SUBMISSION TO THE
Productivity Commission Health Workforce Study

My submission is a collection of various articles published in daily newspapers (The Australian, The Age etc) and the medical journals such as The Australian Doctor, Medical Observer, GP Review etc.

My main points are:

1. There is no shortage of medical practitioners. In fact there is a serious oversupply.
2. The main reason which affects the demand for doctors is Price, as in the case of any service. 'Free' health care provided (due to bulk billing) creates artificially inflated (almost infinite) demand.
3. The factors which affect the supply of doctors is the government budget- ie the money that is available for health care. Since this must be controlled, the number of doctors must be controlled as well.
4. The 'shortage' of doctors in the rural areas is no different to the shortage of any other professional (teachers/engineers/lawyers etc) in the bush. In fact rural areas are far better served by doctors than other professionals.
5. Greater financial incentives must be used to solve the problem of insufficient doctors in the bush (if it exists) rather than taking in lower quality students from rural areas as happens now.
6. The mal-distribution of doctors in the bush is a myth. There is serious 'churning' or 'over-servicing' which occurs in the rural areas by GPs which would not occur if there is 'real' shortage.
7. The education of medical students is highly inefficient. There should only be one or two medical schools in each state (which may have attached clinical schools in rural areas). There are far too many medical schools with small intakes at present.
8. Like universities, AMA and RACGP have vested interest in increasing doctor numbers, so that they can increase their membership.
9. Every university wants to have a medical school or increase their intake of medical students to improve their prestige and get more COG (Commonwealth operating grant) money. This should be seen for what it is.

10. The best way of ensuring efficient and effective delivery of health services is to encourage co-payments and discourage bulk billing. Otherwise perverse incentives will result, as is happening now.
11. Free health care results in over-servicing and over-consumption of drugs which is harmful to health of citizens.
12. The lack of sufficient number of after-hours services is due to the unwillingness of people to pay, rather than the shortage of practitioners. This unwillingness to pay arises out of the 'bulk billing' or 'free health care' mindset. There are doctors willing to work night shifts in general practice if a reasonable fee of say $150 per consultation is paid by the patients (as is the case for the services of say a plumber)
13. One of the reasons why many doctors (particularly female and older GPs) don't work longer hours is the low rate of pay. The reason why they are unable to charge higher for consultations is because of high competition and oversupply of doctors resulting in numerous doctors 'bulk-billing'.

Relevant published articles relating to this subject are given below:

It never ceases to amaze me how some doctors can be so naïve (Numbers needed, p22, AD 16/11/2001). There is no national shortage of GPs, as Dr Rosevear argues, it is just that demand for our services is unlimited, because they are free.

There are so many factual inaccuracies and contradictions in the letter by Dr Rosevear, that they cannot go unchallenged. Australia does not graduate 2200 doctors a year. The correct figure is close to half of that. Secondly, I am not aware of any 'unemployed' doctors. Thirdly, as a female GP, the restriction on provider numbers does not discriminate against me, in fact it provides greater flexibility by increasing demand for my services. While whining about our lower status relative to specialists, some doctors want GP numbers increased, which is certain to reduce our worth in public's eyes even further!

If you work long hours, Dr Rosevear, that is your choice. Just ask for a minor copayment (from patients who make you believe you are indispensable) and watch all the demand for your services evaporate!

If you want a holiday, just shut up shop and go. Doctors like to think they are indispensable, and insist on providing services free (citing equity, fairness etc) and hence keep the demand unlimited, because it is good for their ego.

The reason governments do not limit the number of lawyers or electricians is that there is no universal compulsory insurance for their services and those services are not provided free to everyone. Maybe we should have a legal services levy, electrical services levy (like Medicare levy)!

Many GPs don't seem to understand the basic principle of economics: the relationship between demand and supply.

The minority who do understand gain comfort in the statement "but the free market doesn't work in health care". In reality what they mean is that they don't want free market principles to work in health care because it doesn't suit them (their ideologies etc).

I operate a solo medical practice and bulk bill. I could work 24 hours a day and still have patients while I bulk bill. However I recently decided that, in order to stay sane, I would charge the patients a minor gap payment of $15 for consultations after 6 pm. I found that all that demand for my services after 6 pm disappeared!

My experience and those of other GPs shows that the demand for our services exists mainly because they are free. It is an insult to the profession that the public value our services so little that they are unwilling to pay the cost of a pizza for healthcare.

