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Why the public cost of GP services is rising fast

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The financing of GP services has become an election issue. Organised medicine is agitating against the Coalition Government's decision in 2014 to freeze GP Medicare service rebates.

The Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) assert that these arrangements will have such a harsh impact on GP's income that, as a consequence, many will stop bulk billing their patients. The RACGP has initiated a campaign encouraging GPs to post notices in their waiting rooms to warn patients about the situation in the hope that patient outrage will hurt the Coalition at the ballot box. This campaign is working. The Labor opposition has promised that, if elected in August, it will remove the freeze, reportedly at a cost of more than one billion dollars a year.

Do the GPs have a case? If bulk billing were to decline, it would undermine the ideal of providing GP services regardless of the patient's capacity to pay.

However, the threat to abandon bulk billing is seriously weakened by the oversupply of doctors. Doctors with a reputation for comprehensive and effective practice may be able to do so but not those who are less experienced and less trained. As we document below, there are so many GPs seeking patients that few could risk charging a co-payment. If they did, patients would go round the corner to a competitor that does bulk bill. As for the growing number of corporate practices, their high throughput business model depends on bulk billing.

Nevertheless, the freeze issue does draw attention to important questions regarding the costs of GP services. This cost is escalating because of the GP oversupply. Given present policy settings, this oversupply will get much worse as many of the OTDs required to serve in undersupplied areas finish their service commitment and move into already oversupplied metropolitan or regional areas. Then to fill the gaps created by their departure, their employers recruit yet more OTDs to replace them. There will also be a flood of new Australian Trained doctors (ATDs) into the GP workforce. They can practise where they please which, if past experience is a guide, will mainly be in metropolitan areas.

The number of GPs per 100,000 people in Australia far exceeds international benchmarks, especially in Anglophone countries. According to independent Australian assessments, by 2005 on this metric, there were already more GPs than was consistent with good medicine.[1] Since then, as the following tables show, the number of GPs per 100,000 has increased sharply in metropolitan areas and even more so in some regional areas.

It is this oversupply that is the cause of the escalation of GP costs that the Coalition Government has sought to curtail. The extension of the freezing of the rebate cap would just apply a band-aid. Any realistic solution has to include a reduction in the growth of GP numbers and controls over where they are permitted to practise while funded by Medicare.

The source of the problem

Since 2004, successive Australian governments, ignoring advice at the time from the Australian Medical Workforce Advisory Committee (AMWAC),[2] have taken as their policy starting point that there is a shortage of GPs. These governments have responded by increasing domestic medical

training and facilitating an open program of OTD recruitment. Despite mounting evidence to the contrary, belief in 'doctor shortage' has developed a life of its own.

The Commonwealth Government has been reassured by its bureaucracy that this is the case and that policy should be guided by this judgement. Successive governments have found it easier to increase the GP workforce with an open chequebook than to seriously tackle the workforce issue.

Organised medicine is also part of the problem. One might think that the AMA and the RACGP would put their members' interests first by curbing the flood of new competitors into their market. Instead the leaders have vocally supported policies aimed at increasing the GP workforce. Warnings, such as we and other commentators have delivered, have been treated with derision.

The GP oversupply and its consequences

Table 1 summarises the record on the growth in GP numbers billing on the Medicare system over the years 2004 to 2015 and the cost to the taxpayer. As is evident, this rate of growth far exceeds the rise in Australia's population, thus generating a major increase in the number of GPs per 100,000 people and an increase in the number of services provided per capita.

