Geographic Allocation of Medicare Provider Numbers – 2002 Revised 2014

1. Background

Under Australian Government legislation doctors can apply for an unrestricted Medicare provider number upon completing specialist training and attaining fellowship of a recognised medical college. Doctors across all specialties including general practice have the right to choose their preferred practice location.

Governments and local communities offer various incentives and programs to encourage doctors to locate and practise in under-serviced areas. These initiatives are generally under-funded, restrictive and fragmented, and the uneven geographic distribution of doctors in Australia remains a serious long-term problem.

The medical workforce shortage is acute in regional and rural areas of Australia, especially in the numbers of GPs and general specialists who maintain a broad scope of practice. Rural and regional areas have only half the medical workforce of metropolitan areas on a population basis. Shortages also exist in some outer-suburban areas of the state capitals.[1]

There is a heavy reliance on international medical graduates in regional and rural areas. Though these doctors provide an essential and appreciated contribution to the health care of these communities, it is not sustainable over the long term.

There is a misconception in some quarters that the medical profession is responsible for the medical workforce shortage, and draconian remedies are proposed as a response. Allocating Medicare provider numbers tied to geographical location and restricting the right of doctors to practise in metropolitan areas are raised periodically as solutions to the maldistribution of doctors.

2. Proposed models

Under the proposals mechanisms are used to allocate Medicare provider numbers to geographical locations according to population and other demographic criteria to induce an equitable distribution of doctors. They could be applied to doctors with established practices, limited to newly qualified doctors or applied to both. The reasoning is that a decrease in the number of metropolitan-based doctors, especially in affluent areas, will force a concomitant increase in the number of doctors in under-serviced areas. Examples of these proposals are outlined below.

- Schemes that restrict the allocation of provider numbers in urban areas and redirect more provider numbers to under-serviced areas.

[1] Australian Institute of Health and Welfare 2014. Medical workforce 2012. National health workforce series no. 8. Cat. no. HWL 54. Canberra: AIHW.

- A system of payments by doctors to the Government for provider numbers, based on no charge for remote practice and an increasing scale of payments for rural, regional and urban practice. Provider numbers would not be transferable, and when relinquished, would return to the Government.
- A government-sponsored auction of provider numbers as a market-based solution to the maldistribution of doctors. Under this scenario doctors bid for a provider number and the right to practise in their area of choice for a defined period. Affluent areas would attract higher bids compared to where there is an undersupply of doctors. In some cases the funds raised from the auction would be used to subsidise doctors in areas of need.
- Compulsory return-of-service obligations where doctors are required to practise for a defined period in under-serviced areas before they are eligible to apply for an unrestricted Medicare provider number.

3. AMA position

The AMA does not support the geographic allocation of Medicare provider numbers or other coercive schemes in any form or under any circumstances.

Proposals to coerce doctors from metropolitan locations by placing criteria other than proficiency on the allocation of Medicare provider numbers are impractical and will not have the desired effect. There is overseas evidence that coercive schemes are ultimately counterproductive in their objectives of attracting doctors to under-serviced and disadvantaged areas.[2]

The AMA believes that well designed and targeted incentives are more effective ways to build a sustainable workforce in under-serviced areas, improve patient care and build professional morale. Patient care is better served by doctors motivated to serve their local community rather than compelled to practise in a particular location.

Allocating Medicare provider numbers tied to geographical location and restricting the right of doctors to choose their preferred practice location could have unintended outcomes:

- coercive schemes that target recently graduated doctors would result in inexperienced doctors working in challenging environments without the requisite skills or support.
- doctors established in under-serviced areas may be unwilling to supervise “conscripted” doctors.
- the restriction of trade inherent in geographical provider numbers is likely to have the opposite effect on the overall number of GPs. Attempts to dictate practice location will make general practice unattractive, especially for new medical graduates. Further, recent medical graduates could choose to move overseas to avoid coercive schemes.
- geographic provider numbers would substantially reduce the capital and professional investment of many established doctors.

[2] Mason, J. 2013. Review of Australian Government Health Workforce Programs, Commonwealth of Australia: 248.

