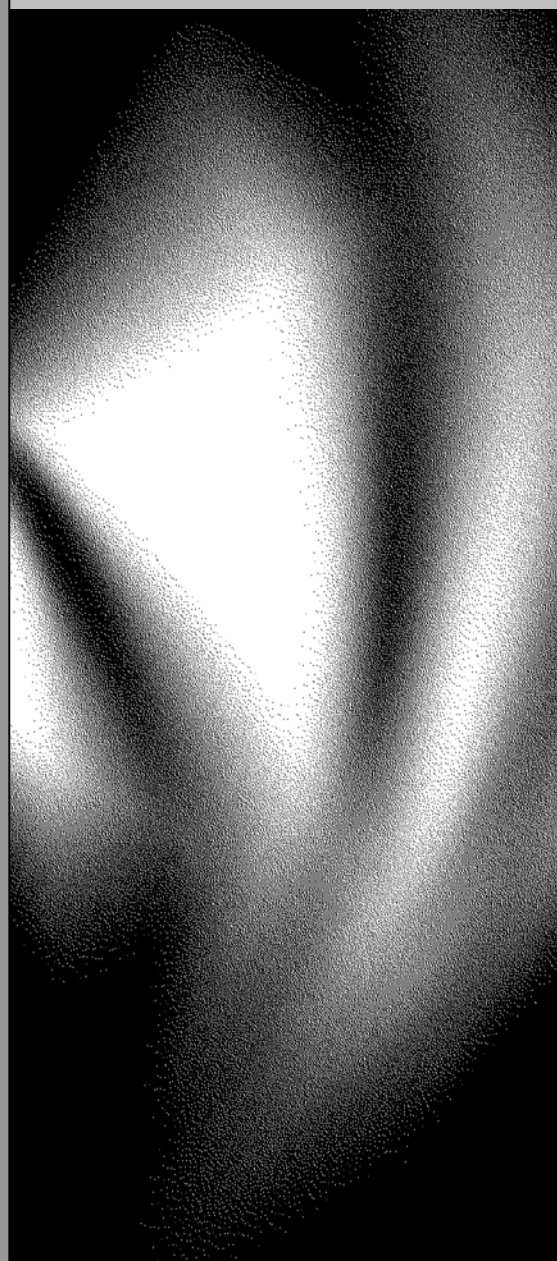




General Practice Administrative and Compliance Costs

Research Report

31 March 2003



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ISBN 1 74037 115 1

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An appropriate citation for this paper is:

Productivity Commission 2003, *General Practice Administrative and Compliance Costs*, Research Report, Canberra.

The Productivity Commission

The Productivity Commission, an independent Commonwealth agency, is the Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Information on the Productivity Commission, its publications and its current work program can be found on the World Wide Web at www.pc.gov.au or by contacting Media and Publications on (03) 9653 2244.

Foreword

General practitioners and their representative organisations have long expressed concerns about the compliance burden associated with their participation in government programs.

Responding to these concerns, the Government asked the Productivity Commission to report on the nature and magnitude of administrative and compliance costs borne by GPs and their practices associated with certain Commonwealth programs. In this report, the Commission provides estimates of these costs, as well as highlighting the main issues that arise and proposing some ways of ameliorating the costs.

In undertaking its analysis, the Commission has drawn on information from various sources — including Commonwealth departments and agencies, a pilot survey, focus group discussions and case studies. The Commission also established an advisory committee, with members drawn from GP organisations and relevant Commonwealth departments and agencies. The committee provided valuable advice and feedback at two roundtable meetings held in August and December 2002.

The Commission is grateful for the time and effort of all those who assisted it in this study.

The study was overseen by Commissioner Helen Owens and conducted within the Inquiry C Branch in the Commission's Melbourne Office.

Gary Banks
Chairman
March 2003

Terms of reference

The Productivity Commission is requested to undertake a research study examining the administrative and compliance costs associated with Commonwealth programmes that impact on general practice. In undertaking the study, the Commission is to consult widely with interested parties including signatories to the General Practice Memorandum of Understanding.

In undertaking the study the Commission is to:

1. analyse the nature and magnitude of the administrative and compliance costs for individual general practitioners and general practice as a whole resulting from Commonwealth policies and programmes that impact on general practice and not on business generally; and
2. having particular regard to the overall objectives of these Commonwealth programmes and the benefits to consumers, report on findings as to worthwhile avenues to ameliorate these administrative and compliance costs.

The Commission is required to report within 7 months of commencing the study.¹

IAN CAMPBELL

5 July 2002

¹ Subsequently extended to 31 March 2003 at the request of the Commission.

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Acknowledgments

The Commission wishes to thank the many organisations and individuals who have contributed to the study, in particular, the many GPs who directly participated during visits, focus group discussions, case studies and by providing submissions.

The Commission also wishes to thank Centrelink, Department of Family and Community Services, Department of Health and Ageing, Department of Veterans' Affairs and the Health Insurance Commission for provided information (including data) on the many programs covered in this study. These departments and agencies, along with the Australian Divisions of General Practice, Australian Medical Association, Royal Australian College of General Practitioners, Rural Doctors Association of Australia and the Australian Association of Practice Managers, also contributed through their participation in the advisory committee for the study.

The Commission appreciates the assistance provided by some divisions of general practice in arranging visits, case studies and focus group discussions.

The Commission also acknowledges the assistance provided on a consultancy basis by Millward Brown Australia (which conducted a pilot survey of GPs and focus group discussions attended by GPs), Campbell Research & Consulting (which conducted case studies of GPs) and Ms Deborah Doyle (who reviewed selected forms).