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[3]

As is shown in Table 2, which tracks the statistical record over a longer time period, the number of GPs per 100,000 and bulk-billing rates bottomed out in 2003. This outcome was a consequence of policies carefully designed to limit the number of GPs during the 1990s. This advice was based on the AMWAC and AIHW studies referred to above. By the early 2000s, these consequences had prompted a public outcry as bulk-billing rates declined and regional and outer metropolitan areas struggled to recruit GPs. The then Coalition Government, and governments since, responded by increasing the number of medical school places and by facilitating the recruitment of OTDs.[4]

Table 2: GP Workforce selected parameters at peak and trough supply, selected financial years

	1984	1986	1992	1996	1998	2003	2009	2013
GP Head Count per 100,000	106	110	125	128	123	115	121	139
Services per capita	4.3	4.6	5.5	5.5	5.6	5.1	5.3	5.8
Per cent bulk-billed	60	69	76	81	79	68	80	84

Source Calculated by DoH 2014 GP Workforce data analysis back to 1984.
Note: GP and Service numbers back to 2004 were revised in the 2015 dataset hence the use of the 2014 dataset here.

The policies certainly succeeded in their objectives, since the number of GPs employed in hospitals and in private practice has increased sharply. But they are now in an overshoot phase.

Government may be happy with ever rising bulk-billing rates but Services per Capita have continued to go up. The freezing of rebates may limit this expansion in government expenditure but expenditure is still certain to rise because, as detailed below, under present workforce policies, there will be an increasing number of ATDs and OTDs doctors practising. They will have to chase patients. The Medicare system allows them to do so.

Where have all these extra GPs come from?

Table 3 details the increase in the total number of GPs over the years of expansion between the financial years 2004-05 to 2014-15. The total increase in the number of GPs billing Medicare was 10,702. Only a minority, some 3,756, were ATDs, of whom 88 per cent were female (not shown in the table but based on customised data purchased from the Department of Health). Nearly all ATDs enter through the registrar training program, which was 64.9 per cent female in 2014. The other ATDs are GPs who hold provisional registration until they complete their Fellowship.

But in a monument to the promotion of OTD recruitment, the bulk of the expansion — 6,946 (64 per cent) — came from OTDs. There were 13,209 OTDs billing on Medicare by 2014-15.

Table 3: Australian GP workforce, numbers and increase, 2004-05 to 2014-15

	2004-05	2014-15	Increase	
	No.	No.	No.	Per cent
ATDs [a]	16,310	20,066	3,756	23
OTDs	6,263	13,209	6,946	111
Total Doctors accessing rebates	27,573	33,275	10,702	42
Estimate of Fellows	18,435	25,287	6,852	37

Source: Calculations made from 2015 DoH GP Workforce Statistics
[a] now include New Zealand and Australian doctors together.

The purpose of the OTD promotion policy was to get more doctors into underserviced areas, particularly RA 2-5 areas. But Tables 4 and 5 show that most of the extra OTDs, by 2014-15, were practising in RA 1 areas.[5] Of the total increase in OTDs (6,946) shown in Table 3, 4,520 were practising in RA 1 areas and 2,426 in RA 2-5 areas.

Table 4: ASGC RA 1 GP workforce, numbers and increase, 2004-05 to 2014-15

	2004-05	2014-15	Increase	
	No.	No.	No.	Per cent
ATDs	11,815	13,878	2,063	17
OTDs	4,030	8,550	4,520	112
Total Doctors accessing rebates	15,845	22,427	6,582	42
Estimate of Fellows	13,718	18,440	4,722	34

Source: See Table 3

Table 5: ASGC RA 2-5 GP workforce numbers and increase, 2004-05 to 2014-15

	2004-05 No.	2014-15 No.	Increase No.	Per cent
ATDs	4,495	6,168	1,673	37
OTDs	2,233	4,659	2,426	109
Total Doctors accessing rebates	6,728	10,948	4,220	63
Estimate of Fellows	4,717	6,847	2,130	45

Source: See Table 3.

What has happened is that there has been a gradual leaching of OTDs into RA 1 areas where there is an ample supply of doctors, as well as into the more attractive provincial cities such as Ballarat, Bendigo and Shepparton in Victoria, where the situation is similar.

As noted, since 2004, successive Australian governments have channelled OTDs into locations and spaces defined as under-serviced. These are commonly referred to as Districts of Workforce Shortage (DWS)[6] and comprise a variety of situations in which OTDs gain Section 19AB Exemption[7] from the Health Insurance Act in order to access Medicare rebates. There are also opportunities through section 19AA[8] for other nationals and permanent residents with medical registration, but without Fellowship, to practise in other programs treated as DWS.

