The Australian Population Research Institute, Research Report, December 2016

GP Oversupply – Ignoring the Evidence

Mike Moynihan

Bob Birrell

The Australian Population Research Institute <tapri.org.au>
PO Box 8107
Monash University LPO
Victoria 3800
Australia

Report authors

Mike Moynihan (mobile 0427 331 370) is a country doctor with 30 years of experience. He was the President of the Rural Doctors Association of Victoria from 2004 to 2014. Bob Birrell (mobile 0413 021 126) is the Head of the Australian Population Research Institute (TAPRI), an independent, non-profit research organisation.

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Summary

The Coalition has tried to curb the costs of GP non-referred attendances. The charge to the taxpayer has grown from $3.3 billion in 2004-05 to $6.8 billion in 2014-15 (Table 1) and $7.2 billion in 2015-16. This is just one of many expenditure blowouts the Coalition has failed to control.

The one measure implemented, first by the Labor Government then extended to 2020 by the Coalition Government, was to put a cap on Medicare rebates paid for GP services. The hope was that this would slow the growth in the public bill for providing GP services. This measure has failed. Why?

The main reason is that the Coalition has presided over a surge in the number of GPs billing on Medicare, particularly in Australia's metropolitan areas. The dominant source of these extra doctors is overseas-trained doctors (OTDs) who have completed their compulsory period of service in undersupplied locations.

Most subsequently move to the major cities and regional centres. These OTDs are the main source of the rapid growth in the per capita provision of GP services in the cities. This is partly because of the surge in their numbers and partly because they bill for far more services per year than their Australian-trained doctor (ATD) counterparts (Table 4).

Meanwhile, in regional areas, the government is allowing employers to sponsor OTDs to replace those who have served their required time in areas defined as in shortage. Employers continue to sponsor more than 2,000 replacement OTDs on 457 visas each year (2,320 in 2015-16). This is more than the 1,529 training places for local graduates beginning their careers as GPs in 2015.

The result is a cycle leading to ever larger numbers of doctors relative to Australia's patient load and ever higher GP Medicare costs.

GPs are being forced to chase patients. However, the competition has not stopped a continuing increase in Medicare services. This is because GPs can manage their patient load to generate extra services (as with repeat visits and tests). For their part, patients, though showing some evidence of resistance to multiple visits and the like, do not have to pay any extra costs. High throughput practices have to bulk-bill. Some 85 per cent of all GP services are now bulk-billed.

Over the next few years, the Coalition Government faces a further surge in GP numbers due to the doubling of Australian medical school graduate numbers since the mid-2000s. Its own Department of Health has proposed dealing with the oversupply by reducing medical migration and requiring Australian graduates to serve where they are needed.

The Coalition Government rejected this advice, partly because it was afraid of the opposition that organised medicine always mounts to such proposals.

As matters stand, GP costs will continue to mount. Worse, because so many GPs are now pursuing patients, increasing numbers of GPs are resorting to high throughput medicine in order to achieve their income targets. Medicare billing costs are rising yet the quality of medical care is diminishing.

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Introduction

The Australian government has become increasingly concerned about the growing cost to the budget of health care. One contributor is the increasing number of GPs and other specialists billing on Medicare. Another is the cost of pathology tests and medical imaging, where the growth in costs reflects the expansion of the GP workforce. Part of this increase is attributable to population growth. However, the rate of growth of GPs billing on Medicare is far higher than the rate of population growth.

The supply of these doctors is growing from both local training and from medical migration. In the statistics cited below, local, or Australian-Trained Doctors (ATDs), include New Zealand trained doctors. All other GPs are referred to as Overseas-Trained-Doctors (OTDs). It is therefore not surprising that the Australian government is taking action to reduce the rate of growth of the GP-related component of Medicare costs. It has put a cap on the value of the rebate paid for each service and proposed (unsuccessfully) in the 2014 budget that patients pay a co-payment with each service.

