

# ANZ – Melbourne Institute Health Sector Report

## General practice trends

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## GENERAL PRACTICE TRENDS

As Australia's population ages and the burden of chronic disease grows, General Practitioners (GPs) are playing an increasingly crucial role in the health care sector, with primary care accounting for more than 35 per cent of the \$162 billion health sector.<sup>(1)</sup> The Melbourne Institute of Applied Economic and Social Research (Melbourne Institute) has analysed nearly a decade of publicly available data relating to general practice, as well as our custom-designed longitudinal study – the Medicine in Australia: Balancing Employment and Life (MABEL) survey of doctors. The aim of this report is to summarise the current policy context relating to GPs and analyse key trends in the GP sector.

### KEY FINDINGS

Government funding reforms, demographic shifts and structural changes are transforming the general practice sector.

#### Changes in the structure and organisation of general practice:

- The number of Australian GPs, which totalled 32,275 in 2014–15, continues to grow relatively slowly. However, for every new GP, there are nearly 10 new specialists.
- Female participation is on the rise, with more women working as GPs. Female GPs earn around 25 per cent less than males after accounting for differences in hours worked, and female GPs' careers are more disrupted by having children, in terms of reduced workforce participation.
- Practice sizes are increasing, with a wider range of services delivered by different types of health professionals, for example, on-site pathology. Meanwhile, the proportion of GPs who own their practice is declining, which signals a potential rise in corporate ownership.

#### The financial health of general practice:

- Medicare revenue per full-time-equivalent GP has declined in real terms since the Medicare fee freeze in 2013, yet total GP personal hourly earnings have increased at double the rate of real wage growth in the economy. There are a number of potential reasons for this divergence including practice efficiencies and increases in revenue from other sources.

#### Job satisfaction and well-being of GPs:

- Reported GP job satisfaction and work-life balance have deteriorated since 2013. This suggests reduced morale which, if continued, could compound existing slow growth and difficulties in recruitment and retention in the sector.

The impact of these trends on costs, quality and access to health care is largely unknown, which is a problem in such a key sector in the health care system. It is imperative to understand the drivers and impacts of these trends in order to ensure that reform efforts support an efficient and healthy general practice care sector, whilst improving health outcomes and access to care for patients.

## BACKGROUND

The health sector has grown to 10 per cent of GDP and 13 per cent of total employment – making it the largest part of the Australian economy. The prevalence of chronic diseases such as diabetes is growing and, combined with an ageing population, primary care is regarded as the most cost-effective way to manage and coordinate health care for patients.<sup>(2)</sup> In 2014–15 GPs managed care in over 136 million visits, an annual growth of 4.3 per cent from 2004–05 and representing over 6,000 visits per full-service-equivalent (FSE) GP.<sup>(3)</sup> GPs play a key role in determining overall health expenditures as they influence expenditures on diagnostic testing, pharmaceuticals, and the \$59 billion hospital sector through their referral decisions.<sup>(1)</sup>

## POLICY CONTEXT

Changes to the funding of the general practice sector are continuing. There is debate about how the primary care sector can be reformed to deliver improvements in population health and access to care whilst restraining costs. The impact of a freeze in the indexation of Medicare rebates has been central in this debate.

A key issue is that the current, fee-for-service payment arrangement rewards high-volume but not high-quality or cost-effective health care. Internationally there has been a trend toward linking funding to quality and outcomes. A recent review (by the Melbourne Institute) of schemes linking funding to improved quality of care and reduced costs included 44 different schemes from more than 10 countries, including 25 schemes from the United States.<sup>(4)</sup> Though there is much to learn from overseas experience Australia has, until now, been cautious in adopting such changes. Current policy is trying to reform the way GPs are paid.