Abbreviations

ABC	Activity-based costing
ACCHS	Aboriginal Community Controlled Health Service
ACIR	Australian Childhood Immunisation Register
ADGP	Australian Divisions of General Practice
AMA	Australian Medical Association
BEACH	Bettering the Evaluation and Care of Health
CHS	Commonwealth Hearing Services
CPD	Continuing Professional Development
CTVS	Country Taxi Voucher Scheme
DMMR	Domiciliary Medication Management Review
DoHA	Department of Health and Ageing
DSP	Disability Support Pension
DVA	Department of Veterans' Affairs
EPC	Enhanced Primary Care
FaCS	Department of Family and Community Services
FTE	Full-time equivalent
FWE	Full-time working equivalent
GARP	Guide to the Assessment of Rates of Veterans' Pensions
GP	General practitioner
GPII	General Practice Immunisation Incentives
GST	Goods and services tax
HIC	Health Insurance Commission
IM and IT	Information management and information technology
LMO	Local Medical Officer

MBS	Medicare Benefits Schedule
MCRS	Military Compensation and Rehabilitation Service
MOU	Memorandum of Understanding
NZ	New Zealand
OECD	Organisation for Economic Co-operation and Development
OMP	Other medical practitioner
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PIFP	Prescriber Intervention Feedback Program
PIP	Practice Incentives Program
QA	Quality Assurance
QPI	Quality Prescribing Initiative
RACGP	Royal Australian College of General Practitioners
RCCS	Repatriation Comprehensive Care Scheme
RIS	Regulation Impact Statement
RRMA	Rural, Remote and Metropolitan Areas classification
RRP	Rural Retention Program
RWAs	Rural Workforce Agencies
SEIFA	Socio-Economic Indexes for Areas
SIP	Service Incentive Payments
TDR	Treating Doctor's Report
VRGP	Vocationally registered general practitioner

OVERVIEW

Key points

- Many Commonwealth policies and programs impact specifically on GPs and the way general practices are managed and operated.
- Under the Commission's base case, in 2001-02 the estimated incremental administrative and compliance costs resulting from Commonwealth policies and programs amounted to about \$228 million (about 5 per cent of GPs' estimated total income from public and private sources).
 - This is equivalent to about \$13 100 per GP per year (for GPs who work at least one day per week).
- Estimates are indicative only and sensitive to assumptions about GPs' annual earnings and the extra time spent on administrative activities attributable to Government programs.
 - For example, if activities such as qualifying for vocational registration would be undertaken anyway, the estimated administrative costs attributable to Commonwealth requirements could be as low as \$85 million.
- Some GPs report rising stress and frustration associated with completing forms and complying with administratively complex programs, the increasing accumulation of forms and programs, and conflicting priorities.
 - However, it is difficult to quantify these intangible costs, and these are not included in the Commission's estimates.
- For many programs, GPs receive Government payments that exceed the *measurable* administrative and compliance costs.
- In the base case, three programs aimed at encouraging high quality care — Practice Incentives Program, vocational registration and Enhanced Primary Care — account for over three-quarters of measurable costs.
- Form filling by GPs accounts for a small share of the measurable administrative and compliance costs, but is a significant source of stress-related and other intangible costs.
- A range of options is available for reducing both tangible and intangible administrative and compliance costs.

Overview

What is the role of general practitioners?

General practitioners (GPs) play an important role in primary health care in Australia, diagnosing and treating illness and injury, ordering imaging and diagnostic tests, and referring patients to other health professionals. Medical information provided by GPs is used by departments and agencies to assess patients' eligibility for benefits. Further, GPs are increasingly involved in promoting population health and managing chronic illnesses under a number of government programs.

GPs and general practice

There are different types of general practitioners. Vocationally registered GPs, GP registrars and other medical practitioners (OMPs) working in private practice surgeries are covered in this study. In 2001-02, about 17 400 GPs provided at least 1500 consultations over the year (corresponding to working on average for one day per week).

General practice revenue was about \$4 billion in 1998-99, accounting for about 8 per cent of total health expenditure. About three-quarters of this revenue came from the Commonwealth Government.

Which programs affect GPs?

GPs and their organisations have raised concerns about the increasing requirements that governments place on individual GPs and general practice as a whole. Thus the Commission has been asked to examine those Commonwealth policies and programs that impact on GPs and general practice, but not business generally. The Commission identified 43 such programs, and classified them into four groups, based on whether the GP is:

- participating in programs that seek to influence the quality and availability of GP services;
- providing information to departments and agencies to assist in the assessment of a person's eligibility for support services;
- participating in programs that seek to promote population health; or
- responding to Commonwealth Government surveys.

Which programs are in and which are out?

What is in:

- Commonwealth Government programs that impact specifically on general practice (such as vocational registration, Practice Incentives Program, Enhanced Primary Care program, Pharmaceutical Benefits Scheme authorisations, Department of Family and Community Services/Centrelink programs, Department of Veterans' Affairs programs).

What is not included:

- Commonwealth programs that apply to businesses generally (such as GST, superannuation);
- State, Territory and local government programs (such as workers' compensation);
- the 'normal' activities of a GP (such as referrals to hospitals and specialists); and
- private requirements (such as insurance).

This is not a cost–benefit or 'cost-of-service' study

Government policies and programs generate a range of benefits and costs for government, businesses and consumers. However, the terms of reference for this study limit the analysis to the costs that GPs face in complying with and administering selected policies and programs (referred to in this report as 'GP administrative costs'). The Commission has not undertaken a cost–benefit analysis (or an evaluation) of these programs. GPs and practices receive some form of payment for many programs within the scope of the study. However, the Commission has not assessed whether these payments are adequate, since this is not a 'cost-of-service' study.

GP administrative costs are incremental costs

In this study GP administrative costs are defined as the incremental or additional costs to GPs and to their practices of meeting the requirements of certain Commonwealth Government programs. These costs are incremental in the sense that they:

- are above those costs incurred in undertaking the normal activities of a GP; and
- would not have been incurred in the absence of the program.

This approach is broadly based on that of the Organisation for Economic Co-operation and Development (OECD).

Three sources of incremental costs are included: labour costs, non-labour costs and intangible costs. The Commission's estimates focus on labour and non-labour costs (monetary costs).

