



AMA

**2005 BIENNIAL REVIEW OF THE MEDICARE
PROVIDER NUMBER LEGISLATION**

AMA SUBMISSION

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Introduction

1. As the professional organisation for medical practitioners in Australia, the AMA covers doctors in all categories and disciplines. The 1996 provider number legislation has a major impact on junior doctors, in that it essentially bars doctors from independent medical practice until they attain a Fellowship from a recognised medical College. Therefore it is relevant to state that the AMA is the only body that can represent junior doctors in all categories and disciplines nationally, including Interns, Resident Medical Officers, those junior doctors wishing to enter vocational training and those who are undertaking a vocational training program leading to the award of a Fellowship from one of the medical Colleges.

2. Part of the AMA's representative structure is the AMA Council of Doctors-in-Training (AMACDT), which is chaired by the elected Doctors-in-Training representative on the AMA Federal Council. It consists of junior doctor nominees from all states and territories who meet regularly to discuss issues affecting junior doctors and to develop strategies and draft policies to address those issues on a national basis. Junior doctors' concerns and proposals are regularly brought forward for consideration by AMA Federal Council, which is representative of the total membership.

3. This AMA submission is written on behalf of our total membership, but with particular regard to the concerns and interests of junior doctors.

Operation of Section 19AA

4. The AMA supports Section 19AA to the extent that it was intended to underpin quality medical practice and to give formal recognition to General Practice as a distinct medical specialty. Concrete evidence has yet to emerge that practice quality has improved since the 1996 legislation, however there is acceptance within the profession that doctors should undertake postgraduate training and meet the standards set by one of the medical Colleges before entering unsupervised medical practice. The recognition of General Practice has been a positive move.

5. The Explanatory Memorandum for the original 1996 legislation stated:

There is currently an oversupply of medical practitioners providing services through Medicare, particularly services provided by non specialists in metropolitan areas. This oversupply places pressure on Medicare outlays as there is now a well established relationship between the number of medical practitioners and the number of services provided in an area.

The amendments require that new doctors entering general practice be appropriately trained and working in a recognised professional framework. The measures will enable growth in the medical workforce to be kept in line with population needs.

6. The AMA opposes the use of provider number restrictions to limit the size of the medical workforce or to control its distribution according to the Government's idea of what is an appropriate doctor:population ratio. The notion of restricting provider numbers to hold down Medicare expenditure, regardless of community and patient needs, is also opposed.

7. There is now universal acceptance of the AMA's position that there was a serious undersupply of doctors, particularly GPs, in 1996 and the ensuing years. This was finally recognised in 2002 by the Government, which announced in 2003 substantial increases in medical school intakes and GP training places. Clearly Section 19AA reduced doctors' practice opportunities and prevented many of them from doing any work in General Practice, thus reducing the available GP workforce and reducing people's access to primary medical care. It also deprived junior doctors of any exposure to General Practice before making decisions about their medical careers.

8. In a situation of national doctor shortage caused by a range of factors, it is difficult to assess the impact of Section 19AA on the GP workforce or the medical workforce more generally. Certainly it had a major effect on junior doctors and medical students who had commenced their medical studies without having any inkling that there would be mandatory, lengthy and expensive training requirements imposed on them after graduation as a condition of entering independent medical practice. For the 1995 graduate cohort who were within weeks of completing their Intern year and qualifying for a Medicare provider number, it was seen as a bitter and unfair blow which rankled for years.

9. Since 1996 the impact of Section 19AA on junior doctors has progressively lessened. Those students and doctors directly caught by the legislation at the time have come to terms with it and made their decisions about their professional medical careers. These days there is general acceptance of the need for specialised postgraduate training before entering General Practice. Medical students and junior doctors are attuned to the requirement for postgraduate vocational training as a condition of independent medical practice.

10. There was another significant group of doctors who felt - and still feel - that the provider number legislation had a severely adverse effect on them and their patients. These were doctors who had entered General Practice under the old conditions but who, unlike many of their colleagues, had not been eligible, due to minor technical reasons, for grandfathering onto the Vocational Register before the provider number legislation came into effect. That matter is picked up later in this submission under *Other Issues*.

