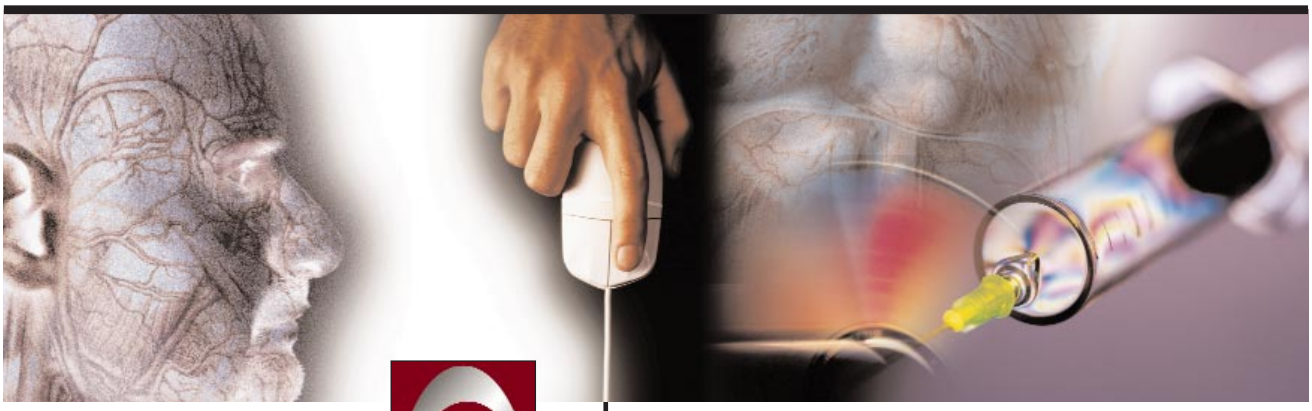
PRIMARY HEALTH CARE FOR ALL AUSTRALIANS:

An Analysis of the Widening Gap between Community Need and the Availability of GP Services



‘There is an acute and obvious shortage of medical manpower in general practice. It is virtually impossible to attract staff to general practice. Why are we not training more doctors?’

Comment volunteered in the AMA GP Workforce Survey 2001

A report to the **Australian Medical Association** by
Access Economics Pty Ltd Canberra ACT February 2002

FOREWORD

When there is a serious and widening disparity between a situation as portrayed by a government compared with day to day observations and anecdotes, it is time to start asking questions.

When I became aware, in late 2000, that the Australian Medical Workforce Advisory Committee (AMWAC) had concluded that there was a large surplus of GPs in urban Australia which more than eclipsed a rural deficit in GP numbers, I started asking questions because the feedback I was getting from AMA members, from community groups and from Members of Parliament, was that GP shortages are endemic and spreading. More and more communities are seeking 'area of need' classification to bring in overseas trained doctors, waiting lists are lengthening and doctors are expressing extreme frustration from overwork and an inability to attract professional support in the form of medical partners, associates and locums.

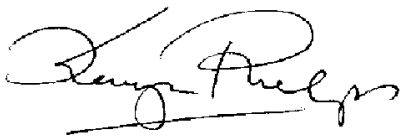
As a consequence of this apparent contradiction between the official version and my observations, I asked Access Economics to conduct a thorough survey of general practice and to provide the AMA with detailed analysis of the demand for GP services in Australia compared to the actual current supply of doctors and also to predict into the future what the likely supply/demand situation is going to be.

This report is not intended to target AMWAC. The AMA recognises that AMWAC operates within financial and political constraints and the AMA has recommended to the Government that AMWAC be given adequate resources and independence to carry out more in depth and broadly focussed analysis than in the past.

The reason for focussing on the AMWAC results in this report is because they have been a primary factor underlying the Government's GP policy which, the AMA considers, as a consequence, has been badly deficient, particularly in its treatment of the Relative Value Study.

Many people in rural and outer urban Australia are not getting the primary health care that they need and which I am sure society would like them to have. If this Report helps to establish a high priority for addressing this issue and focus GP policy on effectively enabling patients to receive the attention they need, it will be money well spent.

I commend this work by Access Economics as I believe that it will do much to inform the debate about primary care policies in this country. Also, I would like to expressly thank Mr Roger Kilham, Mrs Lynne Pezzullo and Mr James Allnutt for the efforts that they have put into this project.



Dr Kerryn Phelps
President
Federal Australian Medical Association

CONTENTS

1) EXECUTIVE SUMMARY

- *In recent years, based mainly on studies by the Australian Medical Workforce Advisory Committee (AMWAC), the orthodox view has been that Australia has an **overall surplus** of GPs, but a shortage in rural and remote areas. The primary findings of this investigation are that, contrary to this 'conventional wisdom', there is currently an **overall shortage** of GPs in Australia as well as a maldistribution;*
- *Shortages of GPs are by no means confined to rural and remote areas but are increasingly apparent in outer urban areas. Inner urban areas generally have an adequate supply, with only very few areas in surplus;*
- *These findings are supported by the GP Workforce Survey (conducted by Access Economics for the AMA in 2001), by a substantial body of anecdotal evidence and by the Access Economics GP Workforce Model;*
- *While the Australian community continues to express its support for Medicare, patients' expectations of access to GP services are not being met;*
- *Unless workforce policy settings are changed, the overall shortage of GPs will get worse. If that is allowed to happen, it will prove even harder to resolve the maldistribution of GPs and to meet community expectations;*
- *Short term ('band-aid') measures which have relied upon heavily in the past, such as recruiting temporary resident doctors (TRDs) and/or overseas trained doctors (OTDs), are losing their efficacy because of the greater international competition for qualified medical practitioners. These measures cannot be relied upon to the same degree for the longer term;*
- *There is a need for early action, and a comprehensive policy response is required. This may include the following elements:*
  - *Review and reallocation of health funding to areas of greatest need;*
  - *Remuneration (possibly differential rebates);*
  - *Demand-side initiatives (review of access to health care cards, patient co-payments);*
  - *Direct support (eg sabbaticals);*
  - *Increased GP training places; and*
  - *Support for complementary health professionals (eg., practice nurses).*
- *It will be important for Australia to achieve an appropriate, harmonious and effective 'policy mix' which addresses both the overall shortage and the maldistribution of the GP workforce.*

2) THE NEED FOR GP SERVICES

In this analysis of the GP workforce, we are not primarily concerned with the ***number*** of GPs. Rather, our focus is the supply of and demand for the primary care services that GPs provide. In this context, the number of services is itself an important indicator and one for which there are quite extensive measures. That said, the number of services is not a constant measure. Services can be of longer or shorter duration, older patients may need more time because of the complexity of one or more chronic conditions, and an episode of care may involve one longer consultation or two (or more) shorter consultations. Ultimately, therefore, we are concerned with the total supply of and demand for GP time applied to patient care. And this will include non face-to-face time as well as face-to-face time.

Section 2.1 presents our findings on the factors that are significant in explaining the ***demand*** for GP services. Section 2.2 isolates particular factors and illustrates the variability in demand for services arising from these factors. Section 2.3 discusses the distinctions between the ***utilisation*** of GP services, the ***demand*** for GP services and the '***need***' for GP services, and explains why the model is concerned with demand rather than 'need'. Section 2.4 describes the methodology used in this part of the GP workforce model.

2.1 What drives the demand for GP services?

Our findings are that the following factors are statistically significant in explaining the utilisation of GP services:

- Age/gender profile of patients;
- Socio-economic factors, aboriginality;
- Price of GP services;
- Supply of doctors;
- Rurality/Remoteness; and
- State/Territory.

Of the items in this list, most relate to the underlying demand for GP services, but the supply of doctors is of a somewhat different nature. It is included because there is an ever-growing body of evidence that there is unmet need for GP services, unmet simply because there are not enough GP hours being made available in aggregate. The links between the utilisation of GP services and the age, gender and socio-economic status of the patient are very strong. We have compared utilisation in particular geographic areas with predicted utilisation based on the demographics and socio-economics. It rapidly becomes apparent from the analysis of the 'outliers' there is a link between the availability of GPs in those areas and the utilisation of GP services. These outliers can be either side of the norm, with GP supply and utilisation above the indications or, more commonly, below the indications.

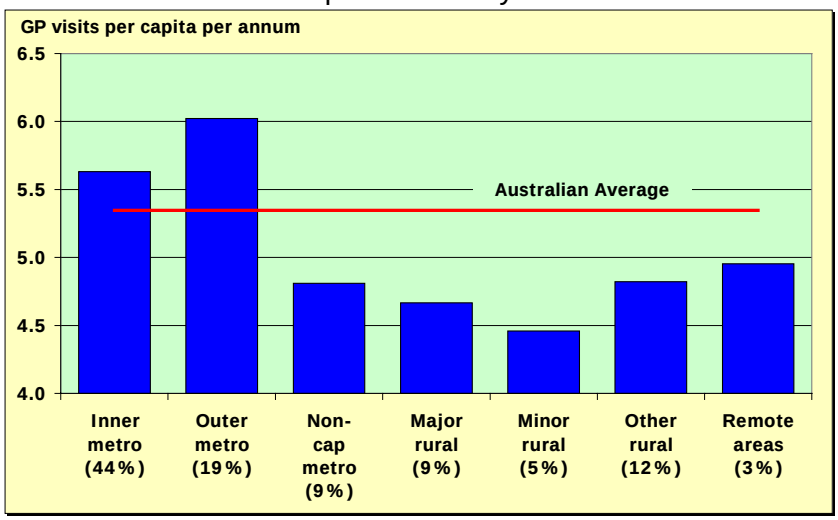
2.2 Factor-driven variations in demand

This section illustrates some of the observed differences in utilisation when aligned with demographic characteristics. When interpreting these data, it is important to keep in mind the interdependence of the various factors.

Chart 1 shows the impact of rurality/remoteness. The data are classified in RRMA categories with the following modifications:

- RRMA 1 (major urban) is split into two categories (inner and outer-metropolitan) as major urban utilisation is not sufficiently homogeneous to be handled sensibly as a single category; and
- RRMA 6 (remote centres) and RRMA 7 (other remote) are combined into a single category.