From July 2017 the Health Care Homes model is being trialled by the Department of Health. Patients with complex chronic conditions will be asked to 'enrol' with their general practice. Fee-for-service will be replaced with a fixed 'bundled payment' per patient, which varies across three

tiers of patient complexity. The payment is intended to cover all costs of GP visits previously funded by Medicare rebates. Government modelling suggests this will increase revenue to general practices by an average of 10 per cent,<sup>(5)</sup> with GPs being able to retain any surpluses while also being liable for costs above the bundled payments. GPs remain free to charge patients, though most of these patients are currently bulk billed.

A point of difference with schemes in other countries is that the Health Care Homes model does not link payments to improved quality of care, though it does reward GPs for reduced costs through their ability to retain surpluses.

Existing research shows that unless quality is also measured and reported, the incentives to reduce costs from applying fixed payments could have the unintended consequence of reducing the quality of care. During 2017 further reform of the Practice Incentive Program, which has existed since 1998, is likely to introduce new quality improvement incentive payments for eligible practices that will include quality measures relating to chronic disease, though details have not yet been finalised.<sup>(6)</sup> This is an essential and complementary reform that will require careful analysis and evaluation.



## TRENDS IN THE SIZE AND COMPOSITION OF THE GP WORKFORCE

There has been a general increase in the supply of new doctors, largely due to the opening of new medical schools in the 2000s which contributed to a doubling in the number of new medical graduates. The number of full-time-equivalent (FTE) GPs per 100,000 of the population has grown by 2.4 per cent over the 10-year period since 2005. However, the number of FTE specialists has grown 10 times as fast, by 22 per cent since 2005<sup>(7)</sup> despite the agreed greater need for GPs due to the increased prevalence of chronic disease and an ageing population. These trends reflect changing demographics as well as a higher proportion of doctors choosing to be specialists.

On average, GPs work fewer hours per week than specialists (38 versus 44 hours respectively), with a higher proportion of women in general practice (42 versus 29 per cent), who are more likely to work part-time. However, though female GPs work fewer hours on average than their male counterparts, female GPs increased their average weekly working hours from 31.5 in 2008 to 32.8 in 2015, whilst average weekly hours for male GPs have fallen from 43.2 in 2008 to 42.2 in 2015.<sup>(7)</sup>

Another striking change in the medical workforce has been the increasing proportion of female doctors. Females represented 40 per cent of the medical workforce in 2015, up from 33 per cent in 2005.<sup>(7)</sup> This reflects an increasing proportion of female medical graduates completing vocational training and becoming qualified GPs and specialists – 62 per cent of GPs under 35 years old are now female, 11 per cent higher than for specialists (Figure 1).

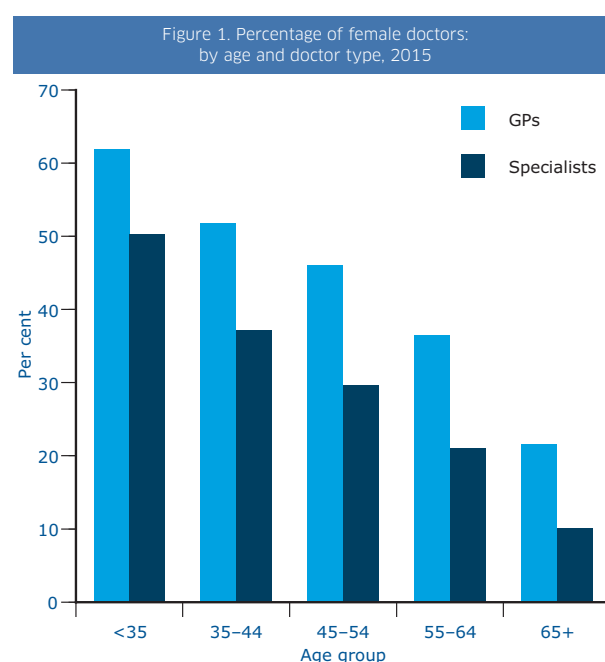
Female GPs earn about 25 per cent less than males after accounting for differences in hours worked and other factors,<sup>(8)</sup> and their careers are more disrupted by having children. After taking account of differences in hours worked and a range of other characteristics, female GPs with children earn over \$30,000 less than comparable female GPs without children, while male GPs with children earn over \$45,000 more than comparable male GPs without children.<sup>(9)</sup> Women tend to choose more family-friendly specialties and jobs, such as general practice,<sup>(10)</sup> and have different practise styles, for example, providing longer consultations.<sup>(11)</sup>

An increased supply of doctors as a result of medical school expansions has been slow to appear due to long training periods, but this is now resulting in increased bottlenecks and competition in the training system, which is placing increased pressure on overall costs.