11. Overall it is probably fair to conclude, as the 2003 Biennial Review did, that Section 19AA does not have a major effect on the medical workforce or doctor shortages. However, a blanket restriction of this kind inevitably throws up a range of situations which do not fit the standard pattern and for which exemptions are necessary. A sensible and responsive exemption process is required.

Operation of Section 3GA

12. The 2003 Biennial Review canvassed the operation of "Approved Placement Programs" under Section 3GA. These allow Medicare provider numbers in defined circumstances for doctors who would otherwise not have access to them because of the Section 19AA restriction. The obvious ones were vocational training programs leading to a Fellowship of a medical College. The others were a range of limited programs designed specifically to tackle workforce shortages. The AMA has a number of comments to make about the exemption process and specific programs.

Exemption Process

13. Exemptions must be approved by the Minister for Health and Ageing. As a rule very detailed guidelines and procedures have to be developed by the Department of Health and Ageing (DoHA) before a placement program is put forward for approval. The whole process is convoluted, tedious and slow. Once a program is approved, the process of actually getting a provider number becomes an issue, in that the Health Insurance Commission requires a separate application and weeks of processing time in order to issue a separate provider number for each practice location. A more flexible and responsive exemption process is required.

14. The case of Sports Physician trainees was addressed in the report of the 2003 Biennial Review (Recommendation 12). It was an unusual situation in that the Minister approved the Sports Physician training program under Section 3GA in the expectation that the College's bid for specialty recognition would be determined well before any trainees neared the end of their training. In the event, there was a lengthy period when there was no specialty recognition process in place and in fact a decision has still not been made on the College's application. Thus there was the prospect of Sports Physicians losing their provider numbers as soon as they left the training program by gaining a Fellowship. While DoHA took action in April 2004 to resolve the situation for the time being, there were over 18 months of repeated representations from the AMA and the College plus a recommendation from the 2003 Biennial Review before any action was taken. The process is far too slow and seems barely able to cope at all with the unusual situations that inevitably arise.

15. At present vocational trainees other than GPs do all their vocational training in the public hospital system. A Senior Registrar has the same limited provider number (for referral purposes) as an Intern. The AHMAC Specialist Training Taskforce reported that, in the future, some training in most specialist disciplines would have to occur in the private sector. This would require Medicare provider numbers for consultations and procedures as part of the funding mechanism for private sector training and for acceptance by patients, in much the same way as General Practice training now works. A Specialist Training Steering Committee is now progressing work on implementation of vocational training in the private sector. Even though the specialist College training programs are already approved, the exemption process for Medicare provider numbers and the actual issue of provider numbers will have to be far more responsive, fluid and efficient in the future to accommodate the needs of specialist training in the private sector.

16. The slow, inefficient process of issuing provider numbers for each practice location was raised by the AMA in the 2003 Biennial Review, which recommended that the Government should improve the approval process for doctors in Approved Placement Programs. It specifically recommended (16.2), in relation to the Rural Locum Relief Program, overcoming the need for doctors to have multiple applications and provider numbers covering each practice they work in. Nothing has been done.

17. AMA member feedback indicates that the provider number process, with its separate application and lengthy process for each practice location, is a significant problem for General Practices in all locations trying to engage locums to cover short term absences of their doctors. It is not uncommon, even when the prospective locum is free of Section 19AA, for a practice to miss out on locum relief due to the slow, inefficient bureaucratic system for issuing provider numbers. This issue is closely linked to the exemption process, indeed forms part of it, and should be addressed and fixed.

Access to Approved Placement Programs

18. Vocational training programs which lead to a recognised College fellowship are all on the Approved Placements Register. As stated above, it is important that the approval processes for provider numbers be sufficiently responsive and quick to accommodate some private sector training within those programs.

19. At this time there are considerably more vocational training places available than there are doctors to fill them. Though numbers are small in some disciplines and may limit preferred options, there should not be a problem for doctors to access a vocational training program which aligns reasonably well with their career choice. But this may not always be the case.

20. Since 2003 a series of decisions and announcements have signalled substantial growth in the number of medical schools and students and the projected numbers of medical graduates. The number of Australian students completing medical school will rise from 1270 in 2004 to more than 2000 by 2010. These figures do not include international students who are now allowed to practise in Australia after graduation. Access to vocational training places is set to become a real issue again in the fairly near future.