Chart 1: Impact of rurality/remoteness



The interpretation of this data requires sharp attention to the interdependence of the various explanatory factors. Outer-metropolitan utilisation is the highest in per capita terms, but that does not mean that utilisation is excessive. Rather, it indicates the poorer health status that is associated with the lower socio-economic ranking of those areas. Minor rural utilisation is the lowest, but that is much more a reflection of the various price and non-price barriers to service, including the shortfall in service provision, than an indication of a healthier sub-population. AMWAC assessed the adequacy of GP supply by benchmarking requirement in terms of utilisation in major rural centres (just 9% of the Australian population live in these centres). Utilisation in these centres is well below the Australian average. In section 3.1, we outline why we consider AMWAC's benchmark to be inappropriate.

Chart 2 shows the impact of demographics (age and gender).

Chart 2: Impact of demographics

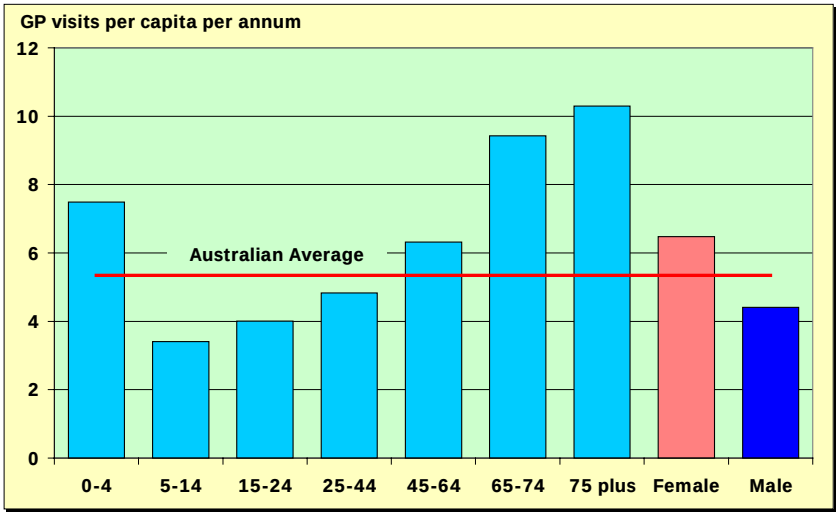
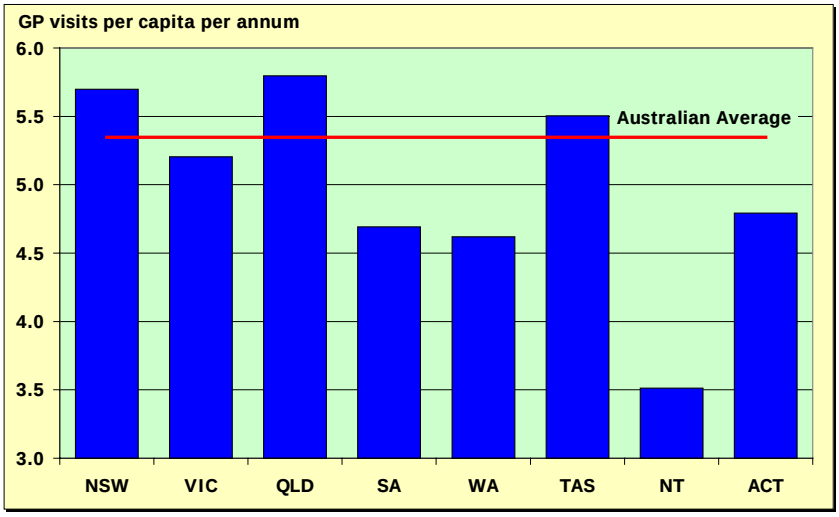


Chart 3 shows the impact of State or Territory of domicile.

Chart 3: Impact of State/Territory



Again, there are many interdependencies behind the differences in utilisation by State or Territory of domicile. Not all primary care services are billed through Medicare. The differences in utilisation which show up in the Medicare data narrow once account is taken of the institutional differences between States. For example, NSW may have gone further than other States in winding down hospital outpatient services and in seeking to discourage patients from regarding accident and emergency services as GP after hours services. Hospital based primary care services can be close substitutes for community-based (and usually, Medicare funded) GP services.

Similarly, the younger population in the Northern Territory does not fully explain the apparent low per capita utilisation there. It is well documented that Aboriginal people make much less use of the benefit entitlement systems (Medicare and the PBS) than the rest of the Australian population, for reasons that include lack of access. Aboriginal medical services (AMSs, which are directly funded outside the Medicare umbrella) may account for an increasing share of primary health care services for Aboriginal people, especially those living in remote communities. There may also be some substitution effects with community nurses in remote community undertaking some of the tasks that might fall to a GP in an inner urban area.

2.3 Utilisation, demand and 'need'

The distinction between the ***utilisation*** of GP services, the ***demand*** for GP services and the ***need*** of GP services is as important for analysis of the GP workforce as it is for policy formulation.

2.3.1 Utilisation

Utilisation is the volume of services that we can see, and measure, as being delivered.

There are some measurement issues with utilisation. In much of the analysis, we have used GP services billed to Medicare as a proxy measure for the utilisation of primary care. Without doubt, Medicare-billed services account for the major part. However, as indicated above, primary health care extends beyond services billed to Medicare. Some services

rendered in hospital outpatient and accident & emergency departments are also primary health care services. Other primary health care services may be rendered by medical practitioners but funded outside Medicare (eg, AMSs). GPs do not provide every primary health care service. Nurses also provide some of these services, and there are other paramedical services which, at least in the eyes of some patients, are regarded as close or direct substitutes for GP services. These can include chiropractic and natural/alternative therapies such as herbal medicine.

2.3.2 Demand

Demand is the volume of services that patients would prefer, but may not get due to price and non-price barriers.

Demand must first be estimated within the framework of the existing health financing system, in particular, within the framework of Medicare benefit subsidisation of access to GP services.

Were the health financing system radically altered—for example, through obligatory co-payments such as those applying under the Pharmaceutical Benefits scheme (PBS), or through front-end deductible insurance structures—demand would change. Different health financing paradigms would possibly produce quite different outcomes in terms of equity and access. These outcomes may or may not be acceptable to electors and to their parliamentary representatives.

It is possible that the Access Economics model could be used to throw some light on alternative health financing options, but if structural change is large enough, it becomes very difficult to obtain data useful for predicting the behavioural changes. Large scale structural change in financing will not only potentially affect the demand from patients, it will also affect the supply by providers.

Demand may include 'inappropriate' under and over-utilisation. It is not a simple open and shut case to define 'inappropriate'. One approach is 'medical necessity'. Plenty of work has been done, for example, in seeking to establish the appropriate frequency of Pap smears for women of various ages. It is quite well documented that men tend to be poor custodians of their own health, under-utilising GP services and not always admitting to symptoms. Some patients may access GP services more often than might be predicted on the basis of physical indications, but may need to do so for mental health reasons. Another approach is to look at the social norms (and it is important to note that these tend to change over time). A heavy cold may send some patients straight to the GP, while the majority might go to the chemist instead.

In estimating demand, we are not concerned to apply judgments as to whether the services that patients demand are 'appropriate' or 'inappropriate'. Demand is not something to be imposed on the patients, but rather it is what they want. There may be very sound public policy reasons for encouraging certain types of demand (for health prevention reasons, eg., immunisation) and for discouraging other demand. As noted above, we estimate demand within the context of the system as a whole, and that system is comprised of a series of positive and negative incentives (these include monetary subsidies as well as educational material designed to influence patient choices on when they ought to see a doctor).

There are, however, issues of ***quality*** and ***accessibility***—which encompass the number and average time duration of services that an individual can command. Demand can be specified in terms of population averages, but that can implicitly build in a degree of

rationing of services which occurs in areas where there are not enough GP services available. If demand is assessed in terms of the expectations of city dwellers, who have high access to GPs, then the overall outcome is greater than if demand is assessed in terms of the expectations of patients living in rural and remote areas.

Any attempt to measure demand will implicitly contain a quality benchmark. We argue that it is preferable for the quality benchmark to be specified. It, too, is an issue for public policy. Governments must constantly strike a balance between the quality and quantity of health services that can be provided and the overall affordability of the publicly funded health programs.

2.3.3 Need

Need is as much a matter of interpretation as it is of fact. From the viewpoint of the patients, need and demand are necessarily the same thing. However, there will be different (and varying) points of view from GPs, health professionals other than GPs, administrators and funders. Need as defined by stakeholders other than patients may include services that patients do not now demand (due to indifference or ignorance), and it may exclude services that patients do demand now.

It can be useful to define need from a clinical point of view, because it helps to inform public policy. As noted in the discussion of demand above, there are medical indications as to when a doctor should be consulted. Within the medical profession, there will be a range of views, of course, and this will apply to both curative and preventive services. There is nothing unique about professionals holding a range of views. A group of engineers might well have a similar range of views if considering the preferred construction technique for a bridge. There will be a degree of solid concordance based on a solid body of scientific evidence. Beyond that, there will be room for experts to disagree and there will be ground-breaking research extending the body of knowledge, but there will still be a consensus position.

It is less useful to have need defined by funders. Funders are primarily concerned with affordability. It is circular, but sometimes politically convenient, to argue that need is simply what the government or the financing system as a whole will pay for. Were the GP workforce planned around an assessment of 'need' by a funder, then we can be quite sure that there would always be a shortfall between supply and demand, and that the GP workforce would never be in equilibrium.

2.4 Methodology of the demand model

The demand model described here is an 'econometric' (estimated) model. It uses multiple regression techniques as these are the only techniques which cope effectively with the interaction of the various explanatory factors (age, rurality, socio-economic status, etc). It uses data based at the Local Government Area (LGA) level, but the results themselves can be applied to larger or smaller regions. The model produces very strong results, which is to say that it is statistically very robust and produces a very good 'fit' (a very good explanation of the impact of the various factors).

