THE AUSTRALIAN MEDICAL WORKFORCE SHORTAGE AND PROVIDER NUMBER RESTRICTION LEGISLATION

THE PERSPECTIVE OF A POST-1996 MEDICAL GRADUATE

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Summary

Thousands of non-VR GP's, and thousands of doctors who have graduated since 1996 have post graduate experience that would enable them to safely contribute to the general practice workforce, but are currently prevented from doing so by provider number restrictions.

The ageing GP workforce, a desire among younger doctors for downshifting, and the projected increases in health demands of an ageing population mean that fossilised restrictions on qualified practitioners accessing Medicare must be reformed, even if it means stepping on the toes of vested interest groups.

The federal government has implemented provider number restrictions that allow Medicare costs to be reined in, and create a means by which doctors can be economically compelled to work in more remote areas. This preference for the stick rather than the carrot will only continue to discourage new doctors from entering general practice.

Fundamental reform of medical workforce planning, Medicare access, training pathways, and oversight mechanisms is urgently needed.

Medicare provider number restrictions – a primer

Prior to 1996, around 800 medical graduates entered general practice every year in Australia after finishing their medical degrees and spending time in the hospital system.

When the coalition government took office, Dr Wooldridge soon implemented Medicare provider number legislation that severely curtailed the access of new graduates to Medicare provider numbers.

Without a provider number, a medical graduate cannot access Medicare, and cannot therefore provide Medicare services.

Immediately following the introduction of the new Medicare provider number legislation, only 400 graduates could enter general practice every year.

Over the last decade, this has slowly been increased to around 650 training positions per year as the shortage in general practitioners has grown more severe. Difficulties have been experienced, however, in filling these training positions.

At the time of the provider number restrictions, Dr Wooldridge that claimed that there was an oversupply of medical practitioners:

> *"there is major oversupply of medical workforce now and that it is not to be quickly remedied."*
>
> Dr Wooldridge's speech to the AMA in 1996 (http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/health/wooldridge_1996.html)

Dr Wooldridge relied on AMWAC (Australian Medical Workforce Advisory Committee) findings to support these claims.

AMWAC workforce modelling relied on flawed assumptions

Unfortunately, the methodology used by AMWAC was flawed. Seemingly ignorant of basic labour market economics, AMWAC somehow concluded that the best measure of medical workforce adequacy was the degree to which patients were not bulk billed. Using this approach, AMWAC concluded that parts of Australia with ideal doctor to patient ratios were large rural centres. AMWAC concluded that the higher rates of bulk billing in city areas therefore reflected oversupply.

This approach completely failed to consider whether Medicare rebates were adequate to sustain the provision of general practice services in rural areas without gaps being charged. Any worker, whether they are a plumber, electrician, or doctor, will have higher costs in the country in relation to the schooling of children, energy costs and other household expenses. In addition to increased costs for essentials, there are often diminished opportunities for cultural and social activities. It is only natural that people with highly transferable skills that are in demand elsewhere within the economy should want to be remunerated more if they are to work in more remote areas.

Accordingly, to conclude that increased levels of bulk billing in the city relative to country areas reflects oversupply of doctors in the city is overly simplistic. Unfortunately, this

simplistic conclusion provided the workforce findings seized upon by Dr Wooldridge and has led to a situation nine years later where doctors are still in short supply in country areas, and a shortage of general practitioners in city areas is becoming critical as well.

Over the last fifteen years, the costs of running a practice have exceeded increases in the CPI, but increases in Medicare rebates have lagged CPI, exacerbating this financial squeeze.

Medicare rebates have also distorted the price mechanism that applies to the remuneration of medical services. Over the last fifteen years, general practitioners that have continued to bulk bill have held out, hoping for increases in the Medicare rebate, with some compensating for rebates that have decreased in real terms by seeing more patients per hour. Bulk billing, and the absence of the need to explain an out of pocket cost to patients, the absence of any need to collect and hold cash from patients, the absence of administrative changes to deal with the collection of cash in addition to Medicare stubs, and the hassle for patients associated with getting the Medicare rebate refunded, creates an initial hurdle to the introduction of a small gap of only a few dollars. The cost of collecting the gap may well exceed the money collected if the gap is small.