If free services are provided, there would be unlimited demand for *any* service: handymen, plumbers, hairdressers, accountants, lawyers. It is ridiculous to argue that there is a shortage of service providers in any profession where the services are provided free.

"Hold on," people say, "but access to health care is essential!" However, access to food, electricity, gas and water services are even more essential. Why don't we provide these for free?

It is theoretically impossible for any government to provide top class services (accommodation, health, education etc) free to the entire population, unless it has unlimited money. The only realistic and pragmatic thing to do is to have dual system (a high quality private system for those who can afford it and a safety net, lower quality system for those who can't).

I find it incredible that many doctors such as Dr Rosevear say there is a shortage of GPs. The reality is there is a severe oversupply and RACGP, AMA and the profession must wake up to this fact. Instead of campaigning for higher rebates, they should support the government's efforts to restrict provider numbers.

The AMA doesn't seem to have its finger on the pulse of GPs' thinking. If it did, Dr Phelps wouldn't make outrageous claims such as "GP shortage will be 11,000", (AD p6, 5/4/2). Since GPs are dime a dozen in every suburb, they have lost the respect and prestige they once had, and are forced to bulk bill.

What's the point in AMA having a tiff with the ACCC to allow doctors to set fees in their practices when the number of GPs is so large that it is impossible to private bill?

If any service is free, there will be an unlimited demand for it. It is analogous to providing a free taxi service to everyone, resulting in unlimited demand and then claiming to have a shortage of taxi drivers.

What AMA should be doing is lobby the government to limit the number of GPs and move towards a 'user pays' system. It is theoretically impossible to provide top quality health care to everyone unless unlimited money is available.

AMA should also educate the public on the need to make a contribution to their health care in the interests of quality: that they can't get a 'lobster and champagne' service at 'fish and chips' (bulk billing) prices.

Your article "Doctors without patience" (Oct 1st) does not cover an important point: unlike most other professionals, GPs are unwilling to use price as a mechanism to control their workloads.

There is no workforce crisis; there is a crisis of confidence among GPs, who do not value themselves, thus do not charge a reasonable fee for their services.

If all GPs were to charge a co-payment of say $30 per consultation, most of them would become unemployed. I have tried this strategy and it sure as hell works!

GPs should stop whingeing about long hours, workloads, shortage of doctors etc and start charging reasonable fees. Then all such 'problems' will evaporate overnight.

Medicare could help GPs, by making it easier to private bill and by not actively discouraging them from working too hard and seeing many patients.

Nathan Pinskier refers to a 'structured appointment system' (also known as 'open-office scheduling') as the cure for the ills of patients' complaints regarding waiting time (GP Review, June 2002, p23).

While the suggested system removes the difficulty of getting same-day appointments, it makes it difficult for patients to obtain appointments at an earlier time. It also puts the onus of deciding the 'urgency' of a patient's problem on staff.

A more appropriate system is to use the magic of 'price signals' to control the demand for appointments. We charge three scales of fees depending on the patient's perceived urgency of their problem.

We charge $15 for advance appointments, $30 for same day appointments and $40 if they wish to be seen as the next patient (all are co-payments).

By using this 'three tiered appointment system', the patients are in control. They decide when they wish to have a consultation, rather than staff making the decision for them.

Dr Paul Sherwin's proposed 'solutions' for reducing PBS costs (MO, 6 July 2001) reek of more regulation of the most regulated profession of all: the medical profession.

For a country to be competitive in the global environment, policies have to be put in place to encourage people (including professionals) to work harder and smarter, rather than impose restrictions that reduce the efficiency and effectiveness of their work.

It is ridiculous for Dr Sherwin to claim that there are laws restricting the number of hours worked by certain people. That may well apply to a few categories of *employees*, but I know of no self-employed business people (many GPs are in this category) to whom such restrictions apply: for example lawyers, accountants, bakers, plumbers and engineers. Would any

one dare impose restrictions on the number of clients seen by self-employed professionals or number of services rendered by self-employed tradespeople?

The simple answer to reducing PBS costs is to send 'price signals', by at least tripling the currently meagre co-payment for drugs. Similar co-payments for visits to GPs would curb demand, introduce some *real* competition and reward efficient GPs. Politicians are reluctant to do this (Labor more so than Liberal) for political reasons and are expecting the GPs to do the dirty work for them. They are diverting the flak they would receive from the patients, to the GPs.

Expecting GPs to restrict the number of scripts they write is analogous to the government providing a free taxi service to everyone and forcing the driver to ration the unlimited demand it would generate.