In addition, the coefficients (the variables indicating the strength of particular relationships) match those expected by anecdotal and clinical evidence. For example, the impact of age and sex on demand for services shows the same pattern as the AMWAC report, with above average demand for the 0-4 age group, the lowest demand at 5-14 and then a gradual rise as age increases. Similarly, increasing the cost of services leads to a decrease in demand.

The analysis also bears out the significant relationship between demand and socio-economic status, measured here by the ABS' SEIFA (Socio-Economic Indicator For Areas) variable.

The results of the modelling allow a determination of the base demand that would be anticipated in a region given its known demographic and socio-economic structure. This base demand can be expressed in terms of 'hours of GP time required' which allows a consistent comparison of demand required by patients and supply available from GPs.

3) THE AVAILABILITY OF GP SERVICES

The demand model allows us to compare the predicted demand for GP services with the current availability of GPs. The difference between the two represents the ***unmet demand***, from the community's point of view the ***unmet need*** for GP services. As noted above, within any assessment of demand there is an implicit quality benchmark being applied.

3.1 AMWAC's approach to the GP workforce

Government policy on GP training and financing has been heavily influenced by the 'conventional wisdom' that there is an overall surplus of GPs in Australia. This is based on the work of the Australian Medical Workforce Advisory Committee (AMWAC). AMWAC's most recent assessment of the GP workforce in Australia was published August 2000.[1]

The report concluded:

> "*In terms of adequacy of the GP workforce, the overall conclusion was that in 1998 there was a shortage of 1,240 GPs in rural and remote areas and supply in excess of benchmark levels of approximately 2,300 GPs in metropolitan areas*" AMWAC 2000.2, p. 2.

Thus, the net national surplus in 1998 was assessed as 1,060 GPs (or 700 FTE GPs). The unstated assumption of GP workforce policy seems to be that with the right sticks and carrots some of the surplus city GPs will move out into the country and all will be well. Such a conclusion would be significantly at odds with the results of this study which suggests a national shortage of GPs. Meanwhile, we observe the perpetuation of factors that are more likely to cause doctors to move away from areas of GP shortage than into them.

A key feature of the AMWAC methodology is the use of a 'lean benchmark'—the utilisation of GP services in major rural centres (RRMA3). As noted earlier, only 9% of the Australian population live in major rural centres, and GP utilisation in those areas is well below the Australian average (4.7 services per capita p.a.[2], cf. 5.3 Australia-wide). While there are a number of aspects of the AMWAC methodology that are of concern, the prime reason for the difference between the conclusions of this study and those reached by AMWAC arise from the differences in approach to the benchmark.

Once AMWAC had determined that GP supply in major rural centres represented adequate supply, by definition any area that had more GPs per capita than major rural centres (most of Australia) had an excess of GPs (excess to benchmark).

> "*The application of the benchmark approach to the calculations of the adequacy of regional supply was made on the assumption that the situation in large rural centres, as a whole, was acceptable as a benchmark for use in metropolitan and other rural/remote comparisons. Hence, the conclusions in adequacy reflect the situation in relation to the chosen benchmark.*" AMWAC 2000.2, p. 1

It seems to us that the key finding of the AMWAC report could be paraphrased as follows:

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1 AMWAC Report 2000.2, "The General Practice Workforce in Australia, Supply and Requirements 1999-2010", August 2000.

2 AMWAC uses different 'units of currency', expressing the benchmark in terms of patient encounters per standardised whole patient equivalent (SWPEs), but the margins are much the same.

If we could re-engineer GP utilisation so that it falls from the current level to a significantly lower level, then we would not need as many GPs as we have now.

Put in those mechanical terms, it is hard to dispute. But it is an entirely different question as to whether it would be appropriate, as a plank of public policy, to reduce GP utilisation to such levels. There would need to be, at the very least, a discussion of the likely health outcomes to inform any debate around that latter question.

In summary, we see two major problems in AMWAC's benchmarking:

- ***First, most Australians do not share AMWAC's view of adequate GP supply***.
- ***Second, AMWAC's assumption of the acceptability of the benchmark is not backed up with any analysis or justification. There is no evidence offered, for example, that the health status of patients in large rural centres is equivalent to that of city dwellers***.

3.2 Findings regarding shortfalls

Using the demand model we estimate that there is currently a shortfall of GPs of between 1,200 and 2,000.

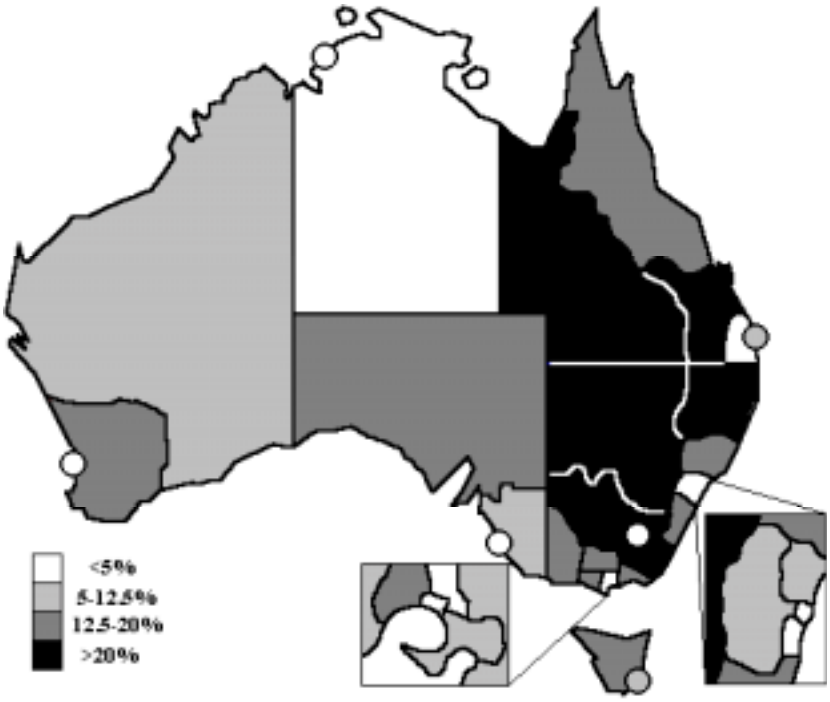
Chart 4 illustrates the lower end of the range. Under this scenario, the rural shortage is estimated at 700 FTE GPs and the urban area shortage at 500.

Chart 4: Areas of shortfall—view 1

Under this scenario, it is assumed that within any region, there will be scope to balance out any over or under-supply (through doctors moving or patient mobility). However, it is assumed that doctors in, say, inner Sydney or Melbourne will be reluctant to move to, say, Western Sydney or the Mallee. Of the estimated shortfall of 500 FTE GPs in urban areas, 350 is estimated to occur in Western Sydney, Newcastle and Wollongong. As the chart suggests, rural shortages are worst in inland NSW and Queensland. In percentage terms, the rural shortfall is 16% and the urban shortfall 3.7%.

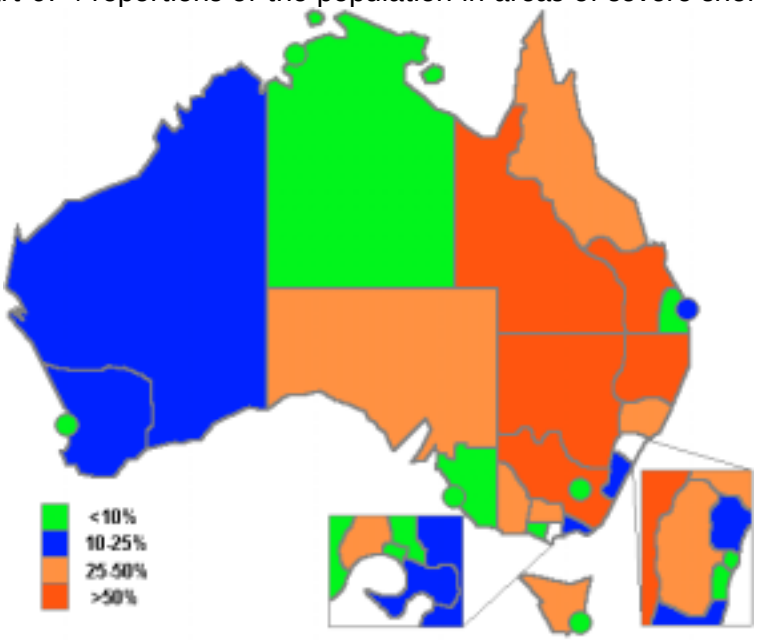
An alternative scenario (Chart 5) shows what happens when doctors are not mobile in moving to areas of shortfall. For example, doctors in Northern Sydney (an oversupplied area) are reluctant to move to Gosford (an under-supplied area in the same region). In this case, the rural shortage is estimated at 800 FTE GPs and the urban area shortage at 975, 1,775 overall. The urban shortages are relatively worse under this scenario because the doctor distribution is more uneven. In percentage terms, the rural shortfall is still the greater at 18% and the urban shortfall is 6.7%. Particular problems are evident in Western Sydney/Newcastle/Wollongong, Western Melbourne/Geelong and Brisbane/Gold Coast. Rural areas show a similar pattern in general, however the imbalance between Townsville/Cairns (sufficient GPs) and the rest of Far North Queensland suggests that there are problems in this area as well.

Chart 5: Areas of shortfall—view 2



Another useful insight into these figures can be gained by considering the proportion of people in each area who are experiencing a 'severe' GP shortfall (a shortfall of more than 20% cf. needs). This is illustrated in Chart 6. Just over one in five Australians (approximately 4 million people) live in areas of 'severe' shortfall. In urban areas, it is one in eight (13%), with the areas of greatest need being the Hunter, Western Melbourne, Western Sydney and the Illawarra. Nearly half the rural population (44%) live in areas of 'severe' shortfall. While the rural regions represent only one-quarter of the total Australian population, they account for half the areas of 'severe' need. Southern NSW is the worst affected area, with five in six (84%) living in an area of 'severe' need.