More remote practitioners, by comparison, already charging a gap to compensate for the increased practice and opportunity costs of more remote practice, are in a better position to increase gaps over time, as patients are already used to paying a gap, and the requisite administrative procedures are already in place.

AMWAC's failure to appreciate how these factors, and others, influence bulk billing rates contributed to their flawed conclusions and has contributed to the dire medical workforce situation we now face.

The arbitrary nature of the grandfathering process and vocational registration

In the years leading up to the introduction of provider number restrictions, a vocational register of practising GP's was established by the Health Insurance Commission (HIC). Inclusion of practising doctors on the register did not require membership or fellowship of the Royal Australian College of General Practitioners (RACGP). Instead, it relied on the number of years experience gained in general practice. A decision was made to freeze the vocational register in 1994. After provider number restrictions were introduced, practicing doctors already accessing Medicare rebates were entitled to a higher rebate if they were vocationally registered ("VR" general practitioners). Any remaining doctors that were not vocationally registered were entitled to a lower rebate ("non-VR" general practitioners). Any new medical graduates were required to obtain fellowship of the RACPGP before being able to access Medicare rebates.

This two tiered system of grandfathering was quite arbitrary, and led to significant injustices being visited on doctors already practicing and doctors still in training. Many practicing doctors missed out on VR status through historical happenstance, being overseas when the register was frozen, or only just missing out on satisfying the VR criteria.

Medical students and interns who had started their studies before 1996 in the expectation that they would be able to enter general practice in the same way their predecessors had were suddenly disenfranchised, and left without access to Medicare rebates, either VR or non-VR, upon graduating.

Resultant disenfranchisement and disgruntlement in the medical workforce

Non-VR GP's have suffered under discriminatory Medicare rebates since 1996, despite having the same qualifications as around two thirds of practicing VR GP's.

Doctors that graduated after 1996 are not even able to access Medicare rebates for daytime general practice, despite having exactly the same qualifications as around two thirds of practicing VR GP's.

Non-VR GP's and doctors that have graduated since 1996 find the idea that they must undergo RACGP "training" which is overseen and delivered in many cases by people that are no more qualified than the trainees to be quite absurd.

Non-VR GP's and doctors that have graduated since 1996 find it outrageous that they must practice in a rural location ("area of need") to access Medicare rebates when the doctor shortage is clearly evident now even in city locations. The fact that many areas of need rely on outdated data relating to shortages, and that many areas of need are coalition constituencies, makes this type of conscription even more irritating.

Non-VR GP's and doctors that have graduated since 1996 find the idea laughable that they are supposedly unsafe to practice unsupervised, but can access VR rebates in isolated rural locations, or working all alone as a night locum in city areas. Being able to access VR rebates between the hours of 6pm and 7am as a locum in the city but not during the day is insulting.

Non-VR GP's and doctors that have graduated since 1996 find it inexplicable that they are supposedly not as qualified to practice unsupervised as VR GP's, yet they often work in emergency departments receiving and treating seriously ill patients that VR GP's have been unable to manage safely in their own practices.

Vested interests

Quoting from the Bills Digest 47 1996-97, Health Insurance Amendment Bill (No. 2) 1996, in relation to the provider number restrictions:

> *"The move is designed to reduce the growth in Medicare payments through a reduction in the supply of general practitioners and is estimated in Budget Paper No. 1 1996-97 to save $25.9 million in 1996-97, $106.1 million in 1997-98, $181.8 million in 1998-99 and $256.2 million in 1999-2000."*

Non-VR GP's and doctors that have graduated since 1996 naturally see provider number restrictions as an expedient means by which growth in Medicare expenditure could be curtailed, and an excellent means by which doctors could be conscripted to perceived areas of need – namely rural constituencies. The community is now paying the price for these savings by way of reduced access to doctors in both rural and city areas.

