Explanatory Notes

Practitioner Classification: Derived Major Specialty (DMS)

Most practitioners have more than one registered specialty. Some means of deriving the most appropriate specialty in each period is required for reporting purposes.

Each practitioner's Derived Major Specialty (DMS) is determined taking into consideration both their medical qualifications (relevant registered specialties) and their Medicare service pattern. The DMS hierarchy has three levels – Group, Major Specialty and Sub Specialty.

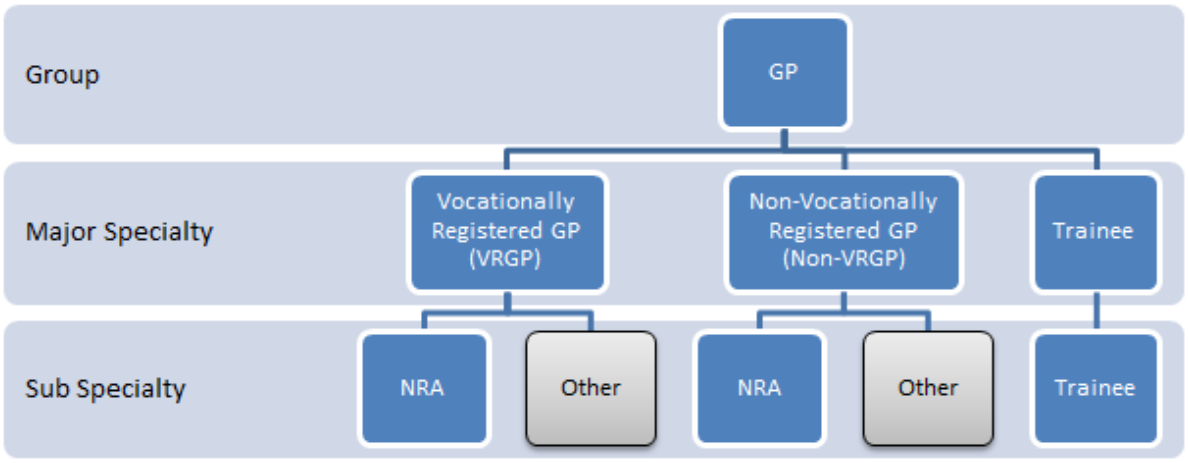
Practitioners are first allocated to the DMS Group corresponding to their highest level of medical qualification. The four DMS groups are:

Each DMS group is divided into DMS Major Specialty categories. Some Major Specialty categories[1] are further divided to a Sub Specialty. In general, these are co-determined by the practitioner's medical qualifications and major service pattern.

DMS Hierarchy for GP Group

GP Major Specialty

Registered specialties are used to further divide GPs into one of three Major Specialties - Vocationally Registered VR), Non Vocationally Registered (Non-VR) and Trainee (see *GP Registration* section in this publication for additional information).



GP Sub Specialty

If the majority of a GP's Medicare income is derived from non-referred attendances (NRA) then the GP is allocated to the DMS Sub Specialty of '*Non-referred Attendances*'. Along with GP Trainees,

[1] VR and Non-VR GPs, Internal Medicine, Surgeons, Allied Mental Health, Dietician and Physiotherapists

these practitioners are considered to be working predominately in primary care and are the focus of the GP Workforce report.

If the majority of a GPs Medicare income is derived from other Medicare services, then the GP is allocated to an alternative DMS Sub Specialty[2]. These practitioners are not the focus of the GP Workforce report, however summary data is provided in Table 18.

The GP Workforce report is limited to GPs who work predominately in primary care and only includes statistics on non-referred attendance items. The report does not include information on the other types of Medicare services claimed by GPs during the reference period.

Table 18 reconciles the figures in the report with non-referred attendances reported elsewhere. Specialists and GPs, who do not work predominately in primary care, claim approximately 2% of non-referred attendance services each year.

Figures in the report may differ slightly from those provided in previous releases as a result of DMS updates. To ensure consistency, the entire time series is back cast when there are significant changes to DMS. For this reason, the latest release should be used.