Free Doctors create shortage

The claim of Drs O'Dea (15/7) and Rankin (19/7) that there is a shortage of GPs is incorrect. Vested interest groups such as those they represent are distorting the truth.

I operate a medical practice in the outer suburbs and bulk bill. While I continue to bulk bill, I could work 24 hours a day and still have patients. However I recently decided that, in order to stay sane, I would charge patients a minor gap payment of $15 for consultations after 5 pm. I found that demand for my services after 5 pm evaporated!

My experience and those of other GPs shows that the demand for our services exists mainly because they are free. It appears that the public values our services so little that they are unwilling to pay the cost of a pizza for healthcare.

If services are provided free at the point of delivery, there would be unlimited demand for *any* service: handymen, plumbers, hairdressers, accountants, lawyers. It is ridiculous to argue that there is a shortage of service providers in any profession where the services are provided free.

Providing free medical services and claiming a shortage of GPs is analogous to providing a free taxi service to everyone and the Australian Taxi Industry Association claiming that there is a shortage of taxi drivers, to cope with the unlimited demand it would generate.

The reality is that there is an oversupply of GPs and people do not consider their health care to be valuable enough to pay for.

FOOD ISN'T FREE, SO WHY DOCTORS?

Kate Stewart's claim (24/7) that health care is essential so it should be provided free, is flawed. Food, clothing, electricity and gas are even more essential. Why aren't these provided for free?

Such arguments reflect a deep malaise in our society. This is what I call the FOHP (From Others' Hip Pockets) syndrome, similar to NIMBY (Not In My Back Yard).

An example of FOHP is when sectors such as health care, education and
child-care claim their services are essential so they must be subsidised or provided free, at the point of delivery.

The fact is people want various services, but do not consider them valuable enough to pay for it at the point of delivery – they expect them to be paid FOHP.

PEOPLE ONLY VALUE WHAT THEY PAY FOR

The impact of universal bulk-billing on the demand for medical services is much worse than Dr ------- outlined in her letter of 23/7 and Kate Stewart 24/7 inadvertently exposes the reason.

People who believe that, having paid their Medicare levy, they have paid for their healthcare, feel free to demand unlimited service without further payment, not only from GPs but from public hospitals.

The truth is that the Medicare levy meets only 67% of Medicare rebate payments, and has never met their full cost, let alone made any contribution to public hospitals or pharmaceuticals.

Even in communist China a small charge is applied. As Mao said: 'What the people are given for nothing, they do not value.'

The article in The Australian 18/4/2, page 1 states that there is a shortage of GPs in general, for eg in western suburbs of Melbourne. This is incorrect.

If doctors work long hours, it is their choice. If they ask for a minor co-payment (from patients who make them believe they are indispensable) they will find all the demand for their services will evaporate!

I operate a medical practice in the western suburbs of Melbourne and bulk bill. I could work 24 hours a day and still have patients while I bulk bill. However I recently decided that, in order to stay sane, I would charge the patients a minor gap payment of $15 for consultations after 5 pm. I found that all that demand for my services after 5 pm disappeared!

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“Hold on,” people say, “but access to health care is essential!” However, access to food, electricity, gas and water services are even more essential. Why don’t we provide these for free?

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American health care model is constantly criticised as one where they spend more of GDP on health care yet have 'worse' health outcomes. This is not quite true. It depends on your definition of 'health outcomes'. People who are very rich receive much better health care and facilities in the US than in Australia. People of lower socio-economic status probably receive better quality health care in Australia than in the US.

So if your definition of 'health outcomes' means lower standard deviation in quality of care then Australia fares better. But if one's definition of 'health outcomes' means higher standard deviation in quality of care, US does much better.

How else do you explain the fact that people from developing countries go to the USA for top quality health care, rather than come to Australia?

You are wrong Dr Auricht (GP Review, Sept 2001, Page 3).

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While the Government does not set doctors fees as you suggest, its policies have the effect of keeping bulk billing rates very high. For example many doctors are unable to charge private fees because of the oversupply of GPs and the difficulties imposed by the government in charging fees (eg., not allowing co-payments while bulk billing).

While I understand the Government's concern with providing quality health care to all citizens, it must realise that **it is theoretically impossible for any Government to provide top quality health care to all, unless there is unlimited money available**. I do not believe mandatory co-payments will result in lower quality health care: in fact it will improve health outcomes by reducing over-servicing and over-consumption of pharmaceuticals.