who had made any initial inquiries concerning the accreditation process were advised by the AMC about the December 31cut-off date. Nevertheless, it is very likely that a sizeable flow of OTDs will enter Australia (via family reunion) from unstable and low income societies (particularly the PRC) since such doctors will still be eligible for AMC accreditation and, if successful, will be able to seek employment in salaried medical positions.

3. New-Zealand trained doctors arriving in Australia after 1 January 1997 are similarly affected by the ten year delay. Though graduates trained in New Zealand medical schools are accredited by the AMC, and thus can register to practise in Australia, they will henceforth not be able to bill under Medicare, unless registered by the end of 1996.

4. Medical students who began their training as full-fee overseas students are also debarred from billing on Medicare for ten years after registration if this occurs after 1 January 1997, even if they become permanent residents or citizens of Australia (as through marriage to an Australian resident).

In all the cases listed, registered doctors can still practise in Australia, but only in salaried positions. Also it will be still be possible for employers like Queensland Health to recruit British doctors on a temporary basis, often with rights to bill under Medicare, though not quite so freely as in the past. Those recruited to positions involving General Practice must hold an equivalent qualification to the RACGP fellowship.

ACTIONS AFFECTING AUSTRALIAN-TRAINED DOCTORS.

The main measures were announced at the time of August Budget Statements in 1996, and were subsequently legislated in the Amendments to the Health Insurance Act passed in December 1996. This is despite (continuing) opposition from local medical students and interns. Their concern is that all those completing their intern year in 1996 (as well as all students in earlier stages of their medical training) will no longer be able to practise as GPs without first entering the RACGP training program. In the past, no post-graduate training was required as a pre-requisite to become a GP Provider on the Medicare system. From 1997, new medical registrants must hold RACGP accreditation as a GP, or be enrolled in the RACGP training program, before they can bill on Medicare as a GP. In addition, beginning in 1995, the RACGP has limited the number of training places to 400. By comparison, when entry to the program was not restricted, 524 enrolled in 1994, 830 in 1993 and 667 in 1992. While in training (three years full time) as RACGP trainees, doctors receive in the order of $40,000 to $60,000 per annum — including income from Medicare billings while in GP placements. Apart from such training places, doctors who were not registered before 1997, whether employed in hospital jobs, or in training as specialists (or who had completed specialist training) cannot now bill as GPs under Medicare, even on a part-time basis.

It is not surprising that the 1996 interns and medical students are up in arms. Gone are the days when a recently registered doctor could put off applying for a training place course and instead enter an entrepreneurial clinic and earn at least $100,000 (expense free) if prepared to do night or week-end shifts.

IMPLICATIONS FOR GENERAL PRACTICE NUMBERS

Table 1: All GPs billing on Medicare in 1995-96 by country of training and by first year registered

Country of training	Year registered							
	pre 1991	1991	1992	1993	1994	1995	1996	Total
Australia	15,709	764	478	485	495	302	76	18,309
New Zealand	205	16	41	40	48	52	15	417
United Kingdom	1,930	117	92	69	131	171	7	2,517
Europe	317	21	23	21	17	10	1	410
USA, Canada	40	1	3	3	5	14	1	67
S. Asia	905	54	44	37	31	11	3	1,085
Rest of Asia	432	15	14	8	17	4	0	490
Africa	411	48	28	33	26	27	5	578
Hong Kong	88	4	5	5	3	6	0	111
China	6	3	3	1	2	2	0	17
Other	58	24	24	42	10	7	1	166
AMC subtotal[a]	2,257	170	144	150	111	81	11	2,924
Total[b]	20,118	1,067	755	744	785	606	109	24,184

[a] The majority will have gained registration through the AMC. However, a few could be hoding temporary OTD positions.

[b] Total includes 17 with unknown year of registration and country of training

Source: Health Insurance Commission, unpublished

Within a few years there will be a sharp contraction in entry rates to general practice. Salaried hospital doctors who registered before 1 November 1996 can still enter General Practice without the RACGP qualification (though they receive a lower Medicare rebate than those who are fellows of the RACGP). But, as their numbers deplete, entrants to General Practice will decline, reflecting the 400 annual limitation on RACGP places. The scale of this contraction is indicated in Table 1, which lists the number of doctors billing as GPs in 1995-96 by year of first registration and by country of training. The average annual number starting (from all country-of-training sources) of those first registered between 1991 to 1995 was 791, of whom 505 were trained in Australia. Clearly, this is well above the maximum implied by the 400 RACGP annual quota.