GP Registration

Vocationally Registered Practitioner (VRGP)

The Government introduced vocational recognition in 1989 to recognise general practice as a discipline in its own right. Between 1989 and 1995, medical practitioners already practising in general practice who met the eligibility criteria could apply to be grandfathered on to the Vocational Register. To be eligible, GPs had to have five years' experience in general practice. The grandfathering period for the Vocational Register ended in November 1996.

VR medical practitioners are now the norm in general practice. In July 2010, a national registration system managed by the Australian Health Practitioner Regulation Agency (AHPRA) commenced. This recognised general practice as a medical specialty accessible through Fellowship of the Royal Australian College of General Practice (FRACGP) or Australian College of Rural and Remote Medicine (FACRRM), or on the General Practice Vocational Register.

VR GPs have access to higher Medicare rebates.

Non-Vocationally Registered Practitioner (Non-VRGP)

Non-vocationally registered GPs are not able to access higher Medicare rebates. The Department of Health website at http://www.health.gov.au/omps provides the latest information on workforce programs which enable access to higher Medicare rebates as well as information on changes to Medicare that impact non-VR GPs.

Non-VR GPs currently have the option to become vocationally registered by undertaking, with either the RACGP or ACRRM, a pathway to Fellowship that takes into account their commitment to the profession, their past experience and their involvement in continuing professional development.

[2] GP Sub Specialty categories include procedural, anaesthesia and obstetrics. In the diagram above, these Sub Specialties are combined under the heading 'Other'.

GP Trainee

Practitioners enrolled in the Australian General Practice Training (AGPT) are classified as GP Trainees in this report. Vocational training is delivered by Regional Training Organisations (RTOs) across Australia

Counting GPs

Two different measures of workforce are provided – headcount and full-time service equivalent (FSE).

Headcount

GP headcount is a count of GPs who have provided at least one Medicare service during the reference period and had at least one claim for a Medicare service processed during the reference period. This ensures that GPs included in the headcount were active in Medicare during the reference period. The headcount figure includes practitioners who only provided a small number of services through Medicare during the reference period.

FSE (Full-Time Service Equivalent)

FSE is an estimated measure of medical workforce activity based on Medicare claims information. Although Medicare claims data does not include information on hours worked it does have sufficient time-based items to estimate a proxy for hours worked. The FSE methodology models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week.

As with any estimate methodology, statistical results may not be representative of actual behavior at an individual level. Individuals with atypical patterns can produce more extreme statistical results. Therefore, FSE is capped at 2.5 (equivalent to a workload of 13 hours per day, every day) for a small percentage of practitioners.

Proportioning Headcount and FSE across geographic areas

GPs that provide services in more than one geographical area during the reference period are fractioned across those geographical areas based on the schedule fee of the services they provided in each area.

The example below demonstrates how the headcount and FSE of a GP working across three states during the reference period is proportioned across each state.

State	Schedule Fee	Headcount	FSE
NSW	$150,000	0.500000	0.435
Victoria	$100,000	0.33333	0.290
ACT	$50,000	0.16667	0.145
National	**$300,000**	**1.00000**	**0.870**

The example below demonstrates how the headcount and FSE of a GP working in multiple SA3 areas across three states during the reference period is proportioned across the multiple geographic areas.

State	SA3	Schedule Fee	Headcount	FSE
NSW	Goulburn - Yass	$50,000	0.166666667	0.145
NSW	Queanbeyan	$100,000	0.333333333	0.290
VIC	Ballarat	$20,000	0.066666667	0.058
VIC	Bendigo	$80,000	0.266666667	0.232
ACT	Gungahlin	$50,000	0.166666667	0.145
National	**Total**	**$300,000**	**1.000000000**	**0.870**

Place of basic qualification

Medicare records the country in which the practitioner obtained their primary medical qualification. Practitioners who obtained their basic qualification in Australia or New Zealand are counted in the category "Australia/NZ". This aligns reporting of practitioner numbers with the definition of "overseas trained doctor" given in Section 19AB(7) of the Health Insurance Act 1973. Practitioners who obtained their basic qualification outside of Australia or New Zealand are counted as "Overseas".

