

NON VR GENERAL PRACTITIONERS

PART OF A SOLUTION TO AUSTRALIA'S MEDICAL WORKFORCE SHORTAGE

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A **BSTRACT:** Non VR GP's represent about 10% of Australia's GP workforce by Medicare billings. Medicare rebates for Non VR GP's have fallen in real terms since 1992 and are now at 68% of VR GP rebates. Non VR GP's are mainly Australian graduates from Australian universities. Most graduated before 1996 and have refused to or not been able to sign on to the government register by virtue of year of graduation. Non VR GP's have identical qualifications to those of two thirds of Australian GP's. Non VR GP's have been leaving general practice due to the lower rebates and moving into other sub specialities such as women's health, cosmetic surgery, skin clinics, insurance companies and workcover clinics where the rate of pay is more attractive. Non VR GP's can be attracted back into general practice simply by equalising VR and Non VR rebates and can thus contribute to solving Australia's GP workforce shortage.

Background

The vocational register was set up in 1989 by the federal government. It is a list of names held by the Health Insurance Commission. When it was first introduced it was fiercely opposed by the AMA who saw it as a mechanism for increasing government control over the profession. In the early 1990's the government introduced differential rebates for VR and Non VR GP's by ceasing to index Non VR Medicare rebates. The criteria for signing on to the VR at the time were 5 years experience in general practice. By 1992 the AMA had changed its official policy and was encouraging doctors to sign. By 1994 a cutoff date was established and no one could sign on to the VR after that date and they could only sign if they had 5 years predominantly general practice experience at the time. Some doctors missed out on the "5 years experience" by a day and could not sign, and some were overseas or were otherwise unaware of the cutoff and missed out. Some of these doctors subsequently joined one of five successful legal challenges over the next few years and were admitted to the VR. Most GP's who graduated between 1989 and 1996 missed out. Some even took the AMA's original advice and refused to sign on principle, even though such a decision has cost them well over half a million dollars by now.

In 1996 the federal government introduced provider number restrictions which meant at the time that no one could become a GP without passing the Royal Australian College of GP's exam. The 1996 provider number restrictions were subsequently bypassed in 1998 for overseas trained doctors if they agreed to work in certain areas.

Non VR GP's thus represent a cohort of GP's who graduated between about 1989 and 1996, plus a smaller group of doctors who graduated before that date. There was and is no difference in the training or standards of a GP who graduated in the mid 1980's vs the early 1990's. Some Non VR GP's have over 30 years of practical experience.

The policy of freezing Non VR rebates at 1990 levels and indexing VR rebates each year was originally a government policy. However, in 1999 an agreement was signed between the government, the RACGP, the Australian Divisions of General Practice and the Rural Doctors

Association of Australia which agreed, amongst other things, that “Non VR rebates were to remain frozen indefinitely”. Since that time the government has been able to claim (probably quite rightly) that the responsibility for the rebate freeze shifted from the government to the signatories of the 1999 MoU agreement. The AMA was not a signatory, but has a policy on its books, never rescinded, which “insists the differential rebate [between VR and Non VR] be maintained”.

The signing of the 1999 MoU was the catalyst for the formation of the Australian College of Non VR GP’s. The organisation has 330 active members plus a number of ex members who have moved into other specialties or away from general practice. The ACNVRGP has been actively lobbying since 2000 for the equalisation of all GP rebates. The ACNVRGP believes the biggest barrier to the equalisation of GP rebates lies not with the government, but rather with policies of the big GP organisations including the AMA, RACGP, ADGP and RDAA.

The worsening GP shortage

It is clear there is an increasing shortage of GP’s. The severity of this problem ranges from mild in inner city areas to extremely severe in some rural areas. A major contributor to the shortage is the 1996 provider number restrictions. For example, in South Australia this decreased the number of new GP’s from about 80 to less than 30 per year. A contributing factor to the shortage is the drift of Non VR GP’s away from general practice. Up until 2004, the only way a Non VR GP could become VR would be to do the RACGP exam. Non VR GP’s object to doing the exam when there are 11,500 VR GP’s who were “grandfathered” onto the VR simply by signing a piece of paper. They also object to doing an exam when the RACGP has had a president who has not done the exam, as well as at least one current state Censor and one state Faculty Chair. If faced with the prospect of doing an exam some have decided to do an exam in another specialty and gain a doubling or tripling of their medicare rebate. There also exist a wide range of special interest areas where income is mainly derived from patient fees rather than from medicare and Non VR GP’s continue to be attracted into these fields. This drift represents a loss of GP’s, albeit not a permanent one. The Non VR rebate is now 68% of the VR rebate and a removal of this rebate differential has the potential to attract many Non VR GP’s back into general practice.

The doctor shortage is currently being addressed by importing doctors from overseas, which raises a number of ethical issues regarding poaching GP’s from countries that desperately need them to address their own health issues.