Chart 6: Proportions of the population in areas of severe shortfall



These scenarios are not the consequence of some sort of normative process about access to GP services. They do not seek to impose a view as to what is appropriate. Rather they reflect what we can observe about demand and combine that with various assumptions about the willingness of doctors to move to under-supplied areas. It is implicit, however, that we are adopting the demand 'benchmark' that comes out of our analysis of utilisation. We are not applying the 'lean benchmark' method favoured by AMWAC, a benchmark that is substantially below utilisation.

These estimates of shortfall are conservative for several reasons:

- The existing unmet demand may be influencing predicted demand (although we have tried to adjust for that);
- There may be 'pockets' of need that are hidden within LGA areas (AMWAC acknowledges this same issue in its work). This may be particularly important for Brisbane, where most of the city area is contained in a single LGA. Comparisons with Sydney and Melbourne would suggest that within the overall picture of sufficient GP numbers there are likely to be areas of significant shortfall; and
- There may be intractable 'stickiness' in GPs relocating from areas that are more adequately supplied to areas of greater need. This is an important issue. Effective policy measures to induce a redistribution of GPs within Australia require a very good understanding as to why GPs are reluctant to move to the areas of greater need.

It is very clear from the analysis that the shortages are not confined to rural and remote areas. There are also significant shortages in outer urban areas, often areas with a lower SEIFA index.

4) DEFICITS AND SURPLUSES IN GP SUPPLY

4.1 Overview of the AMA GP Workforce Survey 2001

A major focus of the survey was to establish the reasons for satisfaction and dissatisfaction in the GP workforce and the motivations for the number of hours supplied. Issues addressed included relative remuneration rates after practice costs, on-call hours, location, ability to 'get away', family and personal lifestyle goals, skills complexity and diversity, administration, surgery practices (such as bulk-billing), patient activity levels, consultation times, practice size and other factors. Also of interest were boundary issues, such as what might induce or discourage a GP from practicing in a rural area, or what might induce a GP to move into hospital employment or other non-GP activities.

The response to the survey was excellent, pointing to the growing recognition among GPs of the importance of workforce issues. More than 7,500 completed surveys were returned, over three times the expected response rate for a survey of medical practitioners. Many doctors responded with passion and detail, some submitting pages of written comments.

Were there an overall surplus of GPs in Australia, one would expect to see indications of under-employment and unemployment of GPs in their chosen profession. The survey uncovered no evidence of significant under-employment or unemployment in either rural or urban areas. Rather, GPs work long hours in all areas and generally would not want more patients.

Key underlying issues, reflecting the problem of overall GP shortage Australia wide, were:

- ***Relatively poor remuneration***—the average remuneration rate was $47.14 per hour before tax, quite low compared to other self-employed professional remuneration rates and to jobs requiring less responsibility, study, training and ongoing professional development (see Chart 7);
- ***Long hours***—FTE GPs work 53 hours per week on average, not including on-call (see Chart 8);
- ***Bulk-billing***—due to bulk-billing pressures and expectations, many GPs are facing a significant conflict between responsibility to the patient (quality of care) and their own survival, be it psychological or the financial viability of their practice;
- ***Rural conditions***—while many country GPs say they love their work, they are growing increasingly disillusioned and disenfranchised as a result of workforce conditions, and a significant number are voting with their feet; and
- ***Increasing complexities***—of training, accreditation and administration. The 'red tape' requirements on GPs are increasing exponentially.

Chart 7: GP remuneration ($ per hour before tax), 2001

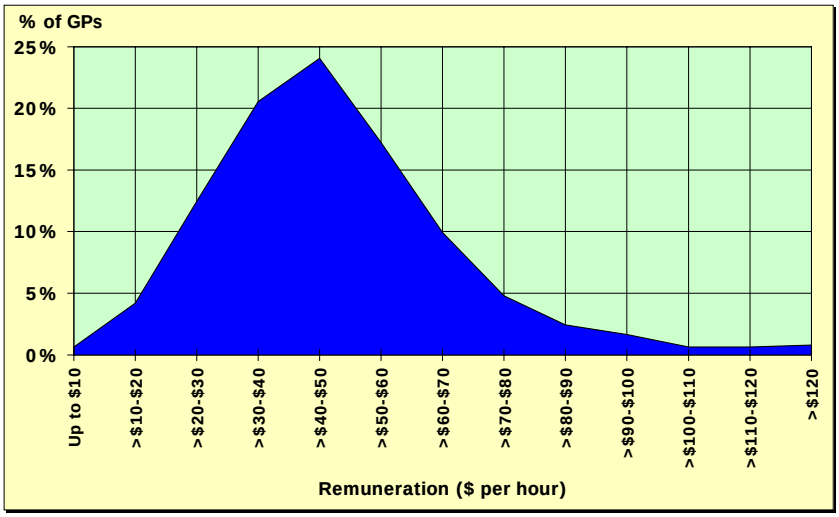


Chart 8: GP hours worked per week, 2001

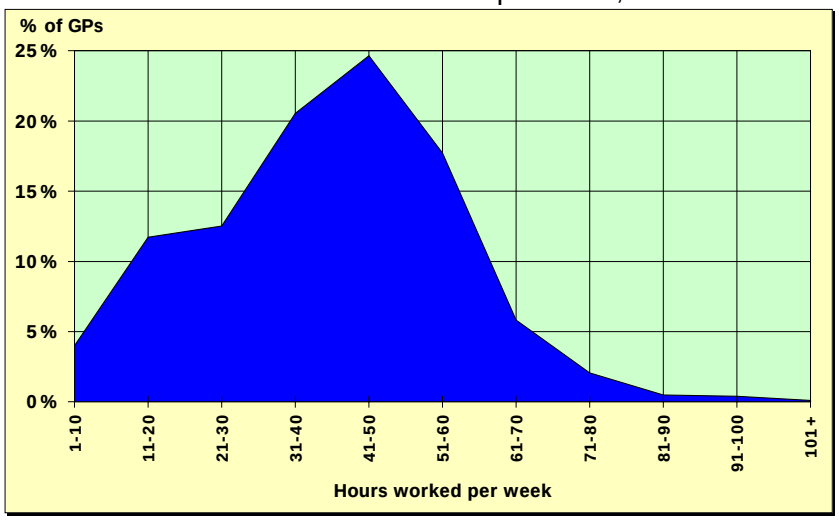


Table 1 outlines the key problems identified by GPs in the survey—with low remuneration the most common difficulty, and ranked the number one reason 43% of the time. Long working hours and conflict with family goals were the next most common issues, followed by difficulty getting assistance and administrative or management problems.

Table 1: Incidence and ranking of problems identified by dissatisfied GPs*

	Rank, as % of total				
Problem	**1**	**2**	**3**	**4**	**Total**
Relatively low remuneration	43.0	16.1	11.4	8.3	19.7
Conflict with family responsibilities/desires	10.7	15.3	18.7	18.8	14.6
Long or inconvenient working hours	11.0	23.4	14.4	12.4	14.0
Inability to take leave, find staff or locums	8.9	15.7	15.7	12.7	12.4
Administrative or management problems	7.5	10.5	12.5	14.9	11.6
Difficulty selling, retiring or changing job	3.3	4.2	7.1	10.2	7.1
Being on call too frequently	4.3	5.2	7.1	8.7	6.9
Social/professional isolation or lack of amenities	2.7	4.0	6.8	8.0	6.0
Under employment	1.4	1.4	1.9	1.8	2.5
Other	7.2	4.2	4.2	4.1	5.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

*GPs who ranked their satisfaction as 1 to 7 in the 2001 AMA GP Survey Question 8.

> *"A large percentage of bulk-billed patients are elderly with complex illness, taking more time in face to face consultations and organisation (letters, referrals, home visits, hospital admissions). The service provided is undervalued."*
>
> "*The impact of being on call on family life/social life is huge.*"
>
> "*I am very keen to move my family back to the city to take advantage of educational facilities for all of us.*"
>
> "*No locum nor replacement GP available in this region.*"
>
> "*Both partners due to retire—own practice—rural town—cannot find anyone to take over—will just have to close our doors after 40 years.*"
>
> Comments volunteered in the AMA GP Workforce Survey 2001

4.2 Why are there deficits in rural and remote areas?

For country GPs, issues such as spouse's career, children's schooling options (particularly later years schooling), long hours with lack of relief and lack of specialist support, isolation and indemnity issues are perhaps as significant as remuneration issues or even more so. All these 'push' factors increase with remoteness, although large rural centres are seen by many GPs as having the best of both worlds (most of the advantages of urban areas with few of the disadvantages of remote areas).

Work intensity—The AMA Survey revealed that GPs frequently perceive huge disadvantages in country practice, many from the point of view of hindsight. They view the long hours, especially after hours, on-call hours and lack of holidays, with lack of locums or relief—'never off duty'—as a fundamental difficulty, causing stress and burnout. Greater work intensity is also due to the greater diversity and skills challenges of rural work, with emergency and hospital work particularly stressful. There is limited hospital, specialist, technological and allied health back up, generating problems of professional and personal isolation, which increase with remoteness. Many GPs view rural or remote work as underpaid relative to the responsibility, with a 120% loading on top of the current rural remuneration rate required to attract the average urban GP to the bush.

Family conflicts and costs—Partner's career, children's schooling and lack of family support are big issues, markedly so for single mothers. As children grow older, there is a substantial problem with education, in terms of the cost of boarding school (around $15,000 p.a.) and university accommodation ('running two houses'), as well as family separation. At this stage, many GPs move back to the city. Discontentment of partners is also often seen as 'unsustainable', necessitating a move back to the city. Separation from extended family and friends can be a problem for young or single people. These issues were mentioned in two thirds of responses to the survey and were non-negotiable—'wouldn't go for any money'.

Business difficulties—Small business administration (often without IT or other support), difficulty getting partners or selling a business, higher practice costs in many cases, lack of capital appreciation and red tape (eg Trade Practices Act) are also barriers to rural GP supply. Medical indemnity insurance premiums (and associated anxieties) are increasingly prohibitive, especially for obstetric and rural procedural work. Maintaining the required variety of skills is difficult given the cost of travelling (and lack of access) to continuing medical education (CME) and other training.