- a system of graded payments for geographic provider numbers could increase the pressure to maximise services in urban practices to pay for the cost of entering practice in urban locations and ensuring their ongoing viability.
- proponents of auction models argue that the use of competitive market forces would provide the means to overcome the market power of corporate medical practices and the reluctance of doctors to work in under-serviced and disadvantaged areas. The AMA does not support this proposition.
    - It is unlikely that an auction of provider numbers based on location would overcome the market power of corporate practices. Instead, it could lead to a concentration of corporate practices with access to vertically integrated health care services in more advantaged areas and may also concentrate expertise in urban areas. This would adversely affect those areas already experiencing a shortage of specialised medical services.
    - There could also be a strong incentive to maximise services in metropolitan areas as GPs endeavour to pay for the cost of a provider number, in addition to servicing mortgages and the usual debts incurred when establishing or buying into a practice.
- serious consideration by the Government of a policy that restricts the right of doctors to choose their preferred practice location could exacerbate the shortage of doctors in under-serviced areas as they move to urban centres to avoid a potentially adverse economic impact.

Finally, AMA legal advice is that the implementation of geographic allocation of provider numbers by the Commonwealth Government could contravene the "civil conscription" clause in Section 51 (23A) of the Australian Constitution. The introduction of compulsory return-of-service schemes would also be problematic. The Mason review of Australian Government health workforce programs noted that "it is likely that even if a universal service requirement could be lawfully devised, the administrative and other costs may outweigh the potential benefits".[3]

Geographic provider number proposals fail to address the real reasons for the reluctance of doctors to take on careers in under-serviced areas. These include long working hours and insufficient locum support, red tape, inadequate financial incentives, the closure or downgrading of rural hospitals by state governments, professional isolation, lifestyle factors, sub-standard housing, and the lack of spousal employment and educational opportunities.

The medical workforce has also become increasingly specialised over the past decade and sub-specialist practices are generally more viable in urban locations. Urban centres are also attractive to the increasing number of doctors who want flexible working arrangements.

4. The AMA's solutions to the maldistribution of doctors

In seeking to address the maldistribution of the medical workforce across Australia, the AMA has always offered holistic long-term solutions that encourage locally trained doctors to work in under-serviced areas.

[3] Ibid: 251.

Medical practice in regional, rural and remote areas is a rewarding vocation for many reasons. The available evidence shows that coercive schemes will not deliver long-term solutions to the complex issue of the maldistribution of doctors. What is needed are meaningful training opportunities, incentives and support mechanisms which signify that doctors working in under-serviced areas are valued, and that moving voluntarily to these areas for a career is an attractive option.

The Australian Government has taken steps to address medical workforce shortages. Medical graduate numbers have grown rapidly since 2004, with nearly 4,000 medical graduates per annum expected by 2016. The AMA has supported this initiative because it provides a great opportunity to address many of the issues identified above; however, it will only succeed provided:

- there are sufficient quality training places for graduates across all medical training programs.
- future policy development is informed by robust workforce planning.
- the right policies are in place to encourage doctors to work in under-serviced areas and have the specialties that are needed.

The early and continuing exposure of medical school students to rural medicine and measures to encourage students from regional and rural areas to enrol in medical schools are initiatives that are proven to increase the workforce in these areas.

The AMA supports incentive-based, voluntary return-of-service schemes. Incentives could include expanded HECS-HELP loan relief, training fee relief, professional development allowances, access to courses and scholarship payments linked to remote locality. These incentives should be available to rural medical graduate trainees as well as other medical students and junior doctors who are interested in working in regional and rural Australia.

Improved and expanded rural training needs to be introduced across Australia to produce appropriately trained doctors for the work required in regional and rural areas. A successful model is the rural generalist pathway in Queensland that is starting to deliver procedurally trained doctors to rural locations across the state. Similar models that will help secure the required workforce should be funded and introduced across the country.

The AMA has proposed a number of initiatives that would provide under-serviced areas with a more equitable share of the medical workforce. These include more funding for rural hospitals, a rural health obligation, more support for patient transport schemes and expanded specialist outreach services and training strategies.

Support is also needed to attract and retain the medical workforce during and after completion of vocational training. This includes implementing the AMA/RDAA Rural Workforce Rescue Package.[4] This package would provide enhancements to rural isolation payments and rural procedural and emergency/on-call loadings to encourage more doctors to work in rural areas and boost the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills.

[4] AMA/RDAA Rural Workforce Rescue Package. 2007: https://ama.com.au/node/4136

These solutions are outlined in greater detail in our position statements *Regional/Rural Workforce Initiatives – 2012* and *Fostering Generalism in the Medical Workforce – 2012*.

See also:

AMA Position Statement *Fostering Generalism in the Medical Workforce – 2012*.
AMA Position Statement *Regional/Rural Workforce Initiatives – 2012*.
AMA submission to the Review of Australian Government Health Workforce Programs (2012).[5]
Rural Doctors Association of Australia Policy Position Paper 5/2010 – *Geographic Provider Numbers*.

[5] https://ama.com.au/ama-submission-review-australian-government-health-workforce-programs