Areas of Need

Through 2004, various suburbs and areas were declared “areas of need” by the government. These were areas where there was a low doctor to patient ratio, and include many rural areas and some suburban outer metropolitan areas. A Non VR GP who moves to such an area can access VR rebates (except for Veteran’s Affairs patients), and can gain access to the VR if they agree to stay in the area for a certain number of years – generally 4 to 5. The “area of need” system has resulted in some movement of Non VR GP’s. However, there are still many Non VR GP’s who do not wish to move, or who would rather not move and instead change to a sub-speciality or leave general practice. There are also some rural areas which are not declared “area of need” and the policy actually acts as an incentive for doctors to leave those areas. Many Non VR GP’s are so angry with the 15 year rebate freeze they will not move to an “area of need” on a point of principle.

The majority of Non VR GP’s who are going to move to an “area of need” probably have made that move by now. Based on the feedback within our organisation, the number making a move to an “area of need” is decreasing, but the number drifting out of general practice

continues. Realistically, a Non VR GP that moves out of general practice nowadays will probably be replaced by an overseas trained doctor.

It would thus seem logical for there to be policies that support the retention of Non VR GP's in general practice.

Statistics and Definitions

There are about 24,000 GP's. This figure is probably an over-representation, as it includes specialists who might bill just one GP item number in a year. The number of GP's working full time or at least several sessions per week is more like 20,000. Of these, about 7,000 are RACGP Fellows, about 11,500 are Non Fellow grandfathered VR GP's, and somewhere between 2,000 and 3,000 are Non VR. Figures are hard to define accurately as overseas trained doctors working in areas of need may be classified as VR or Non VR, and some may classify themselves as VR when completing survey data for medical boards even when this is not technically correct. There are 600 Australian graduates doing the GP training program each year. Most recent data show 1,166 new OTD GP's were granted medicare access in the first six months of 2005.

The rebate for a standard consultation for a VR GP is \$30.85. The rebate for the same consultation for a Non VR GP is \$21.00. The Non VR rebate was fixed at \$17.85 from 1992 to 2004 while the VR rebate was increased every year.

Up until the mid 1990's the AMC exam was compulsory for all overseas doctors, but this is no longer so.

Prior to 1996, the only criteria for becoming a GP in Australia was to graduate from university and work two to three years in the public hospital system, or to come in from overseas and do the AMC exam which was about the same standard as final year medical student exams.

Post 1996 all Australian graduates have had to do the RACGP Fellowship exam (FRACGP). Many recently arrived overseas doctors have not had to do any exam in Australia.

On gaining the FRACGP, GP registrars also gain VR. Grandfathered VR GP's like to associate the VR with the FRACGP, and thus imply that because they are VR they are also FRACGP. This is not so. Grandfathered VR GP's and Non VR GP's have exactly the same formal qualification, which is a medical degree. All Non VR GP's now have more than 5 years experience, which was the original criteria for grandfathering.

The VR is now obsolete and is exacerbating the workforce shortage

The original purpose of the VR was probably an attempt to limit GP numbers and hence limit costs to the government. It was not particularly successful at limiting costs, and this is almost certainly why the 1996 provider number restrictions were introduced.

The whole purpose of the VR thus no longer exists.

It is unclear why organisations such as the AMA and RACGP support the rebate differential. It may be that grandfathered VR GP's need to consider themselves somehow "better" than other GP's. It may be that so many political fights were fought in the early 1990's over the VR that supporting equal rebates might be seen as a way of losing face.

Regardless of the reason, Non VR GP's continue to experience a great deal of hostility from the big GP organisations such as the AMA and RACGP.

At the same time, the Non VR issue is of great importance to any state government as the Non VR rebate differential continues to drive GP's out of general practice.

Solutions

The solution to the Non VR problem is political.

State governments are affected by the Non VR issue, and need to share information about how to solve the problem.

Political pressure needs to be brought to bear on all those that support differential rebates, particularly the AMA and the RACGP. Less important players would be the ADGP, RDAA and to a small extent the Federal Health Minister.

The AMA and RACGP would almost certainly claim they have done a lot to remove the differential. This is simply not true, and the reality is that they have both said a lot and done very little. Both organisations would be in breach of their own policies if they were to support removing differential rebates.

Assuming 5000 standard consults per full time doctor per year, the cost per Non VR GP of increasing rebates to VR levels is \$49,250 per doctor per year. The cost of bringing in an overseas doctor to replace a lost Non VR GP is \$154,250 per doctor per year.

The proposal is simply to end all rebate differentials between VR and Non VR GP's, and hence remove the incentive for Non VR GP's to leave general practice.

Declaration of potential conflict of interest

- Dr Moxham is a member of the RACGP.
- Dr Moxham is a member of a division of general practice which in turn is a member of ADGP.
- Dr Moxham is a Non VR GP working in an "area of need" and is able to access VR rebates and thus would have no personal financial gain from any proposal to end the Non VR rebate differential.