Lifestyle and other factors—Many GPs perceive the rural lifestyle to be lacking in social choices, amenities, and peer interaction—isolated, parochial (the 'small town' mentality), yet lacking anonymity (the 'goldfish bowl' syndrome). This is particularly true for minorities.

Many GPs are unable to pursue their secondary interests in the bush (eg., academic or research pursuits). Other barriers are the lack of access to adequate childcare especially after hours, higher levels of community expectations, the cost of travel, and the difficulty of working part-time.

4.3 Why are there deficits in low income areas?

Despite the growing shortages of GPs in socio-economically disadvantaged areas, bulk-billing rates remain high. This is most notable for GPs working in outer urban areas with a low SEIFA who are under constant pressure to make ends meet—bulk-billing jeopardises their ability to provide quality care to patients, but because of entrenched patient expectations there is often no or little pricing option. They lose heart, leave and are often not replaced.

Most doctors in lower income areas, particularly on the urban fringe, bulk-bill because they feel forced or pressured to do so. In some cases this is because it is the policy of the practice in which they work—increasingly true with corporatisation, the proliferation of medical centres and feminisation (more part-timers together). Others buy into a bulk-billing practice—or establish a practice with a philosophical commitment to bulk-billing—and would lose patients if they changed policy, particularly in areas of high demographic concentration, or where there is a hospital A&E nearby to take the spill-over. They are left with patients who present with relatively trivial issues (repeat scripts, coughs etc), but who use a private billing doctor for long or complex issues ('doctor-shopping').

Many comments in the survey observed the erosion of patient loyalty arising from the belief in a 'right' to free care, especially from the proliferating number with health care cards ('HCC creep'), although patients tend to have little knowledge of either rebate levels or health costs. The lack of a price signal leads not just to trivial presentations but to GP de-skilling, devaluation and 'all hours over-servicing' such as the 'toe bunion that must be seen at 10.30pm and bulk-billed'. GPs feel they have to take on an educational role, and have become the meat in the patient-government sandwich.

> "*Patients expect bulk-billing but, to spend adequate time with them, remuneration is inadequate to meet costs. I feel I should have been a plumber or electrician to meet my family's financial requirements and time demands*."
>
> Comment volunteered in the AMA GP Workforce Survey 2001

By far the greatest reason for bulk-billing (and hence lower remuneration) stated in the AMA GP Survey, rested on the practice being located in an area of genuine need—aged, unemployed, working poor, disabled, students, drug and alcohol patients. Any private bills would just not be paid, and chasing them would not be cost-effective. Many GPs fear for the health outcomes of patients, particularly children, who may not be able to afford to come if they were not bulk-billed. These patients' needs tend to be long and complex, attracting the least returns in the MBS system.

The dilemma is that many GPs are inherently 'helpers' by nature who try to alleviate suffering, yet become entrapped in their own compassion. A surprising number cross-subsidise some of their patients' health completely, either by higher private billing for wealthier patients, or by doing better-paid work elsewhere part-time, or sometimes simply charity from their own or their partner's pockets.

While some patients who present are genuinely needy, an increasing proportion of patients feel entitled to welfare. This puts GPs in a difficult position having to decide who is

genuinely deserving and who could afford to pay. They would prefer to practise medicine rather than determining social policy. Yet they may be berated or mistreated if they refuse to bulk-bill. These social factors have become entrenched over the late 1980s and 1990s, resulting in the surprising anomaly of high bulk-billing rates together with both very high demand and relatively poor GP remuneration.

GPs in outer metropolitan areas believe the situation has deteriorated to such an extent that it has become largely untenable. Only two doctors said 'competition' impelled them to continue bulk-billing, while hundreds reported they are gradually increasing their private billing or, more often, ***moving to a location in a higher SEIFA area where they feel comfortable about private billing and which is worth the change in terms of the ability to practise quality care and maintain self-esteem***.

GPs would rather re-locate to a higher SEIFA area than try to charge lower income patients on the outer urban fringe.

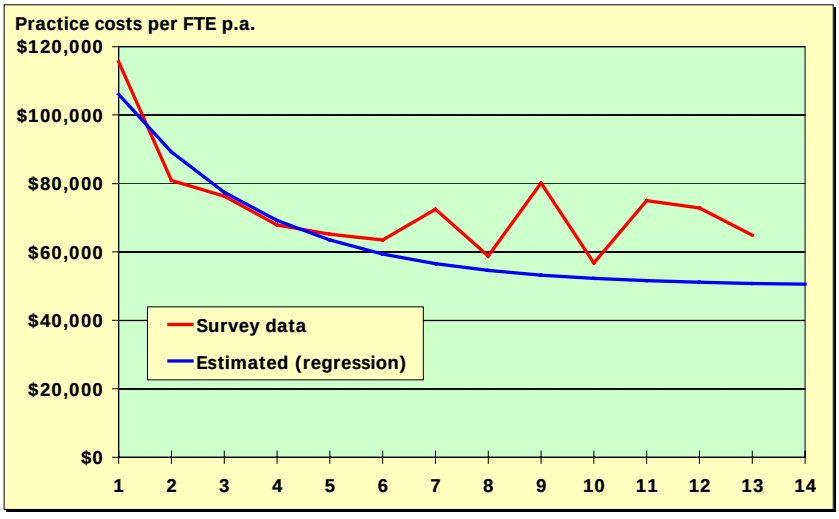
4.4 What is the relative attraction of inner urban areas?

Inner city areas may attract an adequate supply of GPs because remuneration is better and practice is relatively 'easier'—there is ready referral of patients to specialists and acute hospitals, less pressure to bulk-bill, and greater ability to provide quality care with commensurate higher job satisfaction.

After analysing the 'push' factors from rural and remote general practice and from outer metropolitan lower income areas, it is not difficult to locate the relative pull of the 'inner' city (middle to upper income suburban) practice. It is no surprise that corporatisation activity is most intense in these high catchment areas, where conditions are ideal to co-locate multiple part-time or full-time GPs and thus achieve the economies of optimum practice size. Equally, it is no surprise that there is no sign of corporate activity in the 'one-doctor' towns where these economies of scale are not available.

The AMA GP Survey identified practice costs as falling significantly from a solo practice to a two-doctor practice, and continuing to diminish with increased practice size, although after six FTE GPs the data limitations made the relationship unstable. Econometric estimation suggested, however, that there were very limited gains in practice expansion past eight FTE GPs (see Chart 9).

Chart 9: Relationship between practice size and practice costs



5) LONGER-TERM DEMAND PROJECTIONS

Based on our analysis of the age and gender-based demand for GP services, we can project the likely future demand for GP services based on the expected demographic structure of the population.

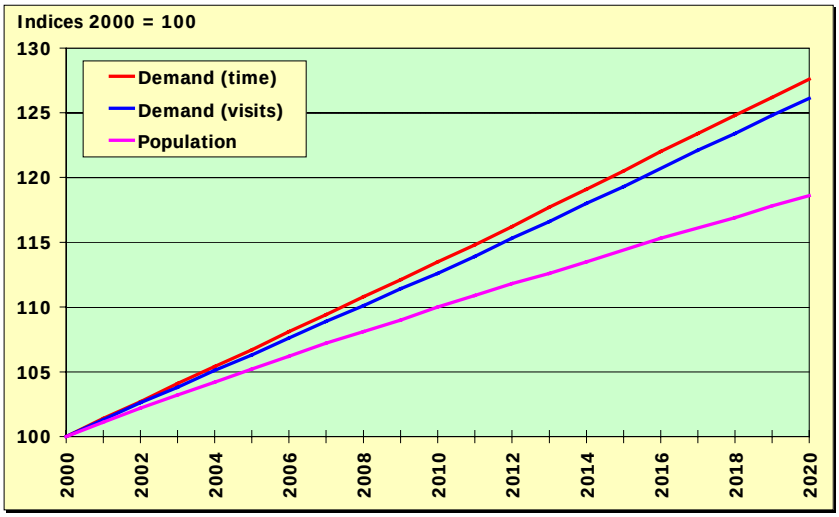
The projections are based on the Australian population projections published by the Australian Bureau of Statistics (ABS). The ABS takes account of projections of trends in birth rates and death rates as well as various assumptions about Australia's net intake of migrants.[3] Our projections are based on the ABS 'central case' assumption regarding net migration to Australia. There are a couple of cautionary issues to note here, but they do not justify any large concern:

- Proponents of higher migration intakes look to one of the outcomes as being a younger population than would otherwise be the case. Were there a policy change in this area, the demographic structure would be a little different and our projections of the demand for GP services would be a little lower within the 20-year horizon of the projections; and
- If, for example, there were a sharper decline in the birth rate, we would see an older demography in the future and our projections of the demand for GP services would be a little higher within the 20-year horizon of the projections. Countries such as Italy have seen a sharper fall in the birth rate than we have seen in Australia to date, and this may be a foretaste of what could happen here as members of 'Generation X' make choices between family, lifestyle and career.

There are two issues to note with the future demand for GP services of an ageing population. First, elderly people consume more services per head of population, so the number of services required grows faster than population. Second, elderly people present with more complex health problems and with more chronic conditions that require management. Hence, consultation times are longer than for younger people. Combined with the larger number of services for elderly people, this means that average consultation times of all GP services are increased. Therefore, the total supply of GP services, expressed in terms of hours of service, grows faster than the nominal growth in the number of services. This is illustrated in Chart 10.

[3] The ABS also produces State by State figures which rely upon assumptions about internal migration, but our analysis is not affected by this factor as we are looking at the age and gender structure of the whole Australian population.