21. More importantly, there is already enormous strain on the public hospital system. This translates into increasing difficulty for junior doctors in accessing supervision, mentoring and education and for senior doctors in providing it. The AMA has concluded that there was little planning for the increased numbers of medical students and that little has been done to strengthen the resources and infrastructure, especially for clinical teaching, to accommodate the increased numbers of students. Similarly, there is little evidence of cohesive plans to provide funding and resources for the increased numbers of Interns, Residents and vocational trainees entering the system downstream. Further, even if funding and university resources were increased, one wonders where the additional clinical teachers will come from.

22. These changes, together with the evident lack of planning and resources, have the potential to lower the standard of medical training from medical school through to vocational training. There will be increasing emphasis on training in private sector clinical settings for Residents, Interns and medical students. It is not clear how this will impact on training and funding models and on the provider number system, but it needs to be considered in any review of the latter.

Workforce programs

23. If the essence of the provider number restrictions is support for quality practice, there is an inherent conflict in granting provider numbers purely on the grounds that there is a shortage of doctors in a particular location or area of practice. The AMA's view is that exemptions should be granted primarily on the grounds of widening medical practice experience in a supervised environment i.e. supporting quality training and practice, not just trying to provide an unsatisfactory, short term fix for specific doctor shortages.

24. For this reason, exemption programs are approved with guidelines requiring, among other things, reasonable supervision arrangements. While the extent and detail of such guidelines are open to debate, the AMA believes that each program should contain a rationale, an element of training for doctors as a contribution to quality practice and a requirement for appropriate supervision or mentoring by senior clinicians and ongoing

professional development. Programs that allow doctors to work in areas of workforce shortage should ultimately require a commitment to fellowship of the relevant medical College.

25. The Queensland Country Relieving Program was the only Approved Placement Program which had no accompanying explanation or guidelines at all. This was raised in the AMA's submission to the 2003 Biennial Review and addressed in the report of that review. The AMA is pleased to note that much work has been done on this program and that proper guidelines are nearing completion.

Prevocational General Practice Placements Program

26. One of the effects of the 1996 provider number legislation was to prevent doctors spending any time in General Practice unless and until they entered the formal GP training program. This was seen as an important factor in the declining interest of Australian medical graduates in a General Practice career and inability to fill the increased number of GP training places that the Government approved from 2004 in an effort to address the critical national shortage of GPs. Also, there was a view in the profession that some GP experience had value for many doctors even if they chose to pursue a completely different specialty.

27. The AMA proposed to the 2003 Biennial Review a prevocational GP program to enable doctors to experience General Practice before making their career decisions. This was duly recommended in the Review's report. The Government introduced such a program, but confined it, with very few exceptions, to rural and remote locations as a workforce initiative.

28. While the PGPPP is still at an early stage and there is not yet enough information to evaluate its effectiveness, the AMA believes the program is flawed in two ways:

1. Its primary goal is to address workforce shortages, not contribute through widened experience to quality practice;
2. It is confined to locations which prevent participation by many doctors whose family and personal commitments do not allow them to relocate and by many city-based practices which between them have much of the capacity to take on placements.

29. The AMA believes this program should be extended to all locations to maximise its effectiveness.

Operation of Section 3GC

30. The AMA supports the continued operation of the Medical Training Review Panel (MTRP). It brings together a solid representation of the medical profession and other key stakeholders. It has had a positive influence on prevocational education and training, selection for vocational training and in monitoring access to vocational training and associated issues affecting junior doctors. It discharges a reporting role which has been progressively enhanced to include, for example, the number of new College fellows and PGY 1 & 2 doctors. Its obligation to report to Parliament ensures continuing attention at a national level to postgraduate medical training and practice and its implications for the availability and quality of medical care for all Australians.

31. It has been pointed out that there are significantly more vocational training places available than there are doctors to fill them. While that may be true at the moment, it does nothing to suggest that the MTRP has served its purpose or run its course. With the large increases in medical students and graduates over the next few years, there is no guarantee

that there will be ready access to vocational training in the future. In fact, the whole current system of postgraduate medical education, training and employment will come under pressure and it is likely that issues will arise that fall very much within the purview of the MTRP.