In the case of the 580 British-trained doctors billing on Medicare who registered between 1991 and 1995, most would have arrived on temporary visas. Many would still be filling such positions in 1995-96, especially in Queensland, where they often do part-time private work as an adjunct to a public hospital position. The outlook for temporary OTD recruitment is clouded by the Government's proposal to give Australian permanent resident doctors first call on positions which would be otherwise be offered to OTDs. This is one of the concessions to be discussed below which the Government offered to the Democrats in return for their support for the December 1996 legislation.

The changing gender make-up of the GP workforce will also contribute to a slow down in the growth of GP service delivery and probably its maldistribution. According to a recent analysis, in 1994 some 83 per cent of female GPs were working in a capital city or major

urban centre and 65.5 per cent were working part-time. By comparison, 77.5 per cent of male GPs were working in a urban location but, more significantly, only 23.3 per cent were working part-time.[4] The female part-time preference will have a major impact on General Practice given that this field is the first choice of most female doctors. As of December 1996 there were 908 females enrolled as GP registrars at all levels in the RACGP training program compared with 695 males.[5]

CAREER CHOICES FOR RECENT GRADUATES

What are those doctors who previously would have entered general practice now going to do? This is a real dilemma since, according to the Government's latest count, there will be about 1,100 training places available in 1997 — 700 in Specialist programs and 400 with the RACGP.[6] But between 1,100 and 1,200 locals will graduate over the next few years and their numbers will be augmented by over 200 OTDs who pass through the AMC accreditation process. The hardest hit will be the AMC group since they are not well placed to compete against local graduates for training places. In 1996 there were about 530 applicants (120 AMC accredited and 410 local graduates) for the 400 RACGP training positions. Approximately 85 per cent of the Australian-trained graduates were offered places and 65 per cent of the AMC doctors. For those without a training place the future is a salaried career in the hospital system. While this is bad news for doctors expecting access to Government guaranteed fee-for-service medicine, it is good news for non-metropolitan hospitals struggling to fill medical officer positions. The latter hospitals may henceforth find more interest in these positions from doctors who miss out on a training place, and from those who are debarred for ten years from accessing Medicare Provider rights as described above.

IMPLICATIONS FOR THE DISTRIBUTION OF GENERAL PRACTICE SERVICES

This question is considered in the context of the well documented existing maldistribution of GPs. The average number of people per full-time equivalent GP in Australia's capital cities is just over 1,000, compared with around 1,700 in small rural communities. Other areas are located in between these numbers, though regional cities are close to the capital city level.[7] The RACGP view is that a ratio of 1,500 persons (or potential patients) per full-time doctor is appropriate for good medicine to be practised (that is it provides a situation where the doctor can exercise some disciplined judgements about service needs without worrying about patients going elsewhere). The 1,500 standard was adopted by the recent Australian Medical Workforce Benchmarks inquiry.[8] By these standards there are far too many GPs practising, especially in the capital cities. The 'Benchmarks' inquiry put the excess (of full-time equivalent) GPs in the capital cities at 2,525.[9] On the other hand it estimated that there was a shortage of 445 doctors in rural areas outside the bigger non-metropolitan centres.

Table 2: All GPs billing on Medicare in 1995-96 by country of training and by time of first registration compared with the distribution of population

Year of registration	Location	Country of training				Grand Total	Estimated resident population 1995
		AMC[a]	Aust	NZ	UK		
pre 1991	Sydney	1,038	3,771	52	272	5,133	
	Melbourne	440	3,406	35	245	4,126	
	Other metro	419	3,784	57	593	4,853	
		547	5,512	77	937	7,073	

	Non metro	2,444	16,473	221	2,047	21,185	
	Total						
1991 on	Sydney	161	309	51	13	534	
	Melbourne	129	337	42	38	546	
	Other metro	100	673	50	156	979	
	Non metro	107	517	53	263	940	
	Total	497	1,836	196	470	2,999	
Total	Sydney	1,199	4,080	103	285	5,667	3,772,700
	Melbourne	569	3,743	77	283	4,672	3,218,100
	Other metro	519	4,457	107	749	5,832	3,832,800
	Non metro	654	6,029	130	1,200	8,013	7,230,400
	Total	2,941	18,309	417	2,517	24,184	18,054,000
Share of total of year registered group							Share of population
pre 1991	Sydney	42.5	22.9	23.5	13.3	24.2	
	Melbourne	18.0	20.7	15.8	12.0	19.5	
	Other meto	17.1	23.0	25.8	29.0	22.9	
	Non metro	22.4	33.5	34.8	45.8	33.4	
	Total	100.0	100.0	100.0	100.0	100.0	
1991 on	Sydney	32.4	16.8	26.0	2.8	17.8	
	Melbourne	26.0	18.4	21.4	8.1	18.2	
	Other metro	20.1	36.7	25.5	33.2	32.6	
	Non metro	21.5	28.2	27.0	56.0	31.3	
	Total	100.0	100.0	100.0	100.0	100.0	
Total	Sydney	40.8	22.3	24.7	11.3	23.4	20.9
	Melbourne	19.3	20.4	18.5	11.2	19.3	17.8
	Other metro	17.6	24.3	25.7	29.8	24.1	21.2
	Non metro	22.2	32.9	31.2	47.7	33.1	40.0
	Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Health Insurance Commission, unpublished