Most overseas trained doctors and foreign graduates of an accredited medical school need a visa to practice in Australia. Detailed information on the types of visa available to doctors is available on the Department of Home Affairs website.

Non-Referred-Attendances (NRA)

Non-referred attendance services and benefits are reported across the three Broad Type of Service (BTOS) item groups listed below. These three item groups represent the majority of Medicare items claimed by GPs. The sum of services and benefits across the three item groups represent total non-referred attendances in this report.

BTOS:

- Non-referred attendances - VRGP
- Non-referred attendances - Enhanced Primary Care
- Non-referred attendances - Other

Non-Referred Attendances	Group / Subgroup / Item
VRGP	A1, A7(193,195,197,199), A11(585,594,599), A18, A22
Enhanced Primary Care	A14, A15(Items 735,739,743,747,750 & 758), A15(Subgroup 01), A17, A20(subgroup 1), A34
Other	A2, A5, A6, A7(Item 173), A11(588,591,600), A19, A20(subgroup 2), A23, A27, A30

Table above is accurate as at 30 June 2018. The Medicare Benefits Schedule is updated throughout the year and may impact the items included under BTOS. The latest changes and Item descriptions can be found at http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

Geography

State/Territory

State/Territory is determined by the provider's practice location.

Remoteness Area (RA)

Remoteness Area (RA) is determined by the providers' practice location.

The Remoteness Structure of the Australian Statistical Geography Standard (ASGS) divides each state and territory into several regions on the basis of their relative access to services. Detailed information on the structure and delineation of RAs is available from ABS catalogue 1270.55.005 Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure Australia July 2011.

Remoteness Area Classification:

0. Major Cities
1. Inner Regional
2. Outer Regional
3. Remote
4. Very Remote

Statistical Area Level 3 (SA3)

Statistical Areas Level 3 (SA3) is determined by the providers' practice location.

SA3 of the Australian Statistical Geography Standard (ASGS) is designed to provide a meaningful regional breakdown of Australia. SA3 areas generally have a population of between 30,000 and 130,000 people. In regional areas, SA3s represent the area serviced by regional cities that have a population over 20,000 people. In the major cities, SA3s represent the area serviced by a major transport and commercial hub. In outer regional and remote areas, SA3s represent areas which are widely recognised as having a distinct identity and similar social and economic characteristics.

Primary Health Network (PHN)

Primary Health Network (PHN) is determined by the providers' practice location.

PHNs are independent primary health care organisations supported by the Australian government. There are 31 PHNs, each working within defined geographical areas. In determining PHN boundaries, a number of factors were taken into account, including population size and projected population growth, state based Local Health Network (LHN) alignment, State and Territory borders, patient flows and administrative efficiencies. More information can be found at http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home.

Estimated Resident Population (ERP)

State and National ERP

ERP for financial years is based on the Australian Bureau of Statistics (ABS) catalogue 3101.0 *Australian Demographic Statistics*, table 51 to table 59, released June each year.

ERP for the latest financial year is based on projected population figures, ABS catalogue 3222.0 Population Projections, Australia, 2012 (base) to 2101, table B1 to table B8, released 26Nov2013.

National figures include other territories comprising Jervis Bay territory, Christmas Island and Cocos (Keeling) Islands. Figures in the tables are based on June quarter population as at the end of the financial year, e.g. June 2017 ERP is used for 2016-17.

ERP is used as denominator to calculate statistics for the number of services per capita, benefit paid per capita and patients as percent of population.

Minor variations in per capita statistics might occur compared with the statistics published previously due to the update of ERP figures by the ABS.

Remoteness Area (RA) ERP

ERP for financial years is based on Australian Bureau of Statistics (ABS) catalogue 3218.0 *Regional Population Growth, Australia,* table 1 *Estimated Residential Population, Remoteness Areas, Australia*, released March each year.

The ERP for the financial year is based on the June Quarter as at the start of the financial year e.g. June 2017 ERP is used for financial year 2017-18.

Disclaimer

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