GPs' views on GP administrative costs

Many GPs commented on requirements to complete forms. The GPs in the focus group discussions conducted for this study had different views:

Amongst GPs there were mixed perceptions of the burden placed on their profession by Commonwealth forms. Certainly, there were individuals who felt the forms were an enormous frustration while for others they were inconsequential and simply part of their responsibility. However, there was consensus in the feeling that Commonwealth forms were just one area of the various range of compliance tasks enforced upon GPs. The greatest frustration was the sheer number of forms for every type of government program. (Millward Brown Australia 2002a, p. 13)

The Canning Division of General Practice commented:

Our concern is not so much lack of payment (of course it helps to be paid for it), but rather [that the time spent completing government forms] could be much better spent in patient care. With the growing shortage of GPs in metropolitan areas, the increasing administrative workload is placing more pressure on doctors in a health system that requires all of the available capacity of doctors to meet the clinical needs of patients. GPs need to get back to what they do best: treating patients, not administration. (sub. 11, p. 1)

On the other hand, a GP interviewed in one of the case studies conducted for this study considered that he:

... does not encounter difficulties when complying with the programs. This is because he is able to rely on systems and procedures developed by the practice administration staff and because the practice employs several nurses ... (Campbell Research & Consulting 2003, vol. 2, p. 3)

Another GP commented:

Centrelink forms are all fairly similar in nature, and therefore fairly fast to fill out, especially when doctors know their patients. (Campbell Research & Consulting 2003, vol. 2, p. 11)

There were also comments about other Commonwealth programs. Campbell Research & Consulting concluded that the main concern of some GPs interviewed for the case studies about the Enhanced Primary Care program was that the activities:

... are complex to set up and to carry out, and require developed systems and procedures that are more accessible to larger, urban practices. (2003, vol. 1, p. 20)

In commenting on the Practice Incentives Program, the Australian Medical Association argued:

The constant theme has been that [the Practice Incentives Program] is just too costly and complex and just not worth the trouble. For example, one practice 'ditched' [the program] after calculating that administration costs were likely to swallow \$25 000–\$30 000 of gross income about the same amount the practice estimated it would earn with [the program]. (sub. 13, p. 8)

Estimates of GP administrative costs

Information was obtained from a variety of sources, including Commonwealth departments and agencies, a pilot survey of GPs, focus group discussions with GPs and case studies of 13 GPs in separate practices.

Estimates are indicative only

The GP administrative cost estimates are the best that could be produced within the timeframe and with the information available, but they do have limitations. Many of the estimates of staff time and practice costs are based on small samples of GPs and practices. Consequently, this approach yields results that are indicative rather than precise, and they are sensitive to assumptions about key programs.

Measurable costs are significant

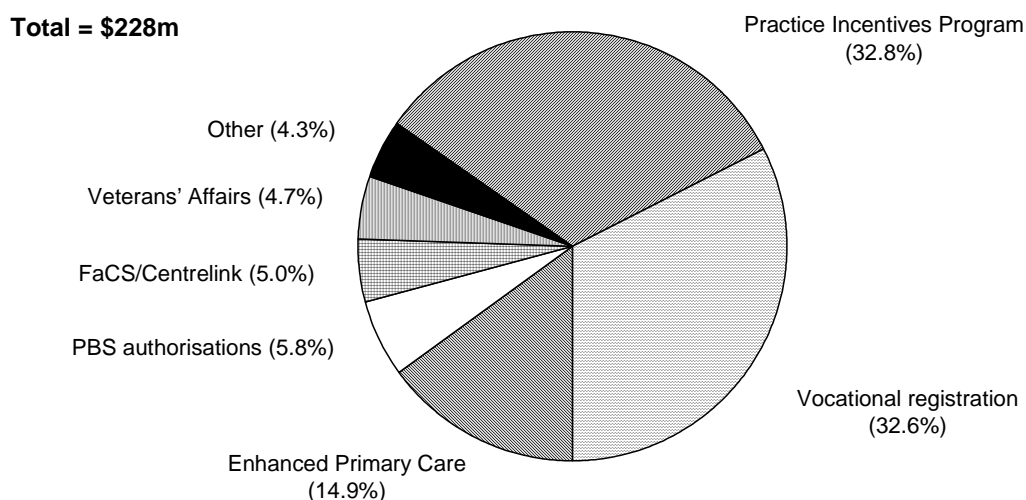
Under the Commission's base case, administrative costs to GPs resulting from Commonwealth policies and programs are estimated to have been about \$228 million in 2001-02 (about 5 per cent of GPs' estimated total income from public and private sources). This is equivalent to an average of about \$13 100 per GP per year (for GPs who work at least one day per week).

These results are sensitive to assumptions. Some participants have argued that some included activities, such as vocational registration, would be undertaken by GPs anyway and therefore do not contribute to administrative costs.

The Commission conducted sensitivity analyses to indicate how the estimates of GP administrative costs might vary with changes in assumptions. If an alternative assumption that most of vocational registration, Enhanced Primary Care and practice accreditation for the Practice Incentives Program are 'normal' activities (not contributing to GP administrative costs) was adopted, the cost estimate could be as low as \$85 million.

Nevertheless, regardless of views about which GP activities are considered to be 'normal' or which are driven by government or the profession, it is important to recognise that GPs and general practices have consumed resources and incurred incremental costs in these areas that need to be recovered.

Estimated GP administrative costs, 2001-02



Under the base case, the Practice Incentives Program, vocational registration (essentially, professional development) and Enhanced Primary Care accounted for over three-quarters of GP administrative costs. These programs are designed to improve quality of patient care. GPs and their organisations helped to develop some of the requirements of these programs (such as Continuing Professional Development for vocational registration and accreditation, a prerequisite for the Practice Incentives Program).