Meanwhile, in apparent contradiction, the government has kept in place its longstanding policy to allow employers to recruit GPs on temporary entry 457 visas and to allow GPs to apply for permanent entry visas under the skilled migration policy.

Our focus in this paper is the surprising recent policy proposal from the Department of Health (DoH) that further medical migration should cease and any vacancies resulting should be filled by the very large number of resident GPs in training and soon to enter the GP workforce. This proposal was rejected by the government. The budget implications for further growth in GP Medicare payments will be serious.

Background

In May 2016 we published a report entitled 'Why the public cost of GP services is rising fast'. [1] This report examined the medical service oversupply problem. As shown in Table 1, the number of GPs billing on the Medicare system is growing far more rapidly than Australia's population.

Table 1: Medicare-funded Primary (GP) medical practice and number and costs of GP services relative to Australia's population, financial years 2004-05 and 2014-15

	2004-05	2014-15	Increase (per cent)
Doctors accessing Primary Care Rebates	22,573	33,275	47.4
GP item Medicare Cost [a]	$3.321b	$6.816b	105.2
Population [b]	20.177m	23.950m	18.7
FSE[c] GP per 100,000 population	72.2	91.9	27.3
GP Head Count per 100,000 population	111.9	138.9	24.1
GP cost per capita	$165	$285	72.7
GP Services per capita	4.70	5.68	20.9

[a] Total Benefit for Non-referred Attendances
[b] Australian Bureau of Statistics Estimated Resident Population prior to 2014-15 and projected for 2014-15
[c] FSE = Full Service Equivalent which is the equivalent of a workload of 7.5 hours per day, five days per week
Source: Department of Health (DoH) 2015 General Practice Workforce and Medicare Statistics[2]

The number of GPs billing on Medicare increased from 22,573 in 2004-05 to 33,205 in 2014-15 — a 47 per cent increase. Some two thirds of this growth in numbers (6,946 out of 10,702) was attributable to additional OTDs. Over the same period, Australia's population grew by 18.5 per cent. The number of GP services provided per capita also increased significantly – by 16 per cent over the eleven years covered in Table 1.

The May 2016 report argued that this increase in the per capita provision of GP services was not attributable to an increased propensity to illness in Australia, or a sudden ageing of the population, but rather to the increasing number of GPs billing on the Medicare system. That is, it was a product of supplier induced demand. Doctors can manage the supply of services in order to meet their income targets. This is because patients rely on their doctor's advice on frequency of attendance, the range of tests they need and requirements for additional consultations. Patients do not have to worry about the cost because the government pays the bill. However, for this strategy to work most doctors have to bulk-bill.

This is the main reason why the share of GP services bulk-billed has increased sharply over recent years from 68.2 per cent in 2003 to 85.3 per cent in 2015. The competition for patients, particularly in metropolitan areas, has been such that few GPs can add an additional charge without the loss of their patients to bulk-billing GPs. Areas where co-payments are required are likely to find that other GPs or GP practices move in and offer bulk-billing services.

The surge in GP numbers has, along with a similar surge in hospital doctor numbers, put Australia close to the top of the chart in regard to the ratio of working doctors to population within OECD nations. For 2012, the OECD reported that there were 3.6 doctors (GPs and other specialists) per 1,000 in Australia compared with the overall average for the OECD of 3.0. The ratio in Australia was far higher than other Anglo countries. It was 2.8 in the UK, 2.7 in NZ and 2.5 in the USA. [3]

The response to our report from organised medicine was hostile. It was claimed that there is no oversupply. Rather the problem was maldistribution. Organised medicine also did not like our proposed solution to the maldistribution problem, which was to cut back on medical migration and to ensure that GPs serve where they are needed. This, we argued could be accomplished by restricting new GP rights to practise to locations where there was an undersupply of GPs.

Australian-trained GPs are maldistributed

There has been a longstanding reluctance for ATDs to practise in regional areas and no requirement that they should do so. This reluctance continues despite significant financial inducements, including higher Medicare rebates in regional areas than in metropolitan areas.

