

# The Australian College of NonVR General Practitioners Inc.

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15<sup>th</sup> November, 2002

Re: Inquiry into the cost of Government imposed programs on General Practice.

Dear Ms Owen

Our College welcomes the opportunity to inform the Commission on various matters concerning Non Vocationally Registered General Practitioners with respect to the terms of reference of its study. Our particular thanks go to Ms Appness who has made us aware of its existence.

We have frequently found that Non Medical people have no idea of what is vocational registration. In order to better understand our position, a little background summary is perhaps appropriate.

The Definition of a General Practitioner.

Prior to 1989 in order for a doctor to become a general practitioner, satisfaction of the relevant states Medical Board minimum postgraduate experience would be required. They could then practice unsuppressed.

In 1989 the Commonwealth Government introduced the vocational register ostensibly to "improve" the standard of General Practice. Ensuring that Medical graduates would have appropriate training and experience before embarking on unsupervised general practice. In other words the Government began to step into the business of medical training through the funding of General Practice. This training program was to be administered by the Royal Australian College of General Practitioners. At the end of the training period the trainee doctor would then sit an exam and if passed would become a Fellow of the Royal Australian College of General Practitioners. This would allow them to gain access to a higher rebate.

Surprisingly many of the training positions were in hard to fill positions in hospitals (which at that time were in desperate need of being filled) or rural areas. The Royal Australian College of GP's training program ensured that trainees would have to spend time in these areas of need. At a stroke the Government had solved its manpower problems of the public hospitals while pushing the envelope on the constitutional prohibitions of civil conscription (section 51 Australian constitution)

Medicopolitical controversy then occurred and the AMA saw the scheme for what it was (namely an attempt to control general practice and conscript Junior doctors into unpopular positions. It threatened to scuttle the scheme but a political compromise was achieved and all doctors who had five years clinical experience were eligible to enrol onto the vocational register. This pacified the majority of established general practitioners. This route of entry closed in 1996 and for various reasons doctors who had graduated after 1991 were not able to access the vocational register via this route.

After 1996 the only way a doctor with a provider no could become vocationally registered was

- 1) To do the college training program.
- 2) To work for 5 years in general practice, apply for membership of the RACGP and then sit the college exam

Therefore the current pool of Non VR GP's represents

- 1) Conscientious objectors to the Vocational Register
- 2) Doctors who graduated after 1991 who have a provider No
- 3) Doctors who graduated before 1991 who for various circumstantial reasons failed to gain entry to the register (late submittal of form, overseas at time and not aware etc)
- 4) Doctors who failed to gain VR through legal action.

Most of these doctors are practicing as general practitioners. Their patients would not know the difference between them and Vocationally registered GP's except for the rebate difference. They are able to fill in Centrelink and DVA forms and all of the other beau effluvia that emanate from Canberra.

In essence the "red tape" that our members are subject to is exactly the same as any other GP and for the purposes of your enquiry should be justly considered as General Practitioners.

### **General Compliance costs.**

In General the compliance costs of non-VR GP GP's are exactly the same as VR GP's as they pretty much perform the same duties. In order to avoid being repetitious I will avoid going over the points mentioned in previous submissions.

### **Specific Compliance costs.**

The actual vocational register scheme is the biggest financial burden

Currently the rebate differential stands at \$6.60 for a standard consultation.

Assuming that the average full time GP sees approx 8000 patients per year the Non VR GP is \$52,800 dollars worse off by not being on the VR. Also except in certain circumstances non-VR doctors are not able to access PIP payments and other "blended payments" This is the yearly penalty the Government imposes on a Non VR GP.

The vocational register has been deliberately designed to be difficult to access. It is civil conscription through circuitous means. It suites the Governments pleasure to have a pool of financial disadvantaged doctors whom they can through financial pressure force into the more difficult to fill positions (ie rural and outer suburban areas). The government is quite happy to let GP's access the VR rebate provide they move towards Government perceived areas of need. The VR rebate is held as an "incentive" to "motivate" Non VR GP's to relocate. The current Rural Other Medical Practitioners Program allows a Non VR GP to access the higher rebate provided they move to the country and give an undertaking to sit the exam in 4 years time. While the GP gives an undertaking there is no obligation to sit the exam

In order to access the VR the following could be considered financial barriers.

Cost of FRACGP exam \$2000

Cost of FRACGP exam (alternative Practice Based Assessment) \$9000

Cost of study (assuming the AMA rate of \$70/hr) 6 hours a week for 40 weeks \$16,800

Intangible costs

Loss of leisure time studying for the exam

Loss of contact with family while studying

Loss of quality of life worrying if will pass the exam.