32. The AMA believes that the MTRP should look beyond reporting just on numbers of doctors and positions at the various stages of postgraduate training. There is an argument for the MTRP to examine and report on things such as:

- projections of medical graduates and capacity to employ and supervise Interns;
- extent to which all Interns have rotations in Accident & Emergency, Surgery and General Medicine as key elements of their postgraduate training;
- numbers applying for particular vocational training programs each year and the success rates;
- details of the amount of postgraduate experience and extra qualifications possessed by successful entrants to vocational training programs, including sub-specialties;
- numbers entering basic vocational training programs and availability of advanced training positions downstream to accommodate them (this has been a major problem in Surgery);
- dropout rates (permanent and temporary) from vocational training programs;
- number of doctors switching from one vocational training program to another;
- extent to which Colleges recognise time spent and skills attained in other vocational training programs and specialised medical practice;
- utilisation of College appeals processes by doctors who fail to gain entry to basic or advanced training programs or complete a stage of formal training;
- number of doctors who are job sharing or utilising other forms of flexible working arrangements as well as the number of doctors who would like to access such arrangements but cannot.

33. MTRP National Project funding could be utilised more effectively to address a range of issues including some of those listed above. One of the weaknesses is that funding can only be accessed by state Postgraduate Medical Councils, when it should be available to the body that can do the best job and deliver maximum value for the money. This can only be determined by a more open and contestable process for project funding. There was a recent evaluation of National Project funding and it did identify weaknesses in the completion and impact of a number of projects funded to date, but it is indicative of the system that the only stakeholders consulted were the recipients of all the funding viz. the state PMCs. A more business-like approach is required for National Project funding.

34. As to the composition of the MTRP, there has been only one meeting with the revised composition approved by the Minister following the 2003 Biennial Review. There is strong and broad representation of the medical profession. The AMA has no other comments in this regard.

Other Issues

Issuing of Provider Numbers

35. As indicated above, the actual process for administering provider numbers needs to change. It is absurd that doctors must lodge a fresh, detailed application for a new provider number each time they want to work in a different practice location and then wait several weeks for a new number to be issued. This is unnecessary, inefficient and wasteful of

resources. It adds red tape rather than value to the system and impedes the flexibility and mobility of the medical workforce. On many occasions it prevents doctors taking up locum positions and it can be the reason why they do not participate in Approved Placement Programs.

36. It is recognised that the Government needs detailed information on where medical services rebatable under Medicare are being provided and who is providing them. There is a need to identify the practice location and to ensure that doctors, particularly those with an exemption from Section 19AA, are using their provider numbers correctly. But surely there is no need to incorporate the practice location code within the provider number and force doctors through the whole bureaucratic rigmarole every time they want to work in another practice location.

37. The AMA does not accept that the need to ensure that Medicare statistics can be broken down to suburb by suburb analysis prevents some simplification of provider number processes. When Australian Business Numbers were introduced in 2000, the Government ensured that companies could simply add two numbers to their CAN. Surely the health sector can look at similar style solutions with a single “core” provider number to which the doctor can then simply add a postcode or other standard code determined by the HIC. This would avoid the need for multiple applications and the additional compliance burden imposed. The AMA recommends that the provider number system be redesigned along these lines.

Grandfathering of pre-1996 GPs

38. When the 1996 provider number legislation came into effect, there was a significant group of doctors who had entered General Practice under the old conditions but who had not been eligible, due to technical reasons, for grandfathering onto the Vocational Register. Although they met the general requirements for grandfathering, they were not actually working in General Practice at the particular point in time that counted. For example, some were overseas and others were absent from work due to childbirth and other family responsibilities. These doctors believe that the passage of the legislation locked in an unfair disadvantage for them and their patients, who can only access non-VR (lower) rebates for their GP visits. There is a case for a one-off solution to this remnant effect of the 1996 legislation.

39. The AMA believes there should be a final round of grandfathering for all non-Vocationally Registered (VR) GPs who were accessing GP Medicare rebates prior to 1 November 1996 and have predominantly been in general practice for a minimum of five years since that date.

40. According to DoHA figures, there were 4,757 non-VR doctors practising in Australia in 2001-02 but only 1,339 were working full-time. This means less than 30% of the potential non-VR workforce is being fully utilised.