Completing forms for the Department of Veterans' Affairs and the Department of Family and Community Services (FaCS)/Centrelink accounted for less than 10 per cent of total GP administrative costs (largely due to the small average number of forms completed per GP).

GPs receive payments for many programs

GPs are paid to undertake many of the administrative activities associated with the programs covered in this study. For many of those programs for which information is available, payments are above the measurable costs, as indicated for the three programs generating the highest administrative costs.

The Commission has not formed a view about whether the payments to GPs are too high or too low. Such conclusions are properly the domain of program evaluations, where the objectives, total costs and benefits, and remuneration are considered as a policy package.

Selected GP administrative costs and direct payments to GPs, 2001-02

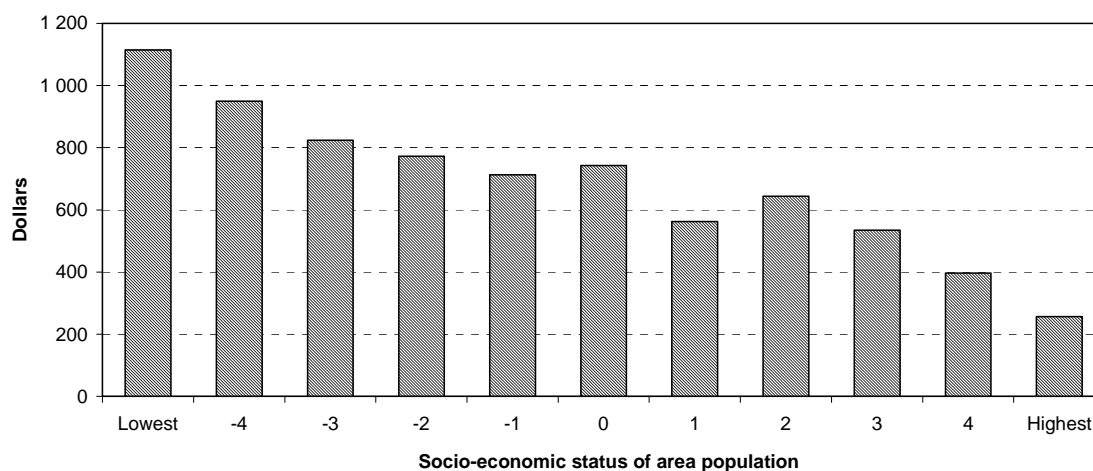
Programs	Estimated GP administrative costs		Payments to GPs
	Base case assumptions	Alternative assumptions	
	\$m	\$m	\$m
Practice Incentives Program	74.6	25.8	193.2
Vocational registration	74.2	7.8	> 493.8
Enhanced Primary Care	33.9	6.1	62.9
Total	182.7	39.7	749.9

Administrative costs per GP vary between locations

The Commission disaggregated the costs that GPs face in complying with some programs to determine whether the level of administrative costs per GP varies between locations.

- It appears that the administrative costs per GP of completing forms for FaCS/Centrelink clients are higher in areas with a lower socio-economic status population, as GPs in these areas are more likely to have patients who require them to complete these forms. These conclusions cannot be extrapolated to other programs.
- There also appears to be a general trend to higher administrative costs per GP associated with FaCS/Centrelink programs as population density decreases. That is, costs are lowest in inner capital cities, higher in rural areas and highest in remote areas.

Administrative costs per GP for FaCS/Centrelink programs, 2001-02



Intangible costs are also important

Intangible costs arising from the stress of undertaking certain activities clearly exist, although it is difficult to quantify them. Some GPs report that there is growing stress and frustration associated with completing forms and complying with administratively complex programs, the increasing accumulation of forms and programs, and conflicting priorities.

Although FaCS/Centrelink programs accounted for only 5 per cent of measured GP administrative costs, their impacts on these intangible costs might be significant. At focus group discussions, GPs expressed most frustration with FaCS/Centrelink Disability Support Pension forms. Over two-thirds of GPs considered that the time spent completing these forms was 'unreasonable'.

Examples of intangible costs

In focus group discussions, one GP stated:

I am overburdened with paperwork as well as patients to the point that I don't enjoy my work half as much as I used to. I feel that some paperwork is necessary and I have to do that. We are taken for granted by a lot of people that our paperwork is just box ticking and signature and there is no responsibility associated to it so therefore just get the doctor to do it. That is wrong particularly in the days of medical litigation and personal responsibility. I find it very stressful. (Millward Brown Australia 2002a, p. 14)

GPs in the focus group discussions considered the FaCS/Centrelink Disability Support Pension Treating Doctor's Report 'to be a very frustrating form and importantly was considered to have little value, thus increasing the frustration with having to fill it out' (Millward Brown Australia 2002a, p. 23).

The Far North Queensland Rural Division of General Practice also noted the psychological impact of administrative activities, stating that paperwork is one of the 'great frustrations of general practice' (sub. 9, p. 5). The Medical Board of South Australia also commented:

The administrative burden of 'paperwork requirement' is a source of complaint, the time it takes to meet these requirements is now beginning to seriously 'eat into' time which should be spent on patient care and consultations. If paperwork requirements are not met during normal consulting hours, these matters have to be attended to out of consulting hours, which contributes to 'burn out', ill health and stress related issues. (sub. 1, p. 1)

Campbell Research & Consulting reported that one of the GPs interviewed for the case studies considered that the asthma service incentive elements for the Practice Incentives Program are:

... 'an insult to the doctor's intelligence' because of the implication that GPs are not treating asthma patients correctly. (2003, p. 132)

The Australian Medical Association argued that issues arising from linking accreditation and PIP:

... contributed to a significant level of stress, frustration and administrative work by GPs and their representative groups to seek solutions. (sub. 13, p. 19)

What are the options to reduce GP administrative costs?