[a] AMC includes all places of training other than Australia, New Zealand and the United Kingdom.

See qualifying note on Table 1.

Successive governments have offered various incentives to encourage doctors to move to rural and remote areas, though with only modest success. The extent of the difficulty is indicated in Table 2, which shows where GPs are locating by time of medical registration and country of training for all GPs billing on Medicare in 1995-96. Some 67 per cent of the GPs billing on Medicare are located in Sydney, Melbourne and the other major metropolitan areas (Perth, Adelaide and Brisbane), yet these areas accommodate just 60 per cent of Australia's population. On the other hand, the other 40 per cent of the population are being serviced by just 33 per cent of GPs. If there is to be a reversal of this situation, one would expect it come from the relatively footloose recent Australian-trained graduates or AMC-accredited doctors. But, as Table 2 shows, an even smaller proportion (28.2 per cent) of Australian-trained GPs registering since 1991 are located in the 'rest of the country' than those registered prior to 1991 (33.5 per cent). The more recent Australian-trained registrants are moving out of Melbourne and Sydney, but to other metropolitan areas.

Table 2 also indicates the location patterns of AMC accredited doctors. Most of those in the 'elsewhere' column (which covers all other places of training) would have become GPs via the AMC route. They are locating disproportionately in Sydney and Melbourne. Only 21.5 per cent of those registered since 1991 practise in non-metropolitan areas. On this record, to the extent that the large number of those in the AMC pipeline gain RACGP places they will simply add to the excessive concentration of GPs in Sydney and Melbourne.

Table 3: GPs billing on Medicare in 1995-96 by metropolitan statistical subdivisions[a] with low population-to-doctor ratios and number of services billed by doctors (percentage)

Statistical subdivision	State	Population per doctor 1995	Number of services billed (percentage of doctors)						Total doctors
			1-2000	2001-4000	4001-6000	6001-8000	8001+	Total	
Eastern	SA	338	11.0	5.4	8.4	6.8	68.3	100.0	643
Eastern Suburbs	NSW	431	15.5	8.3	11.2	6.0	59.0	100.0	529
Lower Northern Sydney	NSW	462	17.7	5.3	7.7	4.9	64.5	100.0	588
Inner Western Sydney	NSW	511	27.9	8.4	6.7	5.7	51.2	100.0	297
Eastern Inner Melbourne	Vic	551	27.5	9.2	13.9	3.3	46.2	100.0	273
Hornsby-Ku-ring-gai	NSW	632	20.7	12.0	4.1	1.8	61.5	100.0	392
Redcliffe City	Qld	646	15.6	16.9	7.8	5.2	54.5	100.0	77
Northern Beaches	NSW	673	14.2	7.1	6.8	4.3	67.5	100.0	323
South West Metro.	WA	688	17.9	6.9	5.6	7.5	62.1	100.0	375

Source: Data on doctors: Health Insurance Commission, unpublished; Population data: ABS Estimated Resident Population, 1995

[a] Not all low ratio metropolitan areas were listed because of problems in matching ABS and Health Commission boundary definitions, especially those in Victoria.

The Government's apparent success in slowing the rate of growth of GP numbers means that new registrants in the medium term will have even less incentive to locate outside the

metropolitan areas because there will be some abatement in the intense competition for metropolitan patients. The Coalition faces some major dilemmas on this account. In the absence of further measures to ensure a more equal distribution of doctors, the existing maldistribution will worsen. Table 3 provides further light on this issue. It shows the servicing patterns of doctors practising in areas with very high doctor-to-population ratios. Most of these GPs are located in the more affluent inner and middle suburbs of Australia's capital cities. If such persons were struggling to win patients we would expect to find them providing relatively few services. But the Table shows that at least half of the GPs with practices in these areas billed for more than 8,000 services in 1995-96. At the average fee charged currently of about $24[10] this is equivalent to a gross yearly income of at least $192,000.