Given the above quotation from the 1996-97 Bills Digest, the conclusion made in the 2003 Biennial review of provider number legislation is a little hard to accept for doctors such as myself:

> *"There is broad agreement that compared with other issues the operation of this section of the Act (19AA) has had very little to do with the medical workforce shortage that is facing Australia and the world."*

This "broad agreement" does not seem to include Professor Bob Birrell, whose reports published by the Monash Centre for Population and Urban Research point out that successive Federal Governments are to blame for cutting back doctor numbers because of a concern about the blow-out in the costs of Medicare. As well as feeling that that this work force shortage is a "self inflicted wound" on the part of the government, Professor Birrell is particularly concerned about the ease with which overseas trained doctors are able to practice without first satisfying basic Australian Medical Council standards that all Australian graduates must satisfy before practicing (http://www.adf.com.au/archive.php?doc_id=127).

The RACGP also benefited from the imposition of provider number restrictions, as they suddenly became the only means by which VR status could be acquired. Non-VR GP's and doctors that have graduated since 1996 are not unaware that Dr Wooldridge re-allocated $5 million in asthma funding around the time provider number restrictions were instituted to allow a new headquarters for the RACGP to be built, and that the RACGP had a consultancy lined at the RACGP up for Dr Wooldridge when he finished his time in politics (when the consultancy did not proceed, Dr Wooldridge sued the RACGP for a breach of contract).

Naturally, the RACGP remain less than enthusiastic about any moves to give VR status to non-VR GP's

Significant sums of money are being spent every year on the new training infrastructure for RACGP trainees, and these training bodies, like most gravy trains, are also reluctant to see any changes to the status quo.

Doctors that have participated in the RACGP training program since 1996 are also reluctant to see grandfathering of non-VR GP's, or other mechanisms by which VR could be attained by already practicing doctors that have graduated since 1996.

Lack of representation for the disenfrachised

It is mainly thanks to Dr James Moxham that the ongoing discrimination by the HIC and RACGP in relation to non-VR GP's continues to be highlighted.

Doctors that have graduated since 1996 are essentially voiceless. The RACGP does not represent them, and the AMA continues to support differential rebates for non-VR GP's; doctors that have graduated since 1996 are therefore completely off the radar in relation to provider number access.

Failure of review processes

The 1996 Medicare Provider Number Legislation contained a sunset provision that required the provider number restrictions to be removed as of January the 1st, 2002. As such, I and many others would have been entitled to a full provider number on the completion of my internship in mid January 2002.

Unfortunately, a review of provider number legislation undertaken in 1999 by Ron Phillips found that because no doctors were without work as a result of the changes, it could be assumed that no doctors were disadvantaged, and therefore the sunset clause should be removed and provider number restrictions should remain. Within 24 hours of this report being tabled in parliament, Item 7 - Subsection 19AA(1) and Item 9 - Subsection 19AA(2) of the *Health Legislation Amendment Bill (No. 4) 1999* were passed, which had the effect of removing the sunset clause on the 1996 restrictions on Medicare rebates. Normally, such efficiency in government would be commendable, but in this case, one can only suspect that the speed with which the sunset clause was removed reflected the certain knowledge by Dr Wooldridge that the measure would be strongly opposed.

The test used by Ron Phillips to assess the effects of the provider number restrictions, namely, that no doctor was without work as a result of the legislative changes, was a foregone conclusion, given that medical workforce shortages were already developing in 1997.

Looking at the 1999 review's findings, one cannot help but be struck by the contradiction between the original intent of the legislation to reduce workforce numbers, and a mere three years after the introduction of the provider number legislation, an acknowledgement of workforce shortages:

> *"the quality and training objectives of the legislation are being weakened by the necessary emphasis on addressing workforce shortages"*

With this somewhat kafka-esque approach to the review of the provider number legislation, it is no surprise that the ramifications arising from the now permanent restricted access to provider numbers were not going to be fully appreciated and considered. This claim in 1999 is also completely at odds with the assertion quoted above from the 2003 Biennial review that provider number restrictions have not affected workforce numbers.