By the early 2000s there were considered to be acute shortages of GP shortages in regional areas. It was this situation that prompted the Coalition Government at the time to facilitate the recruitment of OTDs. In effect, successive governments have, since the early 2000s, put a band-aid over the maldistribution situation by channelling OTDs in large numbers into undersupplied areas. This has been achieved by requiring OTDs to serve for a period in a so-called district of workforce shortage (DWS).

There has been no lack of OTDs willing to accept appointments in these locations. The number of OTDs billing on Medicare increased from 6,263 in 2004-05 to 13,209 in 2014-15.[4] They are mainly recruited on 457 visas by private practices and hospitals. Some others gain permanent resident visas under the skilled migration program. They also have to serve in DWS initially.

The rules on the required length of service vary from five to ten years (depending on remoteness of location). Once the term is complete, as long as the OTD has obtained their GP Fellowship they can bill on Medicare wherever they like. To do this the OTD will only have to retain or renew their 457 visa until they manage to acquire a permanent residence visa.

The rules on the recruitment of OTDs

The rules on the recruitment of OTDs are eye glazing in complexity. However, they have to be untangled if there is to be any comprehension of medical migration situation. The main avenue is via the 457 visa. GPs, like almost all other professionals, can be recruited by employers on 457 visas without limit. However, for GPs, unlike other professionals, there is a form of labour market testing. The employer (private practice, government service or hospital) must be located in a location classified as DWS. This is defined by the DoH as an area where the residents' needs for healthcare are not being met.

DoH states that this is the case 'if a district has less access to medical services than the national average.[5] Each year the DoH draws up detailed maps of locations that meet their DWS definition. The rules have been modified recently so that all small towns less than 15,000 in size are now defined as DWS.

The same rules affect those GPs who obtain a permanent residence visa under the skilled migration program. As indicated, they too must serve initially in a DWS. However, in the case of the skilled program, the main avenue of entry is via the points-tested visa subclasses. Only those with occupations listed on the Skilled Occupation List (SOL) are eligible. Most professional occupations are on this list but, at least in theory, there is an annual evaluation of eligible occupations which assesses whether they are in shortage or not.

The SOL is relevant to our narrative, because during the 2015-16 evaluation of the SOL, the DoH recommended that GPs be removed from the list because the projected growth in GP numbers exceeded Australia's needs. If the recommendation had been accepted (it was not), it would have implied a radical change to Commonwealth policy on medical migration, including the likely abolition of the DWS arrangements. If so, this would have stopped employers from sponsoring GPs on 457 visas. Again, this did not happen. Thousands (detailed below) continue to be sponsored each year.

As indicated in Table 1, the number of GPs practising in Australia has increased far faster than the rate of population growth. Most of this growth has been in the ranks of OTDs. By 2014-15, the number of OTDs billing on Medicare (expressed in Full Service Equivalent terms) had almost reached

Table 2: Full Service (FSE) GPs by place of origin of training, Australia, 2004-05, 2010-11 and 2014-15

	2004-05	2010-11	2014-15
ATDs	9,883	10,613	11,121
OTDs	4,691	7,544	10,824
Total	14,574	18,157	21,945
Per cent overseas-trained	32%	42%	49%

Source: DoH GP statistics December 2015

Notes: Full Service Equivalent (FSE) GP is a 2015 DoH measurement derived from Medicare earnings and estimated time worked from time-based items claimed. ATDs include New Zealand trained doctors.

the ATD level (see Table 2) — so almost half of all GP services were provided by OTDs in 2014-15, even though their headcount had reached only 38 per cent of the total (Table 3).

The issue we now address is where are all these OTDs practising?