## **Practice viability.**

The Government impose scheme is the biggest cost to a Non VR General Practitioners viability. Non VR rebates have remained the same since 1989. Yet Practice costs have risen in line with CPI. It therefore follows that in order to maintain the same income after costs the Non VR doctor has to

- A) Increase patient throughput. This has not occurred refer to Table 1
- B) If bulk billing take a real fall in income. (rewarding the clever country1)
- C) stop bulk billing

However there is a limit to what a Non VR doctor can charge in view of market forces. Since medical services tend to be treated like a commodity by the patients. It follows that the VR scheme is a form of subsidy to government approved doctor and the artificial trade barriers imposed in such a scheme limit the practice of non-VR doctor.

The Government is trying to force Non VR doctors out of business.

So why do Non VR doctors not sit the exam?

- 1) Several may be ineligible because they may have not spent 5 years in full time general practice. To give you an example of this I practiced as an Emergency Registrar in the Emergency Training Program supervising RACGP graduates. None of my previous time has been accredited by the RACGP as General Practice experience. Even the time spent supervising RACGP trainees! So even though I was 7 years postgraduate when I commenced General Practice I still have to wait 5 years before I can sit the exam.
- 2) Older GP's who missed out on the VR see no point in sitting an exam when they are about to retire in a few years. No provision has been made for these individuals. In one unfortunate circumstance a doctor who graduated in 1967 and missed out applying for the vocational register since she was overseas at the time could not become vocationally registered unless she sat the College exam.
- 3) Conscientious objectors. It may surprise the productivity commission and even a few public servants that some doctors are ethically averse to vocational register and refuse to participate in the scheme despite the fact that they will incur financial losses. It is an honour to have these individuals in our organisation.
- 4) Family commitments. Female doctors who have just become mothers, Doctors with sick relatives Sole children of parents etc.
- 5) Doctors planning to leave medicine. Several of our members are planning to opt out of medicine into fields where they may find it more personally rewarding.
- 6) Private billing. Many Non VR doctors have switched to private billing in order to stay financially solvent. Much to this authors pleasure. He has actually been busier since the switch. The gap that the patients are prepared to pay for good medical service has negated some of the real fall in the non-VR rebate.

## **Comments on the outer suburban scheme.**

Several points ought to be made in regard to the Outer Suburban scheme. The position of our organisation is that this scheme is probably going to fail for a variety of reasons. Some of which are as follows;

- Non VR doctors in established practices will not want to move since their will probably be a real fall in their income by doing so. Assuming that it takes approx 3 years to establish oneself in a new practice it follows that when one takes into account the costs of transfer of practice it is likely that that many Non VR doctors would be far worse off transferring rather than staying put.

- The rebate itself is not incentive enough to move. The Governments own modelling of the costs of General Practice put the cost of a standard consultation at approx \$40 the current VR rebate of approx \$25 does not even approximate this.
- Outer suburban areas and areas of need are even less likely to privately bill than inner city areas so the financial incentive is even less.
- To who does a non-VR doctor leave his already established patients? Currently there is a shortage of medical Practitioners and retiring doctors are having a difficult enough time trying to pass on their practices to other doctors.
- Non VR doctors are less likely to become partners/ offered ownership of medical practices because of the lower incomes they generate. Why leave your own practice to work as an employee of someone else?
- Many doctors may have personal reasons for staying in the area, which they are in (proximity to schools, family etc).

## Macroeconomic costs.

To date there has been no audit on whether or not the government VR scheme has actually delivered any benefits in terms of better patient health or economic outcomes. We urge the Productivity Commission to look into this matter as a matter of national urgency. Particularly in view of the millions of dollars that are spent regulating the Medical Profession that would be better spent in direct patient care. In keeping with our cynicism there does not appear to be any formal audit of the VR scheme in the last 13 years despite its lofty aims. We find this particularly intriguing, as any Government that could improve health outcomes through public policy would naturally want to boast of its achievements.

There is some data available but it is not readily available and the Health Insurance Commission has not been helpful. However our organisation has obtained data in a roundabout manner from the HIC which seems to indicate that the average Non VR doctor costs the government less in terms of PBS, radiology and Pathology than the average VR doctor. See Appendix

The RACGP published a study <sup>(1)</sup> comparing its graduates against a cohort of Non training program GP's and found that while there were initial differences in certain practice habits the effects tended to "wear off" after time. It could be surmised that RACGP graduates had to unlearn the skills they learnt during the practice training program in order to run a successful practice.

It seems quite ironic that while the government is cutting the PBS to its political dismay it is rewarding the doctors who are sending it broke while punishing the ones who are saving it money.