However, expanding overall supply is expensive and by itself will not solve the issue of inequalities in distribution between areas of high and low socio-economic status, or between urban and rural areas.

Australia relies substantially on international medical graduates (IMGs), who make up around 40 per cent of doctors in rural areas.<sup>(12)</sup> In the context of a potential oversupply of domestically trained doctors, the government wants to restrict immigration to ensure that domestic graduates have jobs. However, our research has shown that most domestic graduates prefer not to work in rural areas, so it is unclear how the rural doctor supply gap would be bridged.<sup>(13)</sup> Reliance on IMGs is thus likely to continue in the absence of policies that are more effective in persuading Australian-trained GPs to work in rural areas.

Increased competition resulting from higher graduate numbers and doctors' high-pressure work environments can affect family life, mental health and well-being, all of which could affect the quality of care, workforce participation and career pathways. The impact of increased medical workforce supply on population health remains unknown.



Note: All GPs and specialists in Australia in clinical practice.  
Source: Australian Medical Publishing Company, May 2015.



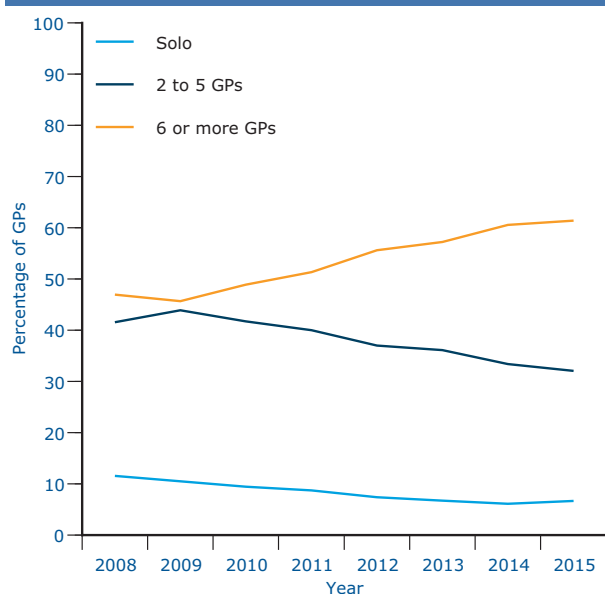
## THE ORGANISATION OF GENERAL PRACTICE

Small, physician-owned businesses have evolved over time and now often employ nurses, liaise closely with allied health professionals to assist in the delivery of care, use on-site pathology, and increasingly use e-health and tele-health. The number of general practices in Australia fell from 8,084 to 7,035 between 2002 and 2011,<sup>(14)</sup> the latest year for which reliable data exist.

Practices are becoming larger. The proportion of GPs working in a practice with six or more doctors has increased from 47 per cent in 2008 to 61 per cent in 2015 (Figure 2). This growth could reflect economies of scale related to changes in ownership that favour larger practices and/or a growing preference for flexible working hours and part-time work, as these data are based on headcounts only, not the FTE number of doctors.

Figure 3 shows the growth since 2008 in the number of GPs and other practice staff. The highest growth of around 40 per cent has been in the number of practice nurses, especially after 2012 when a new funding model, the Practice Nurse Incentive Program, was introduced. The number of practice nurses per GP has increased from 0.39 in 2008 to 0.45 in 2015, suggesting the possibility of efficiency gains. The growth rate in the number of other practice staff mirrors that of GPs, though the use of allied health professionals has increased particularly since 2011.