Consider these costs when evaluating programs

Departments and agencies seem to have given little or no consideration to GP administrative costs in their evaluations of most of the programs covered in this study. An assessment of these costs should be undertaken regardless of whether GPs are explicitly remunerated or their participation is voluntary. This would encourage departments and agencies to design and implement more cost-effective programs; that is, those which achieve their objectives while minimising any necessary costs, including those imposed on GPs. Estimates of GP administrative costs could usefully be informed by consultations with GP organisations before programs are implemented.

Some programs should be evaluated

The Practice Incentives Program, vocational registration and Enhanced Primary Care generated the largest GP administrative costs. However, reducing these costs might have consequences for the achievement of the programs' objectives, particularly their benefits to consumers. Such an assessment is outside the scope of this study. The Department of Health and Ageing should undertake evaluations of these programs (accounting for the administrative costs to GPs).

Monitor and report on cumulative costs

Even if Commonwealth programs individually create small costs for GPs, the cumulative effects of many programs can be large. Cumulative costs appear to have led to frustration among GPs, but do not seem to have been taken into account by departments and agencies.

The Government should establish a departmental coordination group to monitor changes in the cumulative level of GP administrative costs. This group could consist of the relevant Commonwealth departments and agencies responsible for administering programs that impact on GPs (such as Department of Health and Ageing, Department of Veterans' Affairs, FaCS/Centrelink and Health Insurance Commission). The Department of Health and Ageing should report publicly on these costs.

Develop guidelines to improve information collection

GPs have raised issues about the way information is collected, including unnecessary repetition, lack of clarity and simplicity in form design, frequent changes and lack of feedback from departments and agencies. Individual Commonwealth departments and agencies do not seem to apply a common, 'standard' approach when collecting information from GPs. Guidelines should be developed (possibly by the Department of Health and Ageing) to ensure that, when appropriate, there is standardisation of information collection and form design across departments and agencies.

Payments to GPs for medical information should be from the relevant department or agency's budget

The Department of Veterans' Affairs and FaCS/Centrelink require GPs to complete forms that are in some cases long and complicated, in order to provide the information required to assess a patient's eligibility for support services. Although the tasks undertaken for these departments and agencies are similar, remuneration arrangements differ. Department of Veterans' Affairs makes explicit payments to GPs, funded from its own budget. In contrast, for FaCS/Centrelink forms, GPs can be paid a medical consultation through Medicare if a consultation is required to obtain the information and if the form is completed during that consultation.

To the extent that it is Government policy to remunerate GPs for providing medical information, it is preferable that the relevant department or agency funds the arrangement out of its own budget. This would encourage them to limit the administrative costs imposed on GPs by, for example, reducing the amount of information sought, or expanding the use of information technology to collect the information.

Adopt consistent principles for paying GPs

The structure and level of payments should be designed so as to promote both departmental efficiency and the efficient provision of high quality information by GPs. This does not require identical payment schedules across departments and agencies.

Accelerate the use of information technology when there is a net benefit

In recent years, Commonwealth and State governments have been facilitating the adoption of information technology. Nevertheless, most of the Government

programs studied still rely heavily on paper-based systems. Relatively few appear to allow GPs to complete or submit forms electronically. Further, there is varying uptake of information management and information technology by general practices.

Some GPs have suggested that administrative costs could be reduced by accelerating the use of information technology. For example, the appropriate information to be included on a form could be retrieved electronically. GPs completing or submitting forms electronically might also reduce costs to departments.

Departments and agencies should accelerate the use of information technology by GPs, when there is a net benefit. Options that could be examined include integrating forms into the computer software used by GPs, and allowing more forms to be submitted electronically.

Reduce conflicting priorities for GPs

GPs have a duty of care to their patients. However, some GPs feel that the requirements of some programs can place tension on this relationship. For example, some patients might place pressure on their GPs to help gain access to social security benefits.

When a department (or agency) asks GPs to supply information, it should focus its requirements on medical diagnoses based on clinical evidence (rather than seeking, for example, GPs' opinions about when a person will be fit to return to work). This would reduce the likelihood of such tensions.

In sum

GP administrative costs are significant and there is scope to reduce them. The Commission has made a number of recommendations aimed at encouraging Commonwealth departments and agencies to consider GP administrative costs in their program evaluations, and reduce requirements to the minimum necessary. Adopting these recommendations would help to reduce GP administrative costs, without compromising the community-wide benefits that these programs deliver.

Recommendations and findings

Estimating administrative costs

FINDING 5.1

Under the Commission's base case, the estimated administrative costs for general practitioners and general practice resulting from Commonwealth policies and programs were about \$228 million (or 5 per cent of GPs' estimated total income from public and private sources) in 2001-02. This is equivalent to an average of about \$13 100 for a GP who works at least one day per week.

FINDING 5.2

Based on an alternative assumption that some activities associated with certain Commonwealth policies and programs would be undertaken by GPs anyway, administrative costs could be as low as \$85 million (or 2 per cent of GPs' estimated total income from public and private sources) in 2001-02. This is equivalent to an average of about \$4900 for a GP who works at least one day per week.

FINDING 5.3

Under the Commission's base case, three programs aimed at promoting high quality care — Practice Incentives Program, vocational registration and Enhanced Primary Care — accounted for over three-quarters of measurable GP administrative costs in 2001-02. Administrative costs arising from GPs completing forms for the Department of Veterans' Affairs and the Department of Family and Community Services/Centrelink accounted for much smaller shares.

FINDING 5.4

For many of the programs for which information is available, GPs receive Government payments that exceed measurable GP administrative costs.

FINDING 5.5

Administrative costs per GP for the Department of Family and Community Services/Centrelink programs differ across regions. They are lowest in inner capital cities and highest in remote areas.

FINDING 5.6

Administrative costs per GP for the Department of Family and Community Services/Centrelink programs differ according to the socio-economic status of the population in the area in which GPs practise, increasing as the socio-economic status decreases.

FINDING 5.7

Intangible costs arise from stress and frustration experienced by GPs in completing forms and meeting program requirements, but they are difficult to quantify and have not been included in the Commission's estimates.