Chart 10: Future demand for GP services

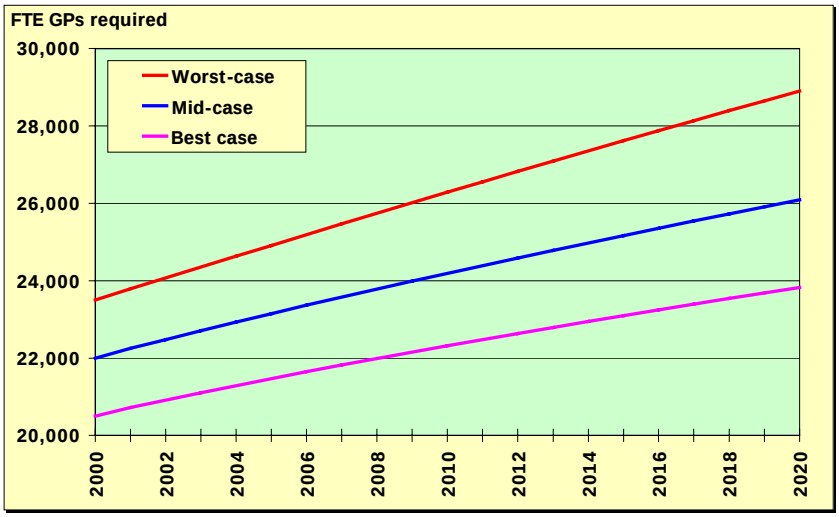


We estimate that the demand for GP services based on an ageing population will increase by 1.27% p.a. over the next 10 years (and 1.23% p.a. if the horizon is extended to 20 years). AMWAC has projected that the requirement for GP services will grow by 1.13% p.a. over the next 10 years. This is very close to our projection of the growth in the number of visits over that period. AMWAC has not made any allowance for the higher intensity of services required by older patients.

As noted above, the future demand for GPs will depend upon the quality and access that patients aspire to (but in the context of the health financing system broadly as it is). The expectations of Australians in regard to access to health care services (including access to the latest technologies) were lifted by the introduction of Medicare and have continued to rise.

Chart 11 illustrates three demand scenarios for the required number of GPs over the next two decades. These use ABS forecasts for both growth in the number of Australians, and the change in the age structure of the population—a trend that will lift demand for GP services more rapidly than the number of people. We assume that GPs themselves will be willing to offer the same number of hours of work as at the present time—an assumption that may understate the size of the problem confronting the health sector.

Chart 11: Three demand scenarios



It is worth reiterating here that we have defined GP demand and supply in terms of the total number of hours of clinical work. In Chart 11 above, this is translated back into the more recognisable number of FTE GPs. The total number of GPs Australia will require is further influenced by average hours worked. Were these to decline (expected with feminisation), the total number of GPS that must be trained or recruited will be higher again.

6) MODELLING GP SUPPLY

6.1 Overview of the supply model

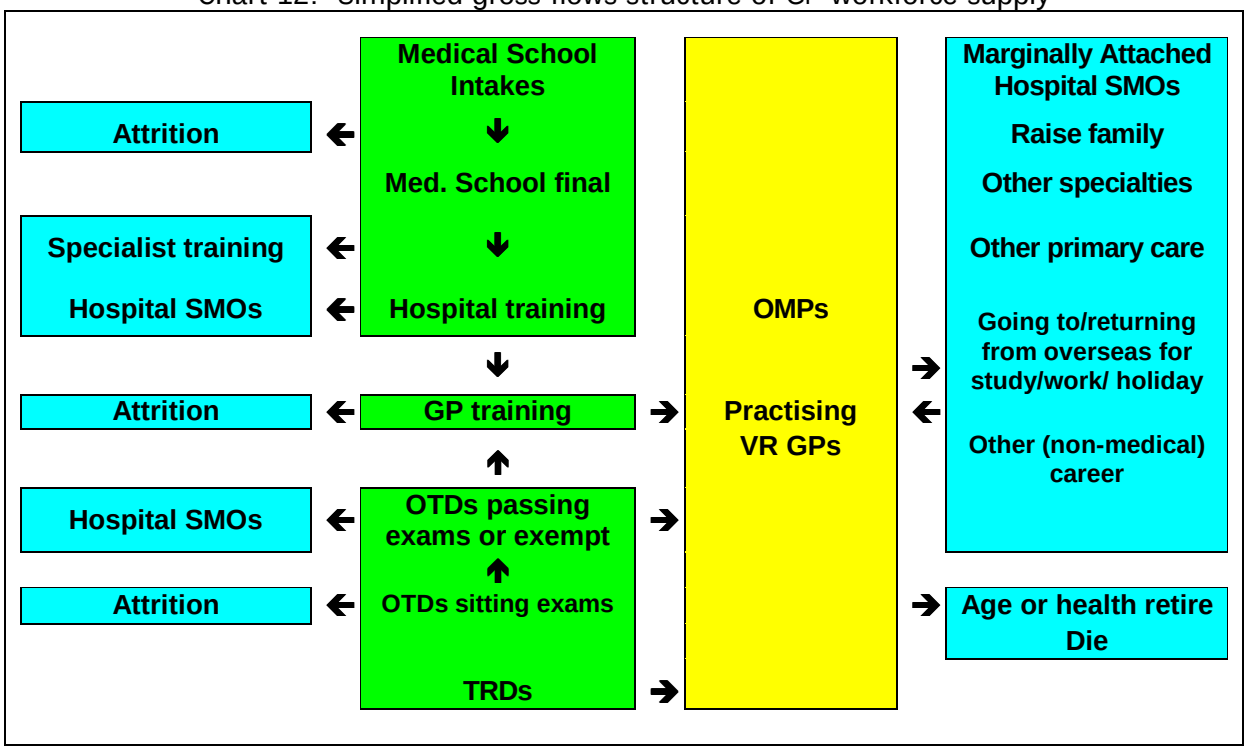
The supply model is a calibrated, gross flows model which tracks GP career paths over the working life cycle of the GP. It allows us to analyse and predict the outcome of policy settings and the demographic composition of the workforce including influences such as the feminisation of the workforce.

Chart 12 shows the flows into the vocationally registered workforce from two sources:

1. Medical school, through the early years of hospital training and RACGP training (all with associated attrition); and
2. Overseas, via the route of AMC examinations or via recruitment of temporary resident doctors.

There are leakages and re-entries at different phases of the life-cycle to pursue other study or work, to raise families, to travel or return overseas, or because of illness, retirement or death. Effects of workforce feminisation and rural recruitment and incentive schemes are factored into the model.

Chart 12: Simplified gross flows structure of GP workforce supply



While workforce demographics and other factors place a role, GP supply is dominated by the very important Government policy 'levers':

- Control over price through the indexation of MBS rebates;
- The numbers of medical school intakes and RACGP training places; and
- The number of overseas trained doctors (OTDs) and temporary resident doctors (TRDs) recruited from abroad.

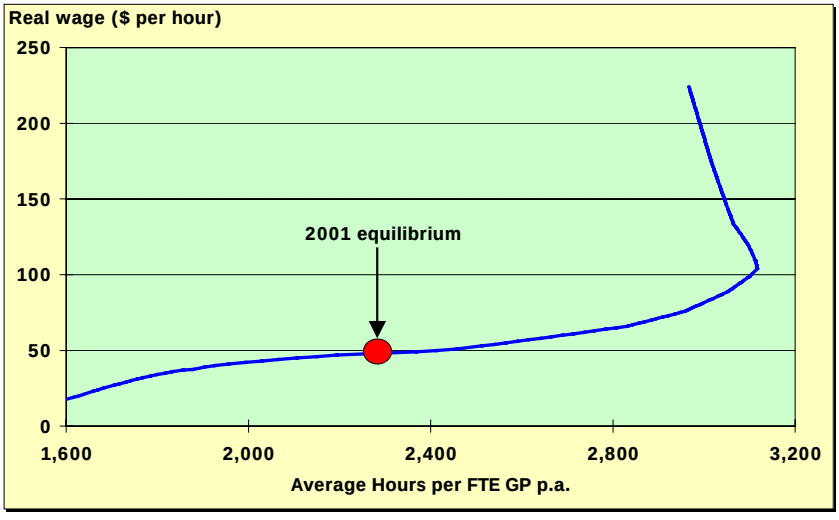
Importantly, supply is not just a function of doctor numbers, but also of how many hours doctors are willing to work. In this context, one purpose of the AMA GP Workforce survey was to elicit GP stated preferences for preferred work hours at various rates of pay. This allows us to assess how changes in remuneration may operate to provide positive or negative incentives (for the provision of increases or reductions in hours worked). It also helps us assess likely demographic change in the workforce, as female GPs are willing to supply less hours of services at each remuneration rate.

Through the 2001 GP Workforce Survey, the AMA has started the collection of data on the real remuneration rates that underlie GP workforce supply. Previous workforce policy and research has largely neglected this important supply side determinant. AMWAC takes no account of the price of GP services in its projections of supply.

7.6% of the surveyed GPs were not currently participating in the workforce. For those participating, the spectrum of hours worked providing primary care was broad, ranging from 2-3 hours per week, to more than 100 hours per week. The economic underpinning for these divergences was largely based on opportunity costs given preferences, both financial and non-financial. Aggregating these preferences across the workforce yields the average supply curve shown in Chart 13.

As is expected, the GP labour supply curve bends backwards. When the starting point is a relatively low rate of remuneration, providers are sensitive to percentage increases in the remuneration rate and will respond to the incentive by increasing their hours worked. Similarly, if the remuneration rate is reduced, there will be a response of reduced hours worked. In this part of the curve, supply is 'elastic'. As the remuneration rate continues to rise, however, and because there are a limited number of hours in a week, the trade-off between leisure and earning more becomes tougher (more inelastic), to the point where people will eventually work fewer hours at higher remuneration rates, being content to simply maintain income and to preserve or increase leisure time.

Chart 13: Long-term supply of GP services, 2001



The GP supply curve shown in Chart 13 is elastic below about $65 per hour, after which it becomes increasingly inelastic. It bends backwards as the remuneration rate approaches $120 per hour.

The important implication for workforce policy is that increased remuneration can be part of the solution to the problems both of overall shortage and

maldistribution of GPs, without the need for the more expensive and more time-intensive process of training new doctors. The current 'equilibrium' supply point is indicated by the black dot, which represents FTE GPs supplying the 2001 norms of 2,285.3 hours per annum at $47.14 per hour.