Figure 2. Changes in practice size (number of GPs, 2008–2015)

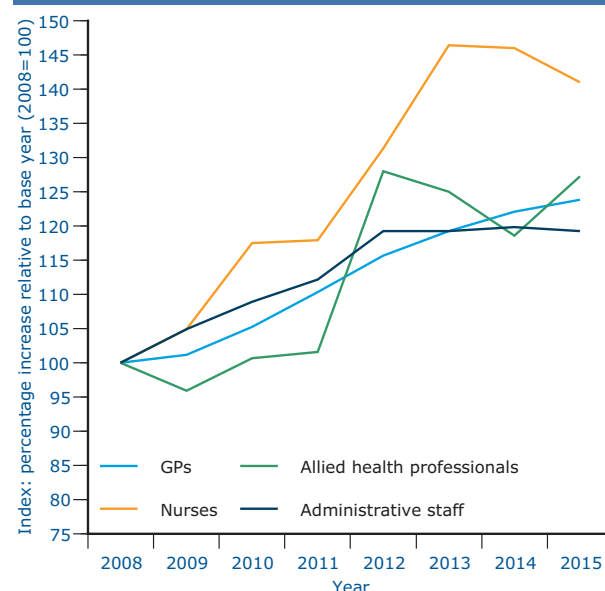


Source: MABEL survey 2008–2015.

There is much anecdotal evidence about the growth in the number of practices owned by corporations, which are likely to be larger and offer a wider range of services. Estimates suggest that 10–15 per cent of all practices are now corporatised, but there are no reliable data documenting growth over time.<sup>(15, 16)</sup> Some supporting evidence from the MABEL survey shows that the proportion of GPs who are owners (practice principals) has fallen from 35 per cent in 2008 to 24 per cent in 2015. This could reflect growing corporate ownership, but could also reflect younger and female GPs having stronger preferences for more flexible work arrangements as employees rather than as small business owners.

There has been some debate about the role and impact of corporate practices. General practices owned by corporations with non-GP shareholders arguably have a stronger focus on profits than practices owned by GPs only, and thus could have a stronger incentive to keep costs under control. However, there is no evidence about the effect of different ownership arrangements on costs, quality and health outcomes and thus further research is needed.

Figure 3. Change in the number of staff per GP practice (2008–2015)



Source: MABEL survey 2008–2015.

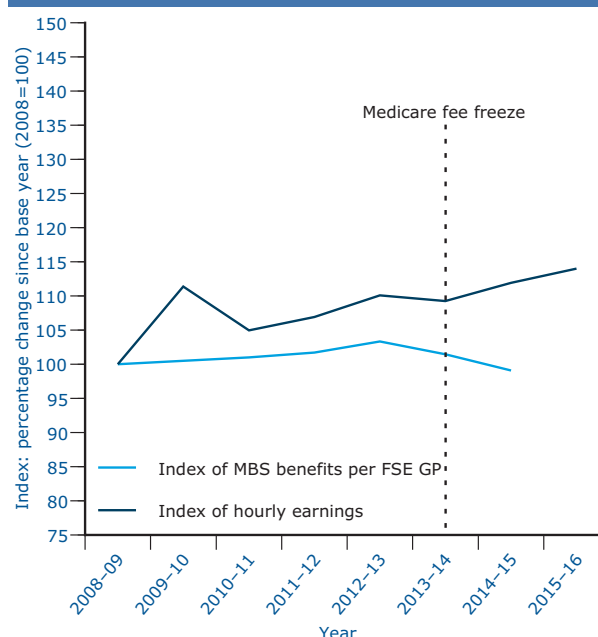


## THE FINANCIAL HEALTH OF GENERAL PRACTICE

In 2014–15 the average full-service-equivalent (FSE) GP received \$305,287 in revenue from the Medicare Benefits Schedule (MBS). This figure excludes revenue from other government sources such as the Practice Nurse Incentive Program, some payments from the Practice Incentive Program, rural incentive schemes and practice infrastructure grants, since such data are generally not available. But rough estimates from the available data suggest this additional revenue is likely to be less than 10 per cent of MBS revenue. Figure 4 shows that MBS revenue per FSE GP has fallen in real terms (after adjusting for CPI) since the end of 2012–13, when the fee freeze was announced, by 4.2 per cent (or 2.1 per cent per year).