Unfortunately there does not seem to be any data comparing the morbidity and mortality of patient of VR as opposed to Non VR doctors and hence the legitimacy of the scheme. The only indirect measure we have is in our insurance premiums. If vocational registration procured better health outcomes it would probably be reflected in lower insurance premiums (being lower for VR doctors). To date the insurance premiums are the same.

Our organisation also believes that the VR scheme distorts the price structure of General Practice services thereby contributing to shortages and lack of flexibility of General Practice.

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(1) Comparison of Practice Profiles using Health Insurance Commission data for GP's who have completed the RACGP training program and those who have not. May 1999 Report by the Family Medicine Research Unit, Dept of General Practice, University of Sydney.

## **Ethical Cost**

Perhaps the most serious cost to the community is the entry of third party element into the doctor patient relationship. It is the government. This third element is not uninterested in the outcomes as it foots the bill' so there will always be pressure to lower costs to the government. Through a system of carrots and sticks the government is directly trying to influence the nature of medical practice by having

- “Approved doctors” by paying them more while “non approved doctors” are being paid less in real terms.
- “Approved asthma, diabetes and mental health treatments” as evidenced by its blended payment schemes.
- “Approved practices” through its PIP scheme.

In essence do it the Governments way or go broke.<sup>2</sup>

Previously what was medically “approved” was decided by the medical profession with regard to the best outcome for the patient. With the government stepping in we now have the prospect of the “right” treatment being determined by transient political or economic pressures.

Eventually what our organisation sees happening is General Practitioners who save the Government money will be given financial rewards while those who don't will be punished. Lip service will be given to Health outcomes. In Britain the rich go to the US for their heart surgery. The poor wait for two to three years, or die on the waiting list (It's happening in Australia as well). The result of this will be a two tier system of health where those who can pay will get deluxe health while those who can't will get the “approved’ government version.

Ultimately our organisation feels that the motivating factor in the doctor patient relationship is the health of patient not the fiscal duty to the ruling government. If the government makes promises that it can't keep then the representatives who proposed these schemes should be sanctioned through democratic means.

Dr Steven Zebic.  
M.B.B.S  
Vice President  
Australian College of Non VR General Practitioners.

**Appendix  
Comparison of City VR and National Non VR Profiles for the period  
Jul 1 2000 to Jun 30 2001  
Non VR Black  
VR Red**

Percentile	10%	25%	50%	75%	90%	99%
Total Patients	170	509	1,472	2,868	4,362	7,763
Total Services	472	1,117	2,981	6,275	10,247	16,928
Total Benefits	15,014	31,649	72,797	139,125	211,675	343,809
Total Services Per Patient	1.24	1.44	2.00	3.32	5.30	16.12
Total Benefits Per Patient	27.48	34.94	49.75	81.38	158.97	690.65
Diag Imaging (DI) Patients	4	38	150	322	527	1,026
Diagnostic Imaging Services	5	51	209	479	762	1,517
Diagnostic Imaging Benefits	360	4,043	14,774	35,709	58,889	108,889
DI Services/ Total Patients	0.01	0.06	0.13	0.25	0.45	1.01
DI Benefits/Total Patients	1.04	4.60	9.86	20.26	38.03	86.18
DI Patients I Total Patients	0.01	0.05	0.09	0.16	0.28	0.68
DI Services / DI Patients	1.05	1.22	1.35	1.50	1.70	2.33
DI Benefits / DI Patients	61.44	82.03	103.05	126.61	157.87	231.45
DI Benefits/ Total Benefits	0.01	0.09	0.20	0.33	0.60	1.65
Pathology UPTAKE) Patients	9	80	291	543	769	1,253
Pathology Services	31	302	1,155	2,276	3,379	5,656
Pathology Benefits	528	5,256	20,053	40,534	60,815	104,859
PTH SVCS / Total Patients	0.07	0.32	0.72	1.39	2.20	6.45
PTH Benefits / Total Patients	1.47	5.75	12.70	24.11	38.41	140.35
PTH Patients I Total Patients	0.02	0.09	0.18	0.30	0.46	1.14
PTH Services I PTH Patients	2.54	3.18	3.78	4.59	5.55	9.58
PTH Benefits / PTH Patients	44.30	55.00	66.70	82.44	101.47	200.32
PTH Benefits I Total Benefits	0.02	0.12	0.25	0.40	0.61	1.80

If we look at the average GP profile (ie 25<sup>th</sup>-75<sup>th</sup> ) Percentiles we find that non VR doctors as a whole are cheaper, service less and cost the community less on a per patient basis in terms of flow on costs such as pathology, radiology and biochemistry as compared to their VR colleagues.