The DWS compulsory period of service or 'moratorium period' is five to nine years in RA 2-5, inversely proportional to remoteness, and ten in RA 1. To be released out of DWS, OTDs must have served the required number of years and have obtained their Fellowship. Thousands have already jumped these hurdles and moved, mainly into RA 1 areas.

The OTDs influx is therefore responsible for most of the growing oversupply of GPs in RA 1 locations. They are also responsible for most of the increase in Medicare service costs. By June 2015, for all of Australia, OTDs made up 39.7 per cent of the workforce but received 49.8 per cent of total rebates. In RA 1 areas they made up 38.1 per cent of the total workforce and received 47.6 per cent of services paid for by Medicare[9].

There are many more OTDs likely to move

As of June 2014, the number of OTDs located in DWS was 7,130. Their numbers have been rising at up to 17.2 per cent per annum since 2010. Some 53 per cent of these OTDs were located in RA 1 locations and the rest in RA 2-5 locations. Of the 7,130, 2,405 had already obtained their Fellowship and the rest were studying for it. When they have completed their service requirements and/or completed their Fellowship they are likely to move from DWS locations as well.

Why are they likely to do this? The first reason is that they can. There are no rules stopping OTDs who jump the stipulated hurdles from moving, no matter how oversupplied their chosen location is. The second is that most GPs of whatever background prefer to locate in the big cities because of family preferences, proximity to top schools for kids, opportunities for research and the desire to be near family and ethnic community in the case of many OTDs.

Third, and very importantly, there are still lucrative jobs being offered. This is particularly the case for corporate practices. More of these are starting up because corporates with big money backing are in the best position to invest in new clinics. Corporates have been offering highly lucrative

contracts on the condition that those employed accept their style of medicine. This is high throughput and depends on the availability of bulk billing. It is notable that advertisements for such contracts dropped off in the brief period that the Coalition Government was proposing a co-payment. After this proposal was abandoned, advertisements for staff again proliferated.

There is no end in sight

With supply well ahead of population expansion, the competition for patients is set to get worse. In the case of the recruitment of OTDs, the Government has taken no notice of the GP oversupply. It continues to allow employers to sponsor new OTDs to DWS locations. So, when OTDs leave, many are being replaced. In 2014-15 there were 1,132 OTD GPs sponsored on 457 visas and in the first six months of 2015-16, another 582. Also, the Australian Government has left GPs on the Skilled Occupation List of occupations that are eligible under the permanent-entry skilled migration program. Hundreds of OTDs are being granted such visas for service in DWS and hospitals each year. Again, once they have completed their service requirements, they can practise where they please.

For those wondering why, with so many GPs already in Australia, some employers continue to sponsor more, it is partly because of the vacancies created as OTDs move out of DWS and partly because GPs employed on 457 visas are central to their business model. Those on 457 visas have to serve in the practices they are sponsored to and, as a result, can be paid very much less than ATDs or OTDs who do not have to practise in DWS locations.

The Australian domestic graduate output is expanding and will add to the surplus. It has grown from 1,287 in 2004, 1,918 in 2009, and 2,777 in 2012 to 2,968 in 2014. An increasing number of these graduates are now moving into the GP training program, which has grown from 450 available places in 2004 to 1,445 entrants in 2015. When ATDs complete their training program they can practise where they like. The only exception is for those who were granted medical school places on the condition that they serve for a period in a regional or remote area.

Consequences

As noted, by international standards the ratio of doctors to Australia's population is already high. And, as documented, it is on course to get higher. This is the main reason why the share of GP consultations that are bulk-billed has increased from 68 per cent in 2003 to 84 per cent in 2014.[10] It is also the main reason why, as Table 2 shows, the number of services per patient has steadily increased across Australia since 2003.

It could be argued that, with more GPs available, more patients have availed themselves of their services with resulting better health outcomes. A more likely interpretation of the extra services provided is that, because of competition for patients, GPs have managed their practices so as to ensure that they reach a target income level.