Although MBS revenue per FSE GP is falling, Figure 4 also shows that real GP earnings per hour (that is, earnings after adjusting for CPI and accounting for practice expenses but before tax) have continued to rise over time. MABEL survey data indicate that average GP hourly earnings in 2015 were \$116. Between 2012 and 2015 GP hourly earnings rose by 3.9 per cent in real terms (an average of 1.3 per cent per year). This is more than double the overall rate of real wage growth in Australia (1.8 per cent over the same period or 0.6 per cent per year). These data suggest that the loss in MBS revenue per GP is being replaced by other sources of revenue, or that GPs have been reducing practice costs to maintain earnings.

Figure 4. MBS revenue per GP and GP hourly earnings adjusted for CPI (2008–09 to 2015–16)



Notes: Number of FSE GPs: Department of Health, General Practice Statistics <http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1> Worksheet 3. MBS benefits revenue calculated from tables: [http://medicarestatistics.humanservices.gov.au/statistics/mbs\\_group.jsp](http://medicarestatistics.humanservices.gov.au/statistics/mbs_group.jsp) [MBS Groups included: A1, A11, A14, A15, A18, A19, A20, A22]. Hourly earnings: MABEL survey 2008–2015 using cross-sectional weights. Sources: Department of Health Medicare Statistics and MABEL survey 2008–2015.





## BULK BILLING AND OUT-OF-POCKET PAYMENTS

Are GPs reducing bulk-billing rates and charging higher out-of-pocket payments to maintain the growth in their hourly earnings? A key indicator being used in the debate about the impact of the Medicare fee freeze is the rate of bulk billing: for each service (visit) where the fee charged is the same as the Medicare rebate the patient's out-of-pocket costs are zero. National data show that the proportion of Medicare services which are bulk billed continued to climb over successive quarters to 86 per cent in the December quarter of 2016. There is no evidence at a national level that the trend in the rate of bulk billing for Medicare services is falling. A possible explanation of why GPs continue to bulk bill services at a high rate despite the fee freeze is that GPs are maintaining their hourly earnings through practice efficiencies (Figure 4). Bulk-billing rates for Medicare services are also high partly because the majority of visits are by the elderly and children under 16, for which GPs receive a bulk-billing incentive payment (of just over \$6 per visit for GPs in metropolitan areas).

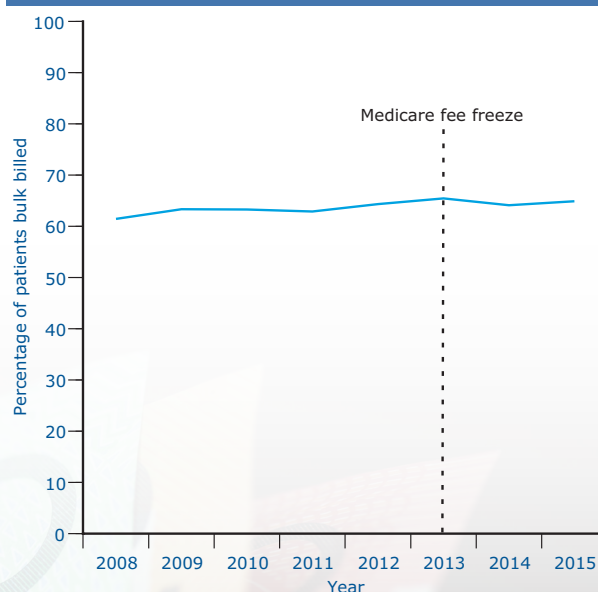
In this debate about the effect of the Medicare fee freeze GPs have questioned the focus on the bulk-billing rate for Medicare services as published by the Department of Health, suggesting that it may 'overestimate' the rate somewhat, in that the bulk-billing rate for patients is likely to be lower than that of services. The MABEL survey questions GPs about the proportion of patients (rather than services) they bulk bill and the results, shown in Figure 5, indicate that the proportion of patients bulk billed in 2015 was indeed much lower than that for services, at 65 per cent. While the overall trend is rising, the series fell by 2.1 percentage points between 2013 and 2014 before increasing slightly in 2015; it has fallen overall by 0.8 percentage points since 2013.