The data confirm the common perception that, to attain such high billings in 'over-doctored' areas, there must be considerable overservicing. The unfortunate conclusion is that if so many GPs can flourish in such areas in present conditions they will be even less likely to move in the future unless the incentives to do so are truly princely.

Put simply, the Government's apparent success in dealing with its number one priority — reducing the number of doctors billing on Medicare — is likely to be achieved at the cost of its number two priority, that of achieving a fairer distribution of the GP workforce.

OPTIONS FOR REDISTRIBUTING THE GP WORKFORCE

Opinions polarise on this issue. On the one hand there are the critics who believe that the existing Medicare system is hopelessly flawed because there are no financial constraints on persons seeking medical services. Such critics are usually also opposed to the current private hospital insurance system because it does not put any restraints on servicing and because the community rating principle enforced by the Government allows older people to avoid insurance until they feel they are likely to need expensive hospital services. This situation implies a major public finance problem when the baby-boomers reach retirement. The advice from hard-line economic rationalists such as Professor Judith Sloan is to ditch 'central planning-type measures' in the health care arena, including bulk billing.[11]

On the other hand there are those who feel that public provision of health care without reference to private means is an important element in Australians' quality of life. Opinion polls have repeatedly shown most voters feel this way. Any Government or opposition party which proposed changes to the present arrangements, such as a mandatory co-payment for each service or, more radically, leaving the provision of medical services to the market-place, would be taking a grave electoral risk.

There are also grounds for concern about the outcomes should such options be pursued. In the US most retired persons receive basic health insurance (Medicare) financed in part through payroll taxes. Low income people and welfare dependents also receive medical assistance (Medicaid) financed by the Government. But all other persons must buy their medical services in the private market place just as the economic rationalists would desire. Most do so through private insurance. The result is a very expensive health care system accounting for about 14 per cent of US GDP in 1993 (compared with 8.4 per cent in Australia in 1995-96 and 6.1 per cent in the UK). One reason for this outcome is the proliferation of expensive specialist services such that only about 30 per cent of US doctors are 'primary care' providers (or GPs), compared with around 61 per cent in Australia.[12] Nor has a rapid increase in doctor numbers solved the cost problem (from the point of view of the consumer) or the distribution problem. Despite a sharp 36 per cent growth in the number of doctors practising in the US over the decade 1980 to 1990 (compared with population growth of nearly ten per cent)[13] there remain many rural and poor inner city areas which are

chronically short of doctors, particularly GPs. These areas have come to depend heavily on OTDs holding temporary entry visas, particularly doctors appointed to 'trainee' positions but who, in practice, dispense front line care within the public hospital system.

On this evidence, reform built around market place incentives hardly seems an appropriate solution. Ironically, the current trend in the US is precisely towards our 'centrally planned' health care arrangements. This is evident with the development of Health Maintenance Organisations or 'Managed Care' in which the insurer takes administrative control of the deployment and efficient utilisation of medical services, as well as of the collection of premiums and payment of doctors bills. In these organisations the emphasis is more on primary care by GPs or nurses than on expensive Specialists.

There is a strong political, moral, and perhaps efficiency, case for retaining the centrally administered Medicare system in Australia. But how can it be done so as to ensure a fair distribution of medical services without expensive financial incentives to the doctors required to relocate? The current Government has taken effective administrative action to reduce the supply of GPs. But if this 'solution' is not to exacerbate the distribution problem it will have to be accompanied by the rationing of Medicare provider rights so as to ensure that the reduced number of new GP registrants do not set up in oversupplied areas. The moral justification is clear. Currently the Australian community pays for most of the training costs for doctors and promptly pays all their service bills once they begin practising, thus ensuring high incomes by the standards of most other professions. Doctors do not have a divine right to bulk bill on Medicare wherever they please. They are in effect public servants. It is therefore not unreasonable for them to serve where they are actually needed, including within the hospital system.