Reducing administrative costs

Assessing program costs and benefits

FINDING 6.1

Many programs within the scope of this study are voluntary, with GPs (or general practices) being remunerated for participation. Departments and agencies have accordingly not been required to prepare a Regulation Impact Statement in developing these programs.

FINDING 6.2

Departments and agencies seem to give little or no consideration to GP administrative costs in their evaluations of most of the programs covered in this study.

FINDING 6.3

Although departments and agencies appear to consult with GP organisations about the details of programs, there appears to have been little discussion on the likely nature and magnitude of GP administrative costs.

RECOMMENDATION 6.1

When conducting program evaluations (for programs within the scope of this study), departments and agencies should include GP administrative costs associated with participation in the program (regardless of whether GPs are explicitly remunerated or their participation is voluntary), unless they can show that these costs are insignificant. Estimates of these costs should be developed after discussions with GP organisations.

RECOMMENDATION 6.2

The Department of Health and Ageing should conduct program evaluations (accounting for the administrative costs to GPs) of the Practice Incentives Program, vocational registration, and Enhanced Primary Care program.

Remunerating GPs for providing medical information

FINDING 6.4

The Department of Family and Community Services/Centrelink and the Department of Veterans' Affairs differ in their approach to remunerating GPs for similar tasks, particularly in relation to the preparation of medical reports.

FINDING 6.5

There is confusion among some GPs regarding eligibility for payment to complete Department of Family and Community Services/Centrelink forms.

RECOMMENDATION 6.3

To the extent that the Government chooses to remunerate GPs for providing medical information, the relevant department or agency should fund the payments out of its own budget.

RECOMMENDATION 6.4

Consistent principles for remunerating GPs should be adopted between (and within) departments and agencies. This does not require identical payment schedules.

Cumulative GP administrative costs

FINDING 6.6

Departments and agencies appear to implement their programs independently, with little consideration given to the cumulative level of GP administrative activity and costs created by these programs.

FINDING 6.7

Even if the GP administrative costs associated with an individual program might be considered small, the cumulative impact of all programs can be large. This appears to have led to frustration among GPs.

RECOMMENDATION 6.5

A departmental coordination group should be established to monitor changes in cumulative GP administrative costs over time. The Department of Health and Ageing should report these costs publicly.

Information collection

FINDING 6.8

There does not appear to be a standard approach by departments and agencies to designing forms and collecting information from GPs.

RECOMMENDATION 6.6

A set of guidelines should be developed (possibly by the Department of Health and Ageing) to facilitate, when appropriate, the standardisation of information collection and form design across departments and agencies.

Use of information technology

FINDING 6.9

The extent to which information technology is used for GP administrative activities differs among Commonwealth departments and agencies, and among GP practices. The reliance on paper-based systems is still extensive.

RECOMMENDATION 6.7

Departments and agencies should examine options to accelerate the use of information technology in reporting by GPs, including integrating forms into computer software used by GPs, and allowing more forms to be submitted electronically when there is a net benefit.

Addressing conflicting priorities

FINDING 6.10

Some GPs can face a tension between discharging a duty of care to their patients, retaining their patients and meeting the requirements of some programs. This can be a source of stress and anxiety for these GPs.

RECOMMENDATION 6.8

When a department or agency is asking GPs to supply information, it should focus its requirements on medical diagnoses based on clinical evidence.

1 Introduction

On 5 July 2002, the Parliamentary Secretary to the Treasurer asked the Productivity Commission to conduct a research study examining the administrative and compliance costs associated with certain Commonwealth Government policies and programs that impact on general practice.

The Commission is required to analyse the nature and magnitude of administrative and compliance costs associated with Commonwealth Government policies and programs that impact on general practice and not on business generally. The Commission was also asked to consult widely and report on ways to reduce these costs, having particular regard to the overall objectives of these Commonwealth programs and the benefits to consumers.

This study arose after general practitioner (GP) organisations raised concerns about the level of red tape imposed by government departments and agencies. Some GP organisations (such as the Australian Divisions of General Practice, the Royal Australian College of General Practitioners and the Rural Doctors Association of Australia) also requested a review of this issue.

For convenience, the Commission refers to ‘administrative and compliance costs’ incurred by GPs and general practice as ‘GP administrative costs’ throughout this report. The definition of these costs is discussed in section 1.2 and chapter 4. Departments and agencies are referred to as ‘departments’.

1.1 Background to the study

Administrative costs for GPs and their practices have been considered in a number of studies (box 1.1). According to a recent survey commissioned by *Australian Doctor* (Cresswell 2002b, p. 1), just over one-quarter of participating GPs claimed that they spent more than seven hours per week completing paperwork associated with Commonwealth and State government policies and programs. *Australian Doctor* also reported that 72 per cent of participating GPs believed that paperwork was compromising the treatment they offered their patients; and 75 per cent believed that the number of forms they faced had ‘greatly increased’ over the past three years.

Box 1.1 **Previous studies of GP administrative costs**

There have been two major international studies in recent years of GP administrative costs; one in the United Kingdom by the Cabinet Office Public Sector Team and the Department of Health (2001, 2002) and another in New Zealand by the General Practice Test Panel on Compliance Costs (2001). Several studies have been undertaken in Australia (Cresswell 2002a, 2002b; Schattner 1996).

The scope of these studies differed. Schattner (1996) included both government and private administrative activities, whereas the NZ and UK studies focused on administrative activities associated with government policies and programs. The NZ study included activities undertaken by all general practice staff, whereas Schattner and the UK study focus only on GPs.

Information on general practice administrative costs come from a wide range of sources. These include GPs (using telephone and mail surveys, face-to-face interviews and focus group discussions), other practice staff, GP organisations, government departments and agencies, and other stakeholders.

The NZ and UK studies both found that although each activity might only result in a small cost, the cumulative cost of a large number of activities can be significant.