Subsequent Biennial reviews have concluded that the current system is resulting in higher standards, and that provider number restrictions should remain so that these standards can be maintained along with the training mechanisms that have been developed. This is completely at odds with the original intent of the provider number restrictions, namely, a means by which Medicare expenditure could be reduced and geographically controlled by temporarily rationing access to Medicare rebates for a period of four to five years after which the restrictions would expire. This panglossian historical revisionism does not help the debate over workforce shortages. The facile recommendation in the 1999 review to the effect that making provider number restrictions permanent would increase morale in the medical workforce by providing certainty simply beggars belief:

> *"This review finds no reason why the sunset clause should remain in the legislation. In fact the review finds that it would be counterproductive to morale amongst junior doctors to maintain the illusion that the legislation will ever be repealed. It would also provide certainty for medical students."*

Recent Biennial reviews have made the incorrect assumption that doctors that graduated after 1996 only work in public hospitals, and therefore provider number restrictions are an important means by which a workforce will continue to be available to the hospital system. This is not the case. Many doctors such as myself work as locums, doing after hours Medicare work, rural locum work, salaried state government and local government

community based work, private hospital work, surgical assisting, defence force work, workcover and third party compensable work, as well as work for private employers and work in various sub-specialties such as aviation medicine and musculoskeletal medicine. Restricted access to provider numbers creates various difficulties and inefficiencies which compromise our ability to deliver care to patients, and these consequences have not been adequately considered by the biennial reviews.

Workforce distortions and inefficiencies arising from provider number restrictions

VR doctors often refer patients to non-VR GP's or doctors such as myself who graduated after 1996. They do this because they do not feel experienced enough, or are simply disinclined to manage cases in areas as diverse as musculoskeletal medicine, industrial medicine, third party compensable cases, or travel medicine. It is also interesting to note that I regularly come across patients who describe humiliation in front of waiting rooms full of people in the clinics of VR GP's, who have told them they "don't do workcover", and that they'll have to go somewhere else. If the gold standard of general practice is indeed the much vaunted Fellowship of the RACGP, why do VR doctors or Fellows of the RACGP not feel competent or inclined to diagnose, treat or manage such patients?

Not infrequently, when working in industrial, musculoskeletal or third party compensable medicine, I find that my management of patients with psychiatric conditions or emergency medical conditions that are aetiologically unrelated but impacting on their main complaint is compromised by my inability to access Medicare rebates. Although I am quite capable of managing a patient presenting with chest pain, I am committing a criminal offence of strict liability under Section 19CC of the Health Insurance Act 1973 if I treat the patient without first explaining that I am not entitled to Medicare rebates and later attempt to charge the patient for my consultation. Clearly, Medicare provider number restrictions can create awkward situations for doctors such as myself working in community clinics catering to walk in workplace injuries and conditions. Likewise, I am unable to undertake or initiate medical management of psychiatric conditions in patients presenting with unrelated work injuries, as I am unable to easily follow-up the patient up. Recent changes to South Australia's third party injury laws mean that in the event a patient is found to be 100% liable for their accident, they are not entitled to medical treatment costs, and I am therefore unable to derive a fee via the third party insurer or Medicare.