The transit of OTDs into metropolitan areas

The service requirements described above have been in place long enough to allow large numbers of OTDs to move from shortage locations if they wish. They can bill on Medicare where they please when they complete their Fellowship and moratorium period. The great majority move, mainly to metropolitan areas, though some stay or move into regional centres. As OTDs depart their DWS location they leave vacancies behind them. Few of these vacancies are being filled by Australian-trained doctors who enter the workforce through the Registrar Training Program. Once this Program is successfully completed ATDs can practise and bill on Medicare wherever they please.

This situation has two consequences. The first is that under present DWS arrangements the employer can recruit another OTD to fill the vacancy. Most do this. This is reflected in the continued high level of GP sponsorship on 457 visas both from private GP practices and hospitals. The number of GPs and Resident Medical Officers recruited on 457 visas was 2,320 in 2015-16. This compares with 2,663 in 2011-12, 2,424 in 2012-13, 2,060 in 2013-14 and 2,145 in 2014-15.[6]

Also, the number of GPs gaining permanent entry via the skilled program has continued at a high level. The number was 660 in 2014-15 and 550 in 2015-16.[7] Most were onshore applicants, including former overseas students trained in Australian universities, who obtained a skilled visa through the points-tested visa subclasses.

The second consequence is that the number of OTDs billing on Medicare in Australia's metropolitan centres has been increasing rapidly because of the influx of movers from DWS locations. Table 2 shows the scale of the growth. The numbers include OTDs who are in metropolitan DWS, such as after-hours services. Many more OTDs are poised to join this influx. As of June 2015 there were 8,165 GPs trained overseas and practising in DWSs.[8]

Table 3: Head count of GPs accessing Medicare Rebates in major cities, by origin of training, 2004-05 and 2014-15

	2004-05	2014-15	Increase
ATDs	11,815	13,878	17%
OTDs	4,030	8,550	112%
Total	15,845	22,428	42%
Per cent overseas-trained	25%	38%	

Source: DoH GP statistics December 2015
Note: Major cities exclude Darwin and Hobart but include Newcastle, Geelong and Gold Coast.

Once these OTDs locate in metropolitan areas, they show a high propensity to bill on Medicare as is indicated in Table 4. For male GPs, the average number of services billed in 2013-14 in the metropolitan areas by OTDs was 6,443 compared with 5,034 for ATDs.

Table 4: Services per GP by sex and origin of training, major cities, 2003-04 and 2013-14

	ATDs		OTDs	
	Male	Female	Male	Female
2003-04	5,245	2,798	6,189	4,441
2013-14	5,034	2,709	6,443	4,886

Source: Customised purchase of Medicare statistics for 2013-14

The combination of this OTD influx into metropolitan areas and their high rate of billing has been the main contributor to the increase in the average number of GP services per capita being billed in Australia's metropolitan areas since 2004-05. There have been increases elsewhere in Australia but not as rapid as those that occurred in the major cities, as Table 5 shows.

Table 5: GP Medicare rebated services per capita of population, major cities, 2004-05, 2009-10 and 2014-15

	2004-05	2009-10	2014-15
All Australia	5.10	5.57	5.94
NSW major cities	5.66	6.05	6.34
Victoria major cities	5.02	5.52	6.01
Queensland major cities	4.93	5.52	6.02

Source: DoH 2015 GP statistics, ABS cat. No. 3218.0

This high and still increasing number of GP services billed in metropolitan areas has occurred despite the fact that these areas have a lower concentration of older people (who have a high incidence of service need) than is the case for regional areas. With 71 per cent of the population residing in the major cities, this is where the main fiscal threat lies.

A vicious circle of dependence on OTDs

The result is a vicious circle in which the number of OTDs practising in Australia continues to increase because employers in DWS are free to replace those leaving with new OTD appointments, most of whom are recruited on 457 visas.