LOCATING DOCTORS WHERE THEY ARE NEEDED

In the course of the House of Representatives debate on the Health Insurance Amendment Bill, his opposition 'shadow', Mr Lee, asked the Minister, Dr Wooldridge, how the Bill would help solve the maldistribution problem. As Lee put it, 'If there is already a shortage of doctors in some of the outer metropolitan areas, and we all know there is a shortage of doctors in rural areas — particularly at hospitals — how will this bill address that?'[14] No clear answer was given at the time, except hints about the allocation of more training places in shortage areas. Subsequently, while bargaining with the Democrats for the passage of the Health Insurance Amendment Bill in the Senate, the Government did address the maldistribution problem in the context of dealing with the protests of the 1996 interns and current medical students. While the measures proposed will not solve the distribution problem, they do set some striking precedents concerning the administrative location of doctors to shortage areas. The Government has foreshadowed the following measures:

1. The establishment of a Register of Medical Opportunity which would provide a 'safety net' for any recent graduates affected by the new legislation who were unable to find a training place or hospital employment. Under this proposal doctors who put their names on the Register would have the right of 'first refusal' to hospital positions before these were offered to temporary OTDs.

2. The allocation of 50 additional places in the RACGP rural training program in 1997 and 100 extra in 1998 and 1999. These places will be offered to recent graduates and presumably to those who pass the AMC accreditation exams but who have been unable to gain a training place. According to the Democrats this measure would tackle 'the shortage of GPs in rural Australia and in other disadvantaged areas',[15] while the Government claimed that in combination with measures one and three (below) the measures 'will encourage more doctors to work in country areas and provide better, highly skilled training for GPs. This will ensure

that all Australian will benefit and enjoy high quality health care.'[16] But, hidden in the small print (not mentioned in either press release), strenuous conditions are attached. All successful applicants for the additional places will first have to complete a four year training program within the RACGP rural training scheme and then promise to stay another six years in 'rural Australia'.[17] In effect, is a first step towards allocating scarce provider numbers to undersupplied areas.

3. A category of Clinical Assistantships for hospital positions located in shortage areas will be created which involve four year appointments, after which the doctor will be given preference in the allocation of training places by the RACGP. Again, this is an indirect administrative technique of ensuring more doctors initially serve in a shortage area. The impact at this stage will be limited since the intention is to offer only 50 of these clinical assistantships in 1997.

4. Another proposal under consideration is to allow doctors who have not completed the RACGP training program to take up locum positions as GPs in areas of need. Again, this measure in effect rations provider numbers to shortage areas.

The significance of these proposals lies in their role as precedents for a more radical administrative attack on the distribution of Australian doctors. In the absence of further measures, the maldistribution problem will worsen, requiring continued reliance on temporary OTDs. For example in Queensland alone, in 1995-96 the Medical Board accepted 380 'area of need' registrations, almost all which went to UK-trained doctors on temporary entry visas (up from 339 in 1994-95).[18] Judging by the large number of UK doctors showing in the earlier tables, most appear to have some rights to Medicare billing.

Indeed, it is unlikely that many of the additional rural training places or clinical assistantships will be taken up at all, given the locational strings attached to them. As the Government has itself noted, there are plenty of hospital jobs around which the minority of recent graduates who miss out on a training place can select from without tying themselves to employment in shortage areas.

Unless the Government acts more resolutely on this issue the outcome is likely to be a continuation of overservicing in metropolitan areas, continued complaints from rural areas about medical service shortages and, as a consequence, continued importation of temporary OTDs.

Australia is moving towards the two-tier medical workforce evident in the US where OTDs do much of the public, 'area of need' work and local graduates handle the better remunerated private work. In Australia the 'area of need' work seems destined to be the preserve of AMC-accredited doctors, the few local graduates who cannot find a training place, and temporary OTDs and Occupational Trainees. The latter, not previously mentioned for fear of making the story excessively complex, nevertheless should be drawn in at this point because of the potential parallels with their role in the US OTD workforce. In 1994-95, DIMA issued 450 visas for 'training' positions in Australian hospitals usually managed by one of the specialist training colleges, and 455 in 1995-96.[19] As in the US, most of these doctors come from non-Anglo source countries and are often involved in front line medical positions which the hospitals find difficult filling.[20]

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[16] Media Release, Dr Michael Wooldridge, 12 December 1996

[17] Ministerial statement on 'Democrat Recommendations and Government Response', Attachment A, 'Provision of additional rural GP Training places', 12 December 1996

[18] Medical Board of Queensland, answer to questions from the author, 1 October 1996.

[19] DIMA, unpublished. The numbers are probably higher because DIMA did not record about 15 per cent of the occupations of those granted visas for all occupational trainees — visa category 442.

[20] See R. Birrell, 'Immigration and the surplus of doctors', op. cit., p. 26 for details of early 1990s movements of occupational trainees, including birthplace.

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