Another finding was that the highest cost administrative activity undertaken by GPs arose from providing departments or agencies with patient-related information to enable them to assess a patient's eligibility for a particular government service or income support payment.

In Australia, the *Australian Doctor* (Cresswell 2002b) reported (based on a survey) that about 27 per cent of GPs claimed that they spent more than seven hours a week on unpaid Commonwealth and State Government paperwork and other administrative requirements. About 31 per cent spent from four to seven hours, and 42 per cent spent three hours or less. GPs considered that completing Centrelink and other social security forms was the most onerous of these requirements. In a similar survey on the Practice Incentives Program (Cresswell 2002a), 49 per cent of GPs reported spending three hours or more a week, and 39 per cent reported spending up to two hours a week doing paperwork associated with this program

The environment in which general practice operates has been changing in recent years. GPs are facing growing pressures from a variety of sources, some internal to the profession and others external, often by governments. These pressures derive from changes in the GP workforce, increased use of information technology, growing financial pressures, and changes in the role of GPs. Many of these pressures are particularly acute in rural areas. They can influence GPs' perceptions of, and reactions to, government-required administrative costs.

1.2 Scope of the study

There are three key issues to address in defining the scope of the study:

- defining the role of GPs;
- defining GP and general practice administrative costs associated with Commonwealth policies and programs; and
- determining the relevant programs that impact on general practice and not on business generally.

Defining the role of general practitioners

GPs play a major role in the delivery of health care in Australia. About 85 per cent of the population visit a GP for a consultation at least once a year (Public Health and Health Promotion SERU 2000).

GPs offer primary medical care. When people experience health-related problems they can go directly to a GP without having to visit another health or related professional (often called a non-referred attendance). For many people, a GP is often the first point of contact with the health-care system.

GPs assess and coordinate patients' health-care needs in terms of the health system as a whole, by identifying their needs and recommending a course of action or treatment. This can include prescribing medicines, ordering diagnostic tests and referring patients to other health-care providers. GPs also provide ongoing care, from the initial consultation to the treatment of patients for complex and chronic health conditions.

GPs also provide information to third-party organisations about their patients' medical conditions. This information is used by these organisations (both government and non-government) to assess patients' eligibility for payments (for example, Department of Family and Community Services/Centrelink payments) and subsidised services or products (for example, subsidised medicines under the Pharmaceutical Benefits Scheme).

The role of GPs in Australia has changed over time. GPs have had to adapt to changes in community expectations and in the environment in which they operate (GPSRG 1998). Government policies and programs play an important role in driving these changes. Tightening eligibility for receiving some government payments, for example, can increase the information reporting requirements for GPs.

GPs are increasingly involved in promoting population health and managing chronic illnesses (GPRSG 1998), partly in response to government programs that encourage GP involvement in these areas. These programs often provide financial incentives, usually linked to GPs undertaking certain activities. The General Practice Immunisation Incentives Scheme, for example, provides incentive payments to GPs to administer age-appropriate immunisations. However, to receive these payments GPs need to notify the Australian Immunisation Childhood Register (chapter 3 and appendix D).

Government and private expenditure on general practice was about \$4 billion in 1998-99; that is, around 8 per cent of total health expenditure (SCRCSSP 2003). Commonwealth Government expenditure through Medicare, the Department of Veterans' Affairs and other programs (including the Practice Incentives Program and the GP Immunisation Incentives Scheme) represented about 77 per cent of total expenditure on general practice.

Defining GP administrative costs

Government policies and programs involve a range of benefits and costs for government, general practice and consumers. Costs to government include the costs associated with developing, implementing and administering the policies and programs. Costs to GPs include costs of undertaking the activities intrinsic to the program, as well as the paperwork.

Many terms are used to describe the costs to GPs, including red tape, administrative costs, administrative burden and compliance costs. Some of this terminology creates confusion. Some participants have argued that compliance costs are defined as those costs incurred in meeting the *mandatory* obligations of a government policy or program. The Department of Family and Community Services considered:

In the strictest sense, general practitioners do not incur a compliance cost in relation to this portfolio's programs since they are not compelled under Social Security legislation to provide information to Centrelink in support of claims for income support. (sub. PR37, p. 1)

It has also been suggested that such costs would be reduced or offset where GPs and general practices are compensated through remuneration for the costs incurred in participating in the programs (Advisory Committee, December 2002). The Department of Health and Ageing stated that for some programs:

There are no compliance costs. GPs [are] fully remunerated for their participation in the program. (sub. 23, p. 33)

The Government pays GPs and general practices for participating in almost all of the programs within the scope of this study (chapter 3). Further, participation is voluntary for almost all of the programs. The implication of adopting the definition of compliance cost suggested by some participants would be that the ‘administrative and compliance’ costs would be zero by definition for almost all programs.

However, participating in these programs is likely to require the use of substantial resources, such as the time of GPs and other practice staff. This is particularly true for programs designed to influence the services that GPs provide.

In the Commission’s view, understanding the administrative costs that GPs and general practices incur is important from a policy perspective, regardless of whether GP participation is voluntary or remuneration is received. Such information is essential for measuring costs and benefits when undertaking program evaluations and defining the GP’s role in program design. These issues are discussed further in chapter 6.

In this study, the Commission defines GP administrative costs as the incremental or additional costs to GPs and to their practices of meeting the requirements of certain Commonwealth Government programs. These costs are incremental in the sense that they:

- are above those costs incurred in undertaking the normal activities of a GP; and
- would not have been incurred in the absence of the program.

This approach, which is broadly based on that of the OECD (2001), is described in chapter 4.

Relevant policies and programs

What is covered

The Commission identified 43 Commonwealth programs (listed in appendixes B, C and D) that impact specifically on GPs and on the ways a general practice is managed and operated. These programs were classified into four groups, based on whether the GP is:

- participating in programs that seek to influence the quality and availability of GP services;
- providing information to departments to assist in the assessment of a person’s eligibility for support services;
- participating in programs that seek to promote population health; or
- responding to Commonwealth Government surveys (chapter 3).