41. The Government has introduced a series of initiatives designed to encourage non-VR doctors to stay in the workforce and fill workforce gaps, such as after hours and in rural areas. These programs give non-VR doctors (or, more accurately, their patients) access to VR GP rebates.

42. The AMA understands that through these Government initiatives 55% of non-VR doctors are already accessing VR rebates. This means the cost to Medicare of implementing

a final round of grandfathering will be limited. In addition, it will remove the expensive administrative burden of managing all the different non-VR programs. It will also help improve affordability for patients, in that patients of non-VR GPs are currently discriminated against by only being able to claim much lower Medicare rebates for their GP visits.

43. The continuing argument against increasing the patient rebate for non-VR GPs has been a quality one. The AMA supports the quality objective of Section 19AA. However, the Government's willingness to provide access to VR rebates depending on when or where a non-VR doctor practises undermines the quality argument. The current policy implies that non-VR doctors working in one location do not provide the quality of medicine required to access VR rebates, but by moving to an eligible area they do.

44. Non-VR GPs may have considerable experience in both general practice and other areas of medicine. It is worth noting that grandfathering these doctors would actually be a quality measure as it would make it compulsory for them to undertake continuing Professional Development (CPD) to retain their VR status.

45. The AMA believes a one-off, final round of grandfathering will help retain and increase this cohort in the general practice workforce and encourage them to increase their hours. As more than half of these doctors already access VR rebates through workforce shortage programs, this would not do damage to the administration of the provider number legislation

Summary of Key Points

46. As a summary of key points, the AMA's position is as follows:

1. Is the only body that can represent junior doctors in all categories and disciplines nationally (paras 1-3).
2. Supports Section 19AA to the extent that it was intended to underpin quality medical practice and to give formal recognition to General Practice as a distinct medical specialty (para 4).
3. Opposes the use of provider number restrictions to limit the size of the medical workforce or to control its distribution according to the Government's idea of what is an appropriate doctor:population ratio (para 6).
4. Opposes the notion of restricting provider numbers to hold down Medicare expenditure, regardless of community and patient needs (para 6).
5. Believes that since 1996 the impact of Section 19AA on junior doctors has progressively lessened. Medical students and junior doctors are attuned to the requirement for postgraduate vocational training as a condition of independent medical practice (paras 7-9).
6. Concludes that Section 19AA does not have a major effect on the medical workforce or doctor shortages (paras 7-9, 11).
7. Believes that a sensible and responsive exemption process is required to resolve unusual situations that do not fit standard patterns and to address issues such as postgraduate training in the private sector; improvements are needed (paras 12-15).
8. Regards the slow, inefficient process of issuing provider numbers for each practice location as a problem which needs to be addressed and fixed (paras 15-17 and 34-36).
9. Sees the large increases in medical school students and graduates and the pressures on clinical teaching and supervision as a major issue that threatens access to vocational training and indeed the standard of medical training; it should be considered as part of the 2005 review (paras 18-22).

10. Believes that exemptions to Section 19AA should be granted primarily on the grounds of widening medical practice experience in a supervised environment i.e. supporting quality training and practice, not just trying to provide an unsatisfactory, short term fix for specific doctor shortages (para 23).
11. Believes that guidelines for each Approved Placement Program should contain a rationale, an element of training for doctors as a contribution to quality practice and a requirement for appropriate supervision or mentoring by senior clinicians (para 24).
12. Supports the extension of the Prevocational General Practice Placements Program to all locations (paras 26-29).
13. Supports the continued operation of the Medical Training Review Panel (paras 30-31).
14. Believes the MTRP should examine and report on a range of things beyond just numbers of doctors and positions at the various stages of postgraduate training (paras 31-32).
15. Believes a more business-like approach is required for MTRP National Project funding (para 33).
16. Recommends that the process for issuing provider numbers be streamlined by use of a stem/branch design to accommodate practice location details instead of requiring a fresh application and approval process for each practice location (paras 35-37).
17. Proposes a final round of grandfathering onto the Vocational Register of those non-VR doctors who generally met the requirements before 1996 and have continued to work in General Practice for the majority of their practice time since then (paras 38-45).

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