For patients who have previously been but are no longer bulk billed, out-of-pocket costs increase. However, the size and characteristics of this group are unknown as their details are buried within the 'averages' of the published aggregate data.

For patients who have never been bulk billed GPs could choose to increase their fees in response to the fee freeze, however there is no evidence in the available published data of an increase in average out-of-pocket payments since the freeze. Though out-of-pocket costs have risen 20 per cent since the fee freeze was introduced, this trend rate of growth is the same as that which existed previously: there is no evidence of any further incremental increase in this trend since the fee freeze began.<sup>(17)</sup>

One possible reason GPs seem to have been reluctant to reduce bulk-billing rates and increase out-of-pocket costs is a fear of losing patients to nearby practices. This could lead to a potential loss in patient revenue which is more than the gain in revenue from higher fees and reduced bulk billing. There is evidence showing that competition helps to keep bulk-billing rates high and restrains growth in out-of-pocket payments.<sup>(18)</sup>

Figure 5. Trends in the proportion of patients bulk billed (2008–2015)



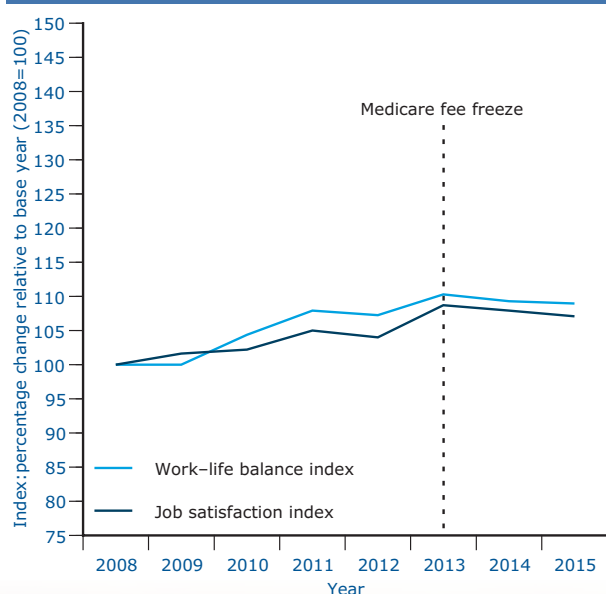
Source: MABEL survey 2008–2015.

## JOB SATISFACTION AND WORK-LIFE BALANCE

New evidence portrayed in Figure 6 shows that GPs' job satisfaction and perceptions of work-life balance have levelled off and started to fall. Job satisfaction fell by 1.5 per cent between 2013 and 2015, reversing the previous trend from 2008, though more data are required to confirm this. The work-life balance index for GPs (Figure 6) has increased overall since 2008, but has declined by 1.2 per cent since 2013 when the Medicare fee freeze was introduced.

Figure 7 shows that the fall in job satisfaction since 2013 is concentrated amongst doctors under 45 years old and, to a slightly lesser extent, doctors over 55 and approaching retirement. Though it is not possible to say that the fee freeze has caused that fall in job satisfaction, there appears to be an association.