They are in a good position to do so because the almost universal availability of bulk-billing means that patients do not have to dip into their pockets. GPs can, for example, engineer extra services by recommending various tests for possible illnesses, and then prompt patients to return to discuss them. For corporate practices, where the GPs engaged are encouraged or even expected to deliver an identified income stream, such 'management' practices are highly likely to be utilised. Table 6 shows how Medicare funded tests per capita have risen over the past ten years.

Table 6: Medicare-funded pathology and radiology tests per capita and Australia's population, 2004 to 2015

	2004-05	2014-15	Increase (per cent)
Population	20.177m	23.950m	18.7
All pathology services per capita	2.69	3.73	42.9
All radiology Services per capita	0.70	1.00	38.7

Source: DoH 2015 Medicare Statistics, Australia. Benefit paid in and out of hospital. This does not include 'services rendered free of charge in recognised hospitals'.

A situation where GPs have to chase patients is not conducive to good medicine. GPs need assurance of a reasonable patient load in order to exercise discipline over patient expectations for medication and maintain professional standards. If GPs could be induced to serve where they were needed, this would encourage better medicine and slow the growth in GP costs to the taxpayer.

This will mean, as a minimum, cutting back on OTD recruitment and no further expansion in domestic medical training for the immediate future. (Alternative models of delivering GP services also need to be considered.) The government should also refuse to grant provider numbers to GPs (whether OTDs or ATDs) where the locations are already manifestly oversupplied. It would not amount to conscripting GPs to serve where they are needed. Rather, it would simply inhibit them from locating where they are not needed. As indicated, the Australian government already does this for newly arrived OTDs. They have to serve in DWS locations.

Endnotes

[1] Bob Birrell, *Australia's New Health Crisis – Too Many Doctors*, CPUR Research Report, September 2011, pp. 14-15. This report is available on The Australian Population Research Institute website at TAPRI. Org.au

[2] Australian Medical Workforce Advisory Committee papers 1996 to 2005 when it's closure marked the end of careful workforce planning policies. Average annual OTD GP workforce growth tripled from 2.4% for the previous 10 years to 7.7% for the next 10.

[3] DoH GP workforce and Medicare statistics are released in the later 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

[4] Detailed in Birrell, op.cit.

[5] DoH GP workforce and Medicare statistics are released in the later part of each year for the preceding financial years. As such they provide the only consistent set, revised in 2015 to 2004 and unrevised for the workforce back to 1984.

[6]DWS District of Workforce Shortage: For GPs and other non-specialists, a DWS is a geographical area in which the number of full time equivalent GPs and other non-specialists is less than the national average for that class of practitioner. Note 1. This now includes the after-hours period for the whole of Australia. It also includes Aboriginal and TSI health services. Once there are enough doctors in an area it loses DWS Classification. However the positions hitherto obtained remain and can be refilled. If they are not refilled then DWS classification may be restored again at annual review. Area of need is a special program in which State Ministers can approve an OTD to receive limited registration from the AHPRA for the purposes of practising within DWS.

[7] 19AB Exemption. Health Insurance Act 1973. Health Insurance (Section 19AB Exemptions) Guidelines 2012. Under the 1996 Act section 19AB Overseas Trained Doctors (OTDs) and Foreign Graduates of Accredited Medical Schools (FGAMS) are barred from accessing Medicare Rebates unless given exemption by the Minister.

[8] Section 19AA refers to Australian citizens and permanent residents with medical degrees but without GP Specialist degrees. They are eligible to work in special programs approved under section 3GA of the Health Insurance Act, namely Rural Locum Relief Program, Queensland Country Relieving Program, Approved Medical Deputising Service Program, Australian General Practice Training Program, Approved Private Emergency Department Program, Special Approved Placements Program, Temporary Resident Other Medical Practitioners Program, Specialist Medical Colleges in Australia, Remote Vocational Training Scheme.

[9] Medical Training Review Panel 14th and 18th reports

[10] See Note 3