The number of GPs and the average hours supplied for different five-year, age-gender rural-urban demographic cohorts are thus brought together in the supply side model, a function of the real remuneration rate as well as the inherent policy lever constraints. The model is able to depict the current workforce structure and forecast future structure and the total hours of GP services supplied at any given remuneration rate. The following paragraphs (Section 6.2) describe the base case for the long-term GP workforce supply projection, including the parameters that have been used. Section 7 brings together the long-term demand and supply projections and illustrates the structural imbalance implied by current GP manpower policies. Section 8 illustrates a number of supply-side scenarios and draws out policy implications.

6.2 The base case long-term supply projection

The base case long-term projection of supply is the projection that reflects current manpower policy settings. Governments do not always articulate current policy with full clarity and may indeed rely on some ambiguity to deflect interest.

We define current GP manpower policy settings as follows:

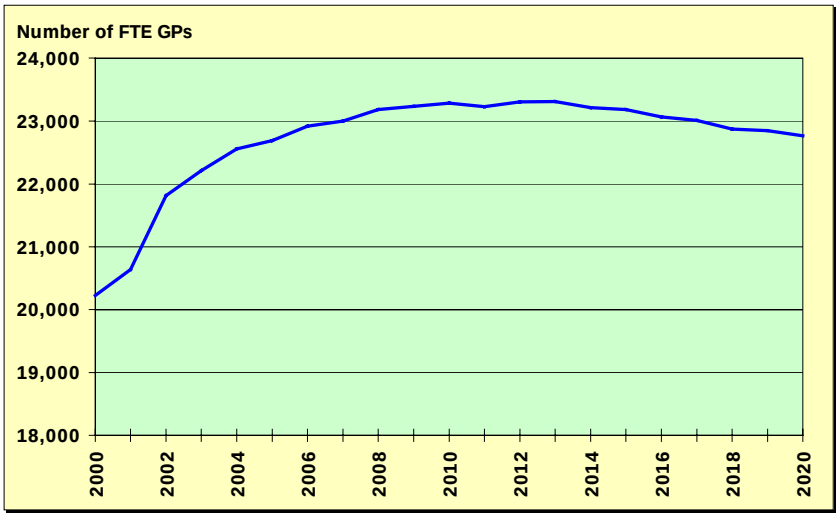
- RACGP training places of 450 in 2002, 200 in the rural stream and 250 in the general stream, each set to grow with the total population—that is, about 1 per cent per annum currently but tapering off with ABS forecasts over the 20-year projected time horizon;
- A continuation of the current levels of net inflows of OTDs (200 per annum in the 35-49 year age groups) and of TRDs (50 per annum in the 30-39 year age groups), with these doctors initially going to rural areas, but with attrition over time to urban areas and back overseas;
- GP rebates indexed by the Department of Finance and Administration's Wage Cost Index 5 (WCI5); and
- Other assumptions including practice size set to increase to 4 FTEs by 2020, productivity growth at 0.3% p.a., bulk-billing rates a function of real prices, constant average consultation times and no net outflows of Australian doctors abroad.

These parameters are combined with:

- the expected feminisation of the workforce based on recent trends—such that the number of females in medical intakes is increased to 60% by 2010, from 57% in 2000, and then stabilised; and
- the expected effects of rural streaming—such that 20% of medical intakes are rurally streamed by 2010, from 16% in 2000, and then stabilised.

The outcome is reflected in Chart 14, which shows an initial increase in FTE GPs in 2002 and 2003 who are responding, through increased hours, to the higher real remuneration rates derived from pump priming MBS rebates in 2001. However, if the rebate increases are not sustained, and given the assumed continued constraints of medical school and RACGP training places and the limitations on doctor imports from abroad, the supply of GPs begins to taper off mid-decade, falling after 2010.

Chart 14: Projected supply of FTE GPs available, 2000-2020

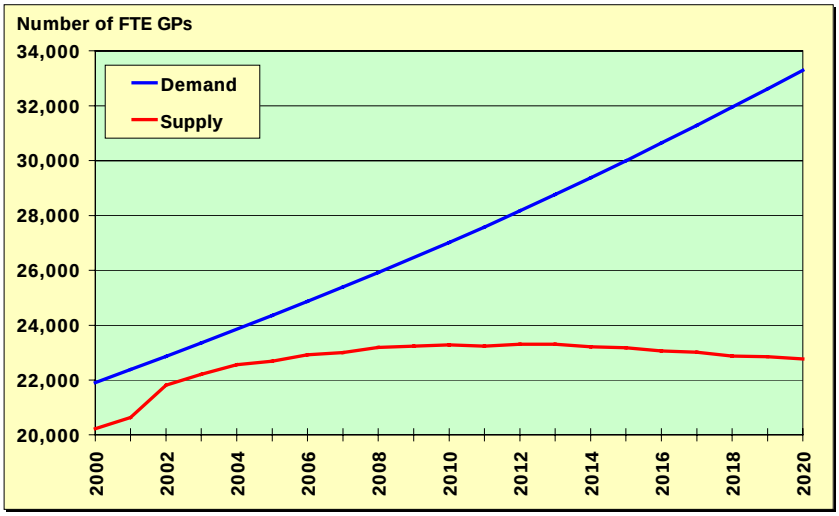


7) PROJECTIONS OF DEMAND AND SUPPLY

As noted in Section 3.2 above, there is currently a shortfall between the requirement for GP services and the current supply. This current shortfall is large enough to warrant an immediate policy response. If early action is not taken, the problem will get progressively worse. Under current government policy settings, current and prospective intakes of GP trainees, TRDs and OTDs will barely be enough to maintain the existing supply, and certainly not enough to match the growth in requirement which is projected to increase by 1.23% per annum on average over the next 20 years.

Were the current policy settings maintained for the next 20 years, the theoretical shortfall in service provision would amount to 19 million GP services p.a. (roughly equivalent to 10,500 FTE GPs). This gap is illustrated in Chart 15.

Chart 15: Long-term projections of demand and supply (policy unresponsive)



Here we would emphasis the word 'theoretical'.

In practice, a gap in service provision of this scale will not be experienced in Australia. Community and electoral pressure for a resolution would become simply irresistible long before 2020, and would overwhelm any government that tried persistently to ignore the issue.

8) DISCUSSION OF POLICY OPTIONS

8.1 Exploring the policy options

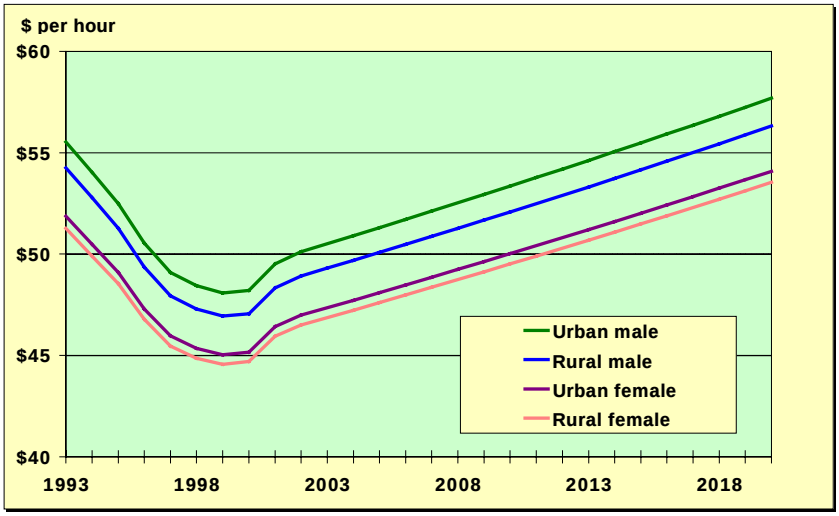
The supply model allows the simulation of policy measures to facilitate an equilibrium between supply and demand. To elucidate the issues confronting effective workforce policy, we illustrate scenarios based on adjusting GP remuneration, relying on overseas trained doctors/temporary resident doctors or increasing local training of GPs.

8.1.1 GP remuneration

Our research establishes the extent of price elasticity in the supply of GP hours at current rates of remuneration.

The theoretical pricing policy needed to match supply to expected demand is for GP remuneration to be increased in real terms by 0.8% p.a. for each of the next 20 years. The real remuneration rates thus implied are illustrated in Chart 16.

Chart 16: Average real GP earning rate (after costs)

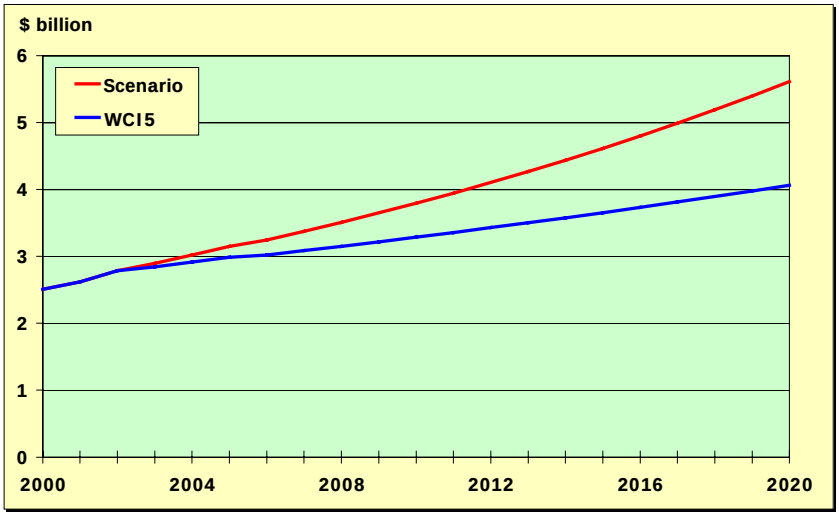


Several points must be noted in regard to this scenario:

- Remuneration alone is unlikely to achieve equilibrium. Within the 20-year timeframe of the scenario, we will 'hit the wall' of simply not having trained enough GPs. There is just not enough latent supply available, that is, not without relying on remuneration to keep an increasing number of GPs in the workforce long after normal retirement age;
- Stated preferences are a very useful way of analysing the supply that might be achieved with the current workforce, but the method has its limitations. GPs may be prepared to trade off leisure for more income in the short term, but may eventually find that the very long hours of work are not sustainable. We do need to keep in mind here that GPs are already very hardworking, with average hours for FTEs up around the 53 hours a week level;
- The remuneration scenario is costly compared with the current baseline of indexation using the Department of Finance and Administration Wage Cost Index 5 (WCI5). Chart 17 illustrates the likely cost difference (over $1.5 billion per annum by 2020). The community of taxpayers may simply be unwilling to pay the expected amount for primary care services, in which case we might expect to see structural changes in the health financing system. These would almost certainly see some transfer of the

financial risks from taxpayers to the household sector, in which case patient demand would be modified in one way or another.