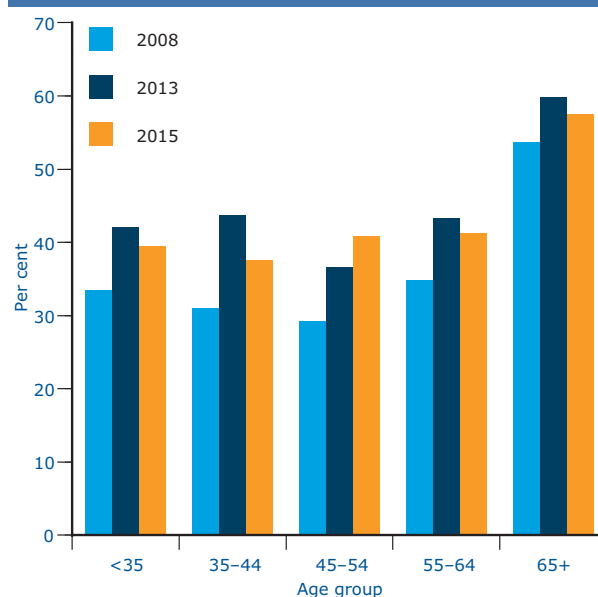
Figure 6. Trends in job satisfaction and work-life balance (2008–2015)



Note: Based on agreement with the statements (i) Work-life balance: "The balance between my personal and professional commitments is about right" using a scale from 0 (Strongly disagree) to 4 (Strongly agree); and (ii) Job satisfaction: "Taking everything into consideration, how do you feel about your job?" using a scale from 0 (Very dissatisfied) to 4 (Very satisfied). Source: MABEL survey 2008–2015.

Falls in job satisfaction suggest falling morale which can in turn reduce the attractiveness of general practice as a career for junior doctors, therefore compounding difficulties in recruitment. If the fall in job satisfaction were to continue it could also drive more GPs away from being practice owners and encourage GPs to retire earlier than planned creating issues for retention.

Figure 7. Percentage of GPs very satisfied with their work, by age (2008, 2013, 2015)



Source: MABEL survey 2008–2015.





## CONCLUSION

GPs play a critical role in the health sector, yet face continuing and significant challenges due to funding and demographic changes in the medical workforce that are influencing the structure of the sector. Increased numbers of women, larger practices and corporate ownership are interacting with declining real Medicare funding per GP and new funding models. This could lead to a more efficient sector, for example, due to increased practice size, and we present some new evidence that this is what has been occurring. However, GP job satisfaction is now falling, which could hurt GP recruitment and retention in a sector that already struggles to compete with the higher earning specialties. It is unclear how the introduction of Health Care Homes in July 2017 and new incentives for quality will affect the sector in the longer term. Moving away from a fee-for-service structure is generally welcomed, but success hinges on GPs' morale and willingness to participate. The key issue is how the sector can generate efficiencies while maintaining access to health care and supporting population health.

## GLOSSARY

**Medicare fee freeze:** Medicare rebates in the Medicare Benefits Schedule define the subsidies patients can claim for medical services provided by medical practitioners. These rebates have been frozen since November 2013 as a budget-saving measure. The freeze has since been extended until 2020. Previously Medicare rebates were increased each year based on inflation.

**Health Care Homes:** This is a new model of health care for patients with chronic disease who voluntarily enrol with a general practice. This is being trialled across 10 of the 31 Primary Health Networks, regional organisations designed to support general practice and other primary and community services. Instead of GPs charging fees, they will receive a fixed payment per patient, with higher payments for more complex patients. Moving away from fee-for-service coupled with enrolment is regarded as important for GPs to deliver improved care to those with chronic disease.

**Primary care:** This relates to the sector of the health care system that provides the first point of contact for patients and continuity of care. This usually includes GPs, but can also include other health professionals such as practice nurses, dentists, allied health and community pharmacists.