In recent years I have also done surgical assisting. When it was realised that implementation of the provider number restrictions in 1996 would make it very difficult for surgeons to find doctors able to access Medicare rebates that could assist them in private hospitals, restricted provider numbers were made available for surgical assistants. These restricted item numbers allowed surgical assistants graduating after 1996 to access Medicare rebates for assisting at surgery. Unfortunately, Mutual Community has in the last two years decided that any surgical assistant with a restricted provider number is not qualified to assist at operations and therefore should not be paid any gap over and above the Medicare rebate by Mutual Community. This position is absurd, as the private hospitals, the private surgeons, the Health Insurance Commission and medical boards all agree that any doctor registered to practice medicine with suitable surgical referees is able to assist at surgery. Mutual Community refused to acknowledge this, refused to pay, and as a result, I have stopped doing private surgical assisting. I found it to be completely untenable that I should have to explain to patients why I am in fact qualified to assist at surgery, despite claims to the contrary from Mutual Community, and having to explain that their health fund was simply discriminating

against me on the basis of the year I graduated so that they could foist the cost of my services back onto the patient, despite their supposedly top table private health cover. The whole purpose of restricted provider numbers being provided in the first place, namely allowing provision of surgery in private to continue, has been undermined by Mutual Community's opportunistic discrimination against doctors with restricted provider numbers who graduated after 1996. Presumably, going by Mutual Community's logic, if I complete training in psychiatry or haematology so that I have a full, unrestricted provider number, I will then be "qualified" to assist at surgery and receive the usual fee from Mutual Community.

Often, it is easier for overseas trained doctors to access Medicare rebates in city fringe areas than it would be for me to get a provider number to access such rebates. Although it has crossed my mind, I am reluctant on principle to leave the country and return with a foreign passport and apply for a provider number so that I can access Medicare rebates closer to home.

Tony Abbott was reported to have pressured state medical boards behind the scenes to register overseas trained doctors who have not met the Australian Medical Council's standards,

> "All overseas-trained doctors will have to undergo rigorous new assessment procedures before being allowed to practice in South Australia. The crackdown – by the Medical Board of SA – follows an admission by the board last night it had been "pressured" by the Federal Government to register overseas-trained doctors, despite having concerns about some credentials."
> (http://news.com.au/common/story_page/0,4057,10053612%255E2682,00.html July 6, 2004)

while Tony Abbot was saying publicly:

> "… overseas-trained doctors are fully qualified to work in Australia - that's the judgment of the medical registration boards and they wouldn't approve anyone they didn't believe was qualified,"
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> (http://thewest.com.au/20040706/news/general/tw-news-general-home-sto127658.html July 6, 2004)

Clearly, it is no wonder that non-VR doctors and doctors who have graduated after 1996 view with some scepticism the publicly aired comments from vested interest groups about provider number restrictions "preserving and improving standards".

Recent schemes to entice general practitioners out of retirement also cause wonderment among non-VR doctors and doctors who have graduated after 1996. Apparently enticing someone back into general practice who graduated before DNA was discovered is preferable to allowing more recent graduates to access Medicare rebates.

Recent schemes by the federal government to extend access to Medicare Rebates to practice nurses has created the quite bizarre situation in which I, unable to access Medicare despite the fact that I work in an area of recognised general practitioner shortage but not classified as such federally, work alongside a nurse with access to Medicare rebates.

Even things as simple as obtaining PBS prescription pads has been made difficult by lack of access to a provider number. Although a provider number is not required for me to write PBS prescriptions for patients, it was only after much discussion that I was finally allowed script pads with a practice address that did not relate to a provider number. I was suggested that I

could have been anyone, i.e. an imposter seeking script pads, despite the fact that I had undertaken the requisite PBS training session and had already had a prescriber number (which is quite different to a provider number) issued.

When I undertook after hours locum work a year or so ago, I felt quite marginalised and discriminated against when I was asked, even though I was born, raised and trained in Australia, for proof of citizenship when applying for a restricted provider number.

If standards of practice have in fact improved with restricted access to provider numbers, it immediately raises the question – do medical indemnity insurance premiums reflect this difference in outcomes and quality of care. The answer is no. Medical indemnity insurers make no distinction, which begs the question: are these supposedly significant differences in standards of care illusory?