This would not be so much of an issue if the supply of ATDs was stable. In fact it is rapidly expanding. The total number of domestic medical school graduates has increased from 1,320 in 2005 to 3,055 in 2015.[9] There has also been a huge increase in the number of these graduates taking up GP training places, which have grown from 450 per annum in 2004 to 1,529 in 2015.[10]

In addition, the government and the medical profession face a serious problem of providing the required number of postgraduate training places to accommodate the surge in resident graduates. Places also have to be found for the increasing number of overseas students completing medical training in Australia. Their numbers have grown from 267 in 2005 to 469 in 2014.[11] In 2015, 72 per cent of these GPs stayed on as hospital residents.[12]

The Department of Health changes its mind

The Commonwealth Department of Health (DoH) and its bureaucrats have for years supported the argument that Australia needs more doctors. DoH has facilitated the overseas recruitment policies described above. Reports of ours over the years that criticised these arrangements have been rejected. This rejection has been based on modelling exercises that assume very high increases in the per capita need for medical services.

As noted, to our surprise, DoH in its submission to the 2016-17 assessment of the Skilled Occupation List (SOL) recommended that GPs and almost all other medical specialists (and dentists) be removed from the list. As indicated, when this occurs a prospective migrant in the occupation in question cannot apply for a points-tested permanent-entry visa under the skilled program.

The DoH's recommendations would have ended the flow of points-tested GPs through the permanent-entry skilled-migration program. That would have had a modest impact. The really big change was implied by DoH's overall judgement about the supply and demand situation for GPs in Australia.

The DoH submission was a shock because its submission argued that there was already an oversupply of doctors in Australia and that it was going to get worse. Its conclusion was that there was no longer a case for continuing medical migration. This implied the end of the past reliance on OTDs recruited on 457 visas. The submission also flagged a new and radical policy for ensuring that ATDs fill the resulting gaps in the regional workforce.

The DoH's submission on the SOL was not published. However, it was released under a Freedom of Information request by *The Australian* journalist Sean Parnell.

The submission challenged the DoH's previous assumptions. It argued that the government should not passively accept the increase in demand for medical services previously projected. Using recent Treasury assumptions, the submission asserted that economic growth was likely to be much lower than assumed in past modelling. On this basis, DoH argued that there was a case for the government to scale back the growth in expenditure on GP services and thus the supply of additional GPs. As Table 1 shows, this expenditure grew from $3.3 billion to 2003-04 to $6.8 billion in 2014-15. It grew again in 2015-16 to $7.2 billion.

The DoH also argued that the expected sharp increase in the number of GPs trained in Australia created an opportunity to fill gaps in the medical workforce in undersupplied areas from this domestic source rather than by importing OTDs.

The RACGP's submission on the SOL with reference to GPs took much the same stance. The College expressed concern about how all those entering GP postgraduate work would obtain the training needed. It worried that continued medical migration would exacerbate this training crisis. [13]

The DoH submission relied heavily on an August 2014 report from HealthWorkforce Australia (HWA). This report provided the modelling showing that, under recent Treasury economic growth assumptions, the need for extra Medicare services would be much lower than previously assumed. In these circumstances fewer extra doctors would be needed. The report also spelled out the implications. If medical migration were to be cut (as recommended) then Australian-trained graduates would have to practise where their services were needed.

The 2014 HWA Report stated that the boom in graduate numbers 'presents an opportunity for us to decide where we want students to go in the future to end up with doctors in the right locations and

specialities that will be needed in the future'.[14] It also noted that any measures to restrict OTD recruitment, 'would need to be counterbalanced with policies that facilitated the domestically trained workforce fulfilling the geographical distribution requirements'.[15]

The Coalition Government rejects DoH advice

The government has kept GPs on the SOL. They can continue to apply for permanent entry visas under the skilled program. Employers, whether running private practices or hospitals, can continue to sponsor OTDs on 457 visas for their vacancies, as long as they are located in DWS. The number of GPs billing on Medicare and their overall costs will continue to rise.