## ABOUT THE DATA

This report uses publicly available data from the Department of Health's Medicare Statistics, the Australian Institute of Health and Welfare, and the Australian Bureau of Statistics. Additional data come from the Medicine in Australia: Balancing Employment and Life longitudinal (MABEL) survey of doctors (<http://mabel.org.au/>). MABEL has been collecting data from about 20 per cent of all Australian doctors since 2008. The sample is broadly representative of the population of GPs in terms of age, gender, location, and hours worked. All analyses of MABEL data in this report use cross-sectional weights to ensure data for each year represent the broader GP population in terms of key variables. Details of the construction of weights are included in the MABEL User Manual ([http://mabel.org.au/\\_\\_data/assets/pdf\\_file/0004/1564825/MABEL-User-Manual-Wave-7.pdf](http://mabel.org.au/__data/assets/pdf_file/0004/1564825/MABEL-User-Manual-Wave-7.pdf)).





## REFERENCES

1. AIHW. Health expenditure Australia 2013–14: analysis by sector. Health and Welfare Expenditure Series no. 55. Cat. no. HWE 65. Canberra: Australian Institute of Health and Welfare; 2015.
2. Scott A, Jan S. Primary Care. In: Smith P, Glied S, editors. The Oxford Handbook of Health Economics. Oxford: Oxford University Press; 2011.
3. Department of Health. GP Workforce Statistics – 2004–05 to 2014–15. Canberra: Australian Government; 2016 [viewed December 2016]. Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1>.
4. Scott A, Yong J, Li J. Using financial incentives to encourage value-based health care. Medical Care Research and Review. 2016;1–30.
5. Department of Health. Health Care Homes Factsheet. Stage one modelling; 2016.
6. Department of Health. Re-designing the Practice Incentives Program. Consultation Paper. Canberra: Australian Government; 2016.
7. AIHW. Medical Practitioner Workforce 2015. Canberra: Australian Institute of Health and Welfare; 2016 (11 October). Available from: AIHW website.
8. Cheng TC, Scott A, Jeon SH, Kalb G, Humphreys J, Joyce C. What factors influence the earnings of General Practitioners and medical specialists? Evidence from the Medicine in Australia: Balancing Employment and Life survey. Health Economics. 2012;21(11):1300–17.
9. Schurer S, Kuehnle D, Scott A, Cheng TC. A man's blessing or a woman's curse? The family earnings gap of doctors. Industrial Relations: A Journal of Economy and Society. 2016;55(3):385–414.
10. Sivey P, Scott A, Witt J, Joyce C, Humphreys J. Junior doctors' preferences for specialty choice. Journal of Health Economics. 2012;31(6):813–23.
11. Roter DL, Hall JA. Physician gender and patient-centered communication: A critical review of empirical research. Annual Review of Public Health. 2004;25(1):497–519.
12. McGrail M, O'Sullivan B, Russell D and Scott A. Solving Australia's rural medical workforce shortage. Policy Brief: Centre for Research Excellence in Medical Workforce Dynamics. Issue 3, 2017.
13. Scott A, Witt J, Humphreys J, Joyce C, Kalb G, Jeon SH, et al. Getting doctors into the bush: General Practitioners' preferences for rural location. Social Science & Medicine. 2013;96:33–44.
14. Carne A, Howard S, Bywood P. Summary Data Report of the 2010–2011 Annual Survey of Divisions of General Practice. Adelaide: Discipline of General Practice, Flinders University; 2012.
15. Department of Health and Ageing. State of Corporatisation. Canberra: Department of Health and Ageing; 2012.
16. Erny-Albrecht K, Bywood P. Corporatisation of general practice – impact and implications. Adelaide; 2016.
17. Scott A. FactCheck: Have average out-of-pocket costs for GP visits risen almost 20% under the Coalition? The Conversation [Internet]. 2016 (19 October). Available from: <https://theconversation.com/factcheck-have-average-out-of-pocket-costs-for-gp-visits-risen-almost-20-under-the-coalition-66278>.
18. Gravelle H, Scott A, Sivey P, Yong J. Competition, prices and quality in the market for physician consultations. The Journal of Industrial Economics. 2016;64(1):135–69.

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