In recent years, significant changes have also occurred in the area of general practice accreditation. Unfortunately, AGPAL accreditation, as it is known, relies on RACGP dictated standards that tend to ignore sub specialty areas of practice, and assume that all doctors are vocationally registered members of the RACGP doing routine general practice. Many sub-speciality clinics, such as workcover or travel medicine clinics, find the RACGP dictated AGPAL standards to be quite a poor fit for their circumstances. This is unlikely to change while the RACGP continue to determine the standards for accreditation, and this discrimination and exclusion is particularly galling for practitioners doing work that many VR GP's refuse to do, such as workcover or compensible medicine cases.

Recommendations

I have grouped my recommendations into general categories

Workforce planning - recommendations

i) I have high regard for Professor Bob Birrell's published work at the Monash Centre for Population and Urban Research. It's rigour and historical perspective stand in stark contrast to other bodies which have advised government on workforce issues in the past. If the Federal government is keen to have independent, non-partisan and rigorous analysis of medical workforce issues in future reviews of provider number restrictions, they could do much worse than to seek Professor Birrell's input.

Access to Medicare rebates - recommendations

ii) The out-dated and quite arbitrary distinction made by the HIC between non-VR and VR doctors should be removed immediately. Once non-VR doctors are grandfathered, they can ensure and maintain their professional standards in exactly the same way that equally qualified VR general practitioners do at present – with continuing medical education. This will encourage greater participation by non-VR doctors in general practice.

iii) Doctors who were in training when provider number restrictions were imposed should have the option of obtaining VR status after five years general experience, in the same way that VR general practitioners did and non-VR practitioners should. Professional standards can then be ensured and maintained in exactly the same way that equally

qualified VR general practitioners do at present – with continuing medical education. This will enable doctors doing a variety of sub-speciality and locum work to help address the critical workforce shortages at present.

iv) The government should consider whether it would in fact be preferable to expand the role of local non-VR and post-1996 graduates, rather than expanding the roles of nurse practitioners, allied health practitioners, retired general practitioners and finally, doctors recruited from developing countries that can ill afford to lose their scarce doctors to the industrialized nations.

Workforce Distribution and Workforce Initiatives - recommendations

v) The government should have realised by now that solutions to the medical workforce shortages in remote areas will not be achieved with provider number restrictions that amount to civil conscription – medical practitioners are far too employable elsewhere for this to work. A more rational approach to workforce distribution would be to incentivise remote practitioners by means of differential rebates tied to remoteness, and to stop discriminating against practitioners on the basis of arbitrary dates of graduation or a signature on a piece of paper that enabled a doctor to join the vocational register ten to fifteen years ago. To this end, plans for rural specialities are not without merit.

Training - recommendations

vi) A critical review is needed of current training arrangements and their supposed merits. The ease with which overseas trained doctors have been able to enter general practice without adequate safeguards stands in stark contrast to the situation faced by local medical graduates following provider number restrictions.

vii) If it decided by people other than RACGP and GPET apparatchiks that sitting the examination for fellowship for the RACGP is indeed desirable and a worthy aspiration for all general practitioners, then practitioners who have achieved this standard should be incentivised with an additional 5% loading on their Medicare rebates. At present, around two thirds of general practitioners have never sat the examination yet get paid the same rebates as RACGP fellows who have undergone the time and trouble to complete the training requirements needed to undergo the RACGP examination.

Regulatory Mechanisms - recommendations

viii) The current state based medical boards should be replaced with a national board with state branches. This will make it easier for practitioners to work in different states without needing multiple registrations, and should facilitate oversight of practitioners, by having a centralised register of practitioners.

ix) Medical boards, as well as working to ensure the safety of the public, have a duty to ensure the safety of practitioners. Given the rise of identity theft globally, and also personal safety considerations, legislative changes that prevent public disclosure of home addresses of practitioners - provided professional practice addresses are available - from Medical Board registers and via internet retrievable state government gazettes will improve doctor safety.

x) Allowing overseas trained doctors to practice before sitting the Australian Medical Council examination – a test which is roughly equivalent to the final examination in Australian medical schools – is really quite unacceptable. This should be reviewed.