Why would the government (in this case now represented by the Department of Education and Training which has taken over the administration of the SOL), dismiss the DoH's recommendations? *The Australian* has been able to shed some light on the reasons, following the release via FOI of briefing notes to the responsible Department of Education and Training Minister. These say that 'major changes to the list from year to year would signal that it (the SOL) is being used to manage short-term labour market fluctuations.' [16]

Most observers think that the presence of an occupation on the SOL is an indication that there is a national shortage in the field. This has not been the case for several years. There are several major occupations, including accounting, that have been oversupplied for some years, yet have remained on the SOL. The government has ducked the oversupply position in these major occupations by redefining the SOL so that it refers to the longer term skill need situation – not the current one. This strategy avoids the embarrassment of having to admit such major occupations as accounting and the IT professions (and general practice) are oversupplied.[17]

This is why the DoH submission was so interesting. Nevertheless, for the time being the challenge is at an end.

The government has since affirmed that the SOL is not shaped by the current state of the labour market. The Department of Education and Training has made this crystal clear. Its advice to those putting submissions on the 2016-17 SOL is that the SOL is concerned only:

> With 'medium to long term' skills needs rather than immediate skills shortages. As such, the Department of Education and Training is only seeking information on longer term trends rather than immediate shortages and costs. 'Medium to long term' means 2-10 years.

Given these nebulous criteria, the decision to keep a particular occupation on the SOL is a political one. What are the politics of decisions concerning GPs?

There are several reasons why GPs remain on the SOL. One, acknowledged in the Ministerial response cited above, was that the government does not want its migration recruitment policy tied to the current labour market situation. Another is that deleting major occupations like doctors from the SOL would undermine the overseas student industry. The number of overseas students enrolled in medicine has been increasing. There were 613 commencing overseas students in medicine in 2016.[18] At a fee level of some $30,000 a year, they add enormously to university revenue. Not surprisingly, universities argue strongly against removing GPs from the SOL. They know that to do so would diminish the attraction of studying medicine in Australia, because it would remove a major pathway to permanent residence in Australia.

A third reason is that the Coalition Government is afraid of antagonising organised medicine. The reason is the inevitable opposition to the measures the DoH would have to implement to make sure that positions left vacant by OTDs were filled by locally trained GPs. Some GPs would have to serve where they are needed rather than where they would like to serve (more on this issue below).

The Medicare crisis

The government confronts a serious Medicare crisis. It has tried a number of measures to encourage (bribe) Australian trained GPs to locate in shortage areas. These have had only modest success so far. The government has responded by wielding the big stick of freezing Medicare rebates, a freeze the Coalition has recently extended to 2020.

This has accentuated the over-servicing problem because, with more doctors chasing patients, their only choice, if they are to maintain their income, is to practise high throughput medicine. As matters stand at present, the rapid growth in GPs billing on Medicare will push the costs of the system ever higher. Non-referred billings per FSE GP cost the government $302,256. However, as the government has revealed, there are large numbers of GPs who bill for 10,000 services or more, whose Medicare income is around $500,000 a year.[19] The associated pathology and imagery costs are in addition.

On the other hand GPs trying to practise comprehensive, careful medicine are seeing their incomes fall. Few can charge a co-payment, despite the bluster of organised medicine prior to the 2016 election. Patients will tend, as indicated, to seek out GPs who bulk bill.

The Australian government is in a nasty fix. It wants to curb the growth in the cost of GP and related pathology and imaging services billed on Medicare, but its one strong measure, capping GP bulk-billing rebates, will promote high throughput medicine.

Because the number of GPs billing on the system is growing so fast, any reduction in government expenditure is likely to be more than offset by growth in the overall number of services being billed. As noted, the total cost of GP services billed on Medicare continues to increase. It grew from $3.3 billion in 2004-05 to $6.8 billion in 2014-15 and to $7.2 billion in 2015-16.

What is to be done?

GPs are understandably resentful that their returns are falling in real terms (relative to plumbers). They also can't produce quality medicine if they have to chase patients and to increase the number of services they offer in order to meet their target incomes.

Organised medicine has much to answer for. The AMA and other representative organisations have stood by while the government pursued its high supply policy and now seeks to control the resulting costs by capping rebates.

There is evidence, not published in this paper, that the ability of GPs to continue to service at a high rate of over 6,000 billings a year is diminishing. Interviews with GPs indicate that some patients are resisting the mechanisms of high throughput medicine (such as multiple attendances and tests for particular medical problems). This is presumably what the government wants to happen.

However, as the growth in the number and public costs of non-referred GP services detailed above indicates, this policy is not working. It is also generating high throughput medicine, rather than the careful medicine the government claims to encourage.

More durable solutions are needed. They should hinge on slowing the rate of growth in the GP workforce. This would free GPs from having to chase patients and allow more time to devote to individual patients. There would have to be parallel increases in GP rebates.

The way to do it was flagged in the DoH SOL submission. This is to reduce OTD medical recruitment and to make sure that the current surge of ATDs fills the resulting DWS vacancies.

A multitude of measures have been tried to encourage ATDs to serve in these locations, with, as indicated, only modest success. ATDs have many reasons for wanting to serve in metropolitan areas (including access to good private schools for children, spouse employment, family and metropolitan amenities).

A different strategy is needed. GPs are public servants, as the 85 per cent bulk-billing rate indicates. Public servants, such as teachers, serve where there are vacancies in particular schools. We do not build schools in order to provide jobs for teachers in locations they would like to work. GPs should be treated in the same way. They should serve in locations that are poorly provided with GPs.

Organised medicine will respond that this is akin to conscription. This is not the case. GPs entering the workforce (like teachers) would be free to choose to work in any of the many locations — mainly in regional Australia, but also in after-hours service in metropolitan areas — where their services are needed. The only limitation would be that they would not be permitted to practise in locations where there were already far too many doctors offering their services.

Endnotes

[1] Mike Moynihan and Bob Birrell, 2016, *Why the public cost of GP services is rising fast*, The Australian Population Research Institute, <http://tapri.org.au/wp-content/uploads/2016/04/The-cost-of-GP-services-2016-May-31-final-Table-1-correction.pdf>

[2] DoH GP workforce and Medicare statistics are released in the latter part of each year for the preceding financial years. As such they provide the only consistent set, revised back to 2004 and unrevised for workforce back to 1984

[3] HealthWorkforce Australia, 2014, *Australia's Future Health Workforce – Doctors*, p. 11

[4] Moynihan and Birrell, op. cit., p. 5

[5] Rural Health Workforce Strategy, 'Overseas Trained Doctors Scaling Factsheet'

[6] Department of Immigration and Border Protection, subclass 457 visa granted pivot table downloaded from <https://data.gov.au/dataset/visa-temporary-work-skilled>

[7] Unpublished skilled migration visa issued data supplied by the Department of Immigration and Border Protection

[8] Department of Health, 2016, *Medical Training Review Panel: eighteenth report. http://www.health.gov.au/internet/main/publishing.nsf/content/work-pubs-mtrp-18*

[9] Medical Deans

[10] Department of Health, op. cit., Table 4.15

[11] Medical Deans, op. cit.

[12] Calculated from Department of Health, op. cit.

[13] <https://submissions.education.gov.au/forms/archive/2015_16_sol/documents/Attachments/Royal%20Australian%20College%20of%20General%20Practitioners.pdf>

[14] HealthWorkforce Australia, op. cit., p. 6

[15] Ibid., p. 28

[16] Sean Parnell, 'Why officials only tinker with the Skilled Occupation List', *The Australian*, 21 November 2016

[17] SOL policy changes are detailed in Bob Birrell, Ernest Healy and Bob Kinnaird, 2016, *Immigration Overflow: Why It Matters,* The Australian Population Research Institute, < http://tapri.org.au/wp-content/uploads/2016/04/Immigration-overflow-final-3-Dec-2016.pdf>

[18] Medical Deans, op. cit.

[19] Australian Government, Department of Health and Ageing, *Full-time Service Equivalent (FSE)* March 2012, p. 5