Chart 17: MBS costs for remuneration options

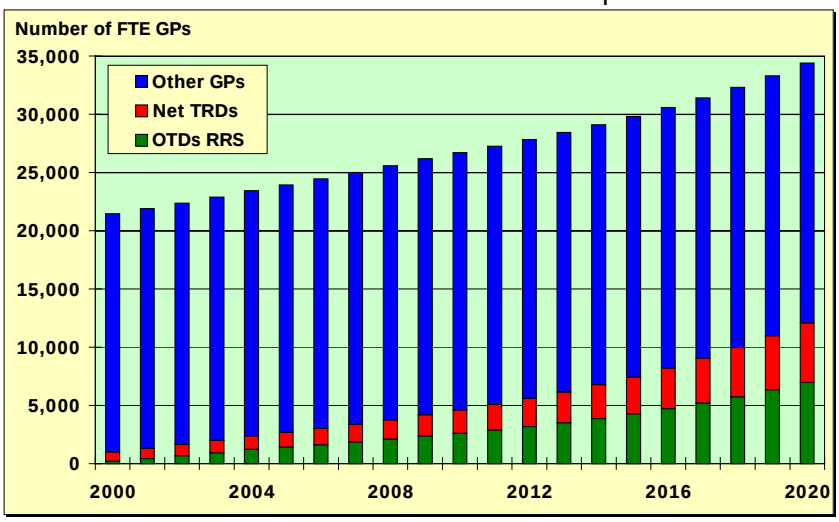


The experience of recent years confirms that indexation based on WCI5 (and before that, half indexation based on WCI5) is simply not a viable way of pricing GP services. And, indeed, the policy has not been sustainable in the context of the current financing system. In summary, a sensible approach to GP remuneration rate (one that ensures that there are appropriate incentives for the provision of quality care) will have to be part of the solution to the growing gap between needs and availability. However, remuneration alone cannot solve all.

8.1.2 OTDs/TRDs

The supply model allows us to simulate the number of OTDs/TRDs that Australia would need to recruit to achieve an equilibrium. The results are shown in Chart 18.

Chart 18: OTDs and TRDs to meet requirements



The expansion required is massive. OTDs and TRDs would have to increase by 10% p.a. in every year through to 2020. By then, we would be needing net inflows of some 2,600 annually—say, nearly 2000 OTDs plus net inflows of nearly 600 TRDs. This net inflow would

represent nearly five times the intake of locally trained GPs (through the training programs). It seems highly unlikely that this scenario would prove workable:

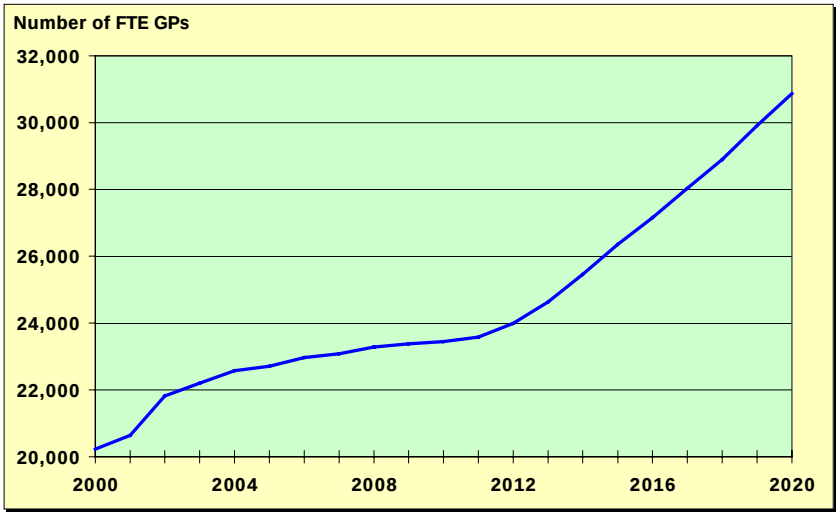
- There has been a build-up in the international competition for medical practitioners. Currently, both the UK and Canada have shortages and are seeking to recruit from Australia. At the same time, Australia is continuing to try to recruit from overseas[4];
- As this competition intensifies, simple demand pressures will push up the remuneration that medical practitioners willing to move country will be able to demand. The recruitment of OTDs/TRDs may cease to be the 'cheap' option;
- There is growing pressure from the poorer countries who can ill afford to lose their own skilled professionals, be it in health care or other areas of their economies.

In short, it is not viable to try to avoid the costs of training doctors by poaching doctors from elsewhere.

8.1.3 GP training

The supply model allows us to simulate the inevitable lags in training, given that any significant expansion of GP training focused on locally grown doctors would need to start, first of all, with an expansion of undergraduate numbers. Chart 19 illustrates the theoretical response to an immediate step-up in training, starting with undergraduate training.

Chart 19: Lagged GP supply under the training option



The feasibility of this option is also open to very serious questioning:

- It would be extremely difficult for the universities to command the financial and human resources that would allow the large increase in medical school places from 2003 (as this scenario requires). There would be a greater chance of winding up GP training programs given the forewarning. There will be sturdy costs at both undergraduate and graduate training points;
- Even if the Universities could expand medical undergraduate training quickly, a shortfall between GP supply and requirements will persist until at least 2013;
- Training is an investment for the future, and it should generate a return for both the individual and the community. However, if GP remuneration is set low enough, training more GPs will prove ultimately futile—they will not continue working in primary care. More training in that context would simply invite large wastage of human and financial resources.

[4] The NSW Government has announced a $2 million program to recruit doctors from abroad.

In summary, some increase in GP training numbers has to be part of the solution. But training alone is not a viable strategy.

8.2 A viable strategy

In the previous section, we canvassed some of the scenarios for achieving an overall equilibrium between demand and supply. It is important to restate, however, that there are two facets to the GP workforce that require resolution:

- there is currently an overall shortage of GPs in Australia and this shortage will get worse over time if current policy settings are not modified; and
- there is a maldistribution with shortages of GPs not just in rural and remote areas (where, in relative terms, the shortages are most serious) but also in outer urban areas.

It will prove very difficult to solve the latter problem if the former problem is not resolved.

The search for a viable policy needs to start with a wide canvass:

1. It is important, in setting the framework, to acknowledge that the cost of GP services to the nation (whether publicly or privately financed) needs to be consistent with the value of GP services to the community.
2. Looking past the national cost, there are issues as to how costs are shared between taxpayers (public funding) and households (private funding). If public funding for GP services is more tightly capped in future, then Government will need to reassess how that funding can be directed to the areas of greatest need. It may be impossible to quarantine policy issues such as the continuation of universal access to bulk-billing if, as a matter of policy choice, the public subsidy of GP services does not keep pace with the costs of such services. And it may be necessary to consider new financing paradigms such as differential rebates;
3. It is not realistic to seek to exclude debate around issues such as demand measures or different, lower cost ways of delivering GP services. Given the extensive use of para-medical professions in some overseas countries, it is inevitable that Australia will reexamine issues such as the changing role of the GP and the scope for practice nurses to help meet the demand for primary care. The challenge with some of these issues is to remove the threat and to make the debate a constructive one that is built around a focus of high quality patient care.
4. The policy framework ought not to be constricted to a narrow budget focus. Budgetary 'imperatives' need to be placed on the table openly and honestly, alongside other imperatives around the overall quality of primary care and the equity and access issues that are central to Australia's health financing system.
5. The elements of policy should be selected to as to maximise the internal harmony.

Given that there are the two parts to the problem (stated above), a multi-faceted policy will be required and, to one degree or another, will encompass all of the following elements:

- Some increase in GP training places over and above the current 'growth with the population' approach in recognition of the increasing needs of an ageing population and the unmet needs in rural/remote and outer urban areas;
- Some initiatives in remuneration to stem the drop-out rate and to draw the 'marginally attached' back into the workforce (this is the most immediate way to deal effectively with the current shortfall of GPs). This might include MBS rebate initiatives as well as direct support in areas previously not considered (eg sabbaticals);

- Reconsideration of 'issues of need' in the rationing of available public funding for GP services. This may involve a reconsideration of existing parts of the framework. For example, should we entertain differential rebates under Medicare? Is the current health care card system working effectively to direct funding to those of greatest need?; and
- Support for complementary health professionals (eg. practice nurses) to bolster the supply of primary health care.

Finally, we warn that the rural/remote and outer urban area GP shortfalls show chronic signs. It is clearly very difficult, in the face of rural depopulation and the withdrawal of other business and professional services from smaller centres to get GPs moving against the traffic. The distribution of the rural population is changing. The larger centres are growing, while many of the small towns are in decline. The forces shaping this change appear irresistible, and health workforce policy cannot be shaped in isolation of an understanding of the social, demographic and economic changes in country areas.

Quite strong medicine has already been applied, but has not markedly reduced workforce imbalances. Governments have promised much, but outcomes have not always matched the spending. It is quite possible that the promise of solutions has created too large a gap between expectations and the way that services can be delivered in reality. When all is said and done, however, it seems unlikely that Australians will continue to accept gladly a large city/country divide, and a large socio-economic divide, in the provision of primary care services.

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