What is not covered

The Commission is focusing on Commonwealth Government policies and programs that impact on general practice and not on business generally. Policies and programs that create administrative costs for all businesses, such as superannuation or the goods and service tax, are thus outside the scope of the study.

Requirements of State and Territory and local government policies and programs (such as workers' compensation forms) and private requests (such as for insurance purposes) are not covered. Further, costs arising from 'normal' and necessary activities undertaken by GPs (such as referrals to hospitals and specialists, pathology requests, writing standard prescriptions and billing) are beyond the scope of the study.

Interpreting results

The Commission's method of measuring GP administrative costs is described in chapters 4 and 5 and appendix F. Several issues have important implications for the way that the study's results should be interpreted.

First, although the data in this report are the best that could be obtained within the timeframe and other constraints of this study, they do have limitations. Various sources of data were used, including departments, focus groups, case studies and submissions. The Commission's approach yields estimates that are indicative rather than precise.

Second, the study is limited to analysing GP administrative costs for selected policies and programs, and does not consider all the other benefits and costs associated with these programs (for example, the impact of preventative care in reducing expenditure in other health areas). Therefore, this study is not a cost-benefit analysis or an evaluation of these programs, nor is it a review of primary care.

Third, this is not a 'cost-of-service' study. GPs are paid to undertake many, but not all, of the administrative activities associated with the programs within the scope of this study. The analysis is not designed to assess whether GPs are adequately remunerated for the incremental costs associated with particular programs. Rather, it only measures the incremental costs incurred in meeting the requirements of these programs and notes the remuneration arrangements applying currently.

1.3 Conduct of the study

Although this study is not a formal public inquiry, the Commission sought to conduct its review in an open and transparent manner. The Commission conducted extensive consultations with, and encouraged input from, a variety of interested parties.

Following receipt of the terms of reference, the Commission issued a circular to parties with a potential interest in the study. This circular included an issues paper, which called for submissions, provided guidance to participants on the range of issues within the scope of the study and provided advice on how to prepare submissions.

In July and August 2002, the Commission held discussions with a variety of interested parties, including the peak GP organisations — the Royal Australian College of General Practitioners, Australian Medical Association, Rural Doctors Association of Australia, and the Australian Divisions of General Practice — relevant Commonwealth Government departments, the Australian Association of Practice Managers, the Consumers' Health Forum and a number of individual GPs.

The Commission set up an advisory committee with representatives of the peak GP organisations and relevant Commonwealth Government departments. This committee provided advice and feedback to the Commission through two roundtables held during the study (in August and December 2002). The Commission released a Progress Report in February 2003 and sought submissions on this report.

A variety of individuals and groups (including individual GPs, divisions of general practice, GP organisations and government departments) provided a total of 35 submissions following the release of the issues paper. The Commission received an additional nine submissions from individuals and groups following the release of the Progress Report. Appendix A contains details of the individuals and organisations that have participated in the study (including through submissions and visits).

The Commission also conducted a pilot survey, focus group discussions and case studies of GPs to provide information on GP administrative costs (chapter 5 and appendix E). (The consultants' reports for these studies are available from the Commission's website.) The Commission's original intention was to conduct a survey of GPs to yield statistically significant national estimates of administrative costs. However, the pilot survey revealed a number of problems. Taking these, and advice from the consultant and the Commonwealth Government's Statistical Clearing House into account, the Commission decided against conducting the main

survey and instead undertook a series of focus group discussions with GPs in a variety of locations. Chapter 5 and appendix E contain further information on the Commission's approach to collecting information.

In October 2002, the Commission wrote to the Parliamentary Secretary to the Treasurer, seeking an extension to the reporting date for this study. The extension was requested to allow for the time required to:

- consult widely with interested parties;
- obtain the information necessary to complete the study; and
- release a progress report on the results and ideas for reducing GP administrative costs and give interested parties sufficient time to respond.

The Parliamentary Secretary granted an extension to 31 March 2003, after consulting with the Minister for Health and Ageing.

1.4 Report structure

The next chapter contains information about GPs and general practice in Australia. Relevant Government policies and programs are highlighted in chapter 3. The Commission's approach to defining and measuring GP administrative costs is described in chapter 4. Indicative estimates of GP administrative costs are reported in chapter 5, and in chapter 6 the Commission discusses ways to reduce these costs.

2 General practice in Australia

The characteristics of general practitioners (GPs) can differ in terms of their level of education and training, where they work (region and setting), the types of services they provide, the hours they work and the types of practices in which they work. GPs also receive payments through different sources. These factors can affect the level of participation of GPs in government programs, and can result in differences in administrative costs between individual GPs.

2.1 GPs

The role of GPs is described in chapter 1. In 2001-02, about 24 300 GPs and non-specialist other medical practitioners (OMPs) billed Medicare in Australia (equivalent to 123.3 per 100 000 people) (SCRCSSP 2003). This figure includes vocationally registered GPs (VRGPs),¹ GPs training to become vocationally registered (GP registrars) and OMPs (some of whom are not principally GPs).

Of these, about 17 400 provided at least 1500 non-referred attendances over the year,² equivalent to about 89 GPs per 100 000 people (Department of Health and Ageing, pers. comm., 30 October 2002; Productivity Commission estimate).

Types of GPs

There are different types of GPs. In 1998-99, 90 per cent of GPs working in primary care were either VRGPs or GP registrars. The remainder were OMPs who work principally in primary care, but who were not VRGPs or GP registrars (Harding 2000).

¹ The Commission uses the term 'vocationally registered' to describe GPs on the HIC's vocational register or RACGP fellows list. Similarly, the term 'vocational registration' applies to GPs on the register or fellows list.

² Corresponding to working, on average, one day per week in general practice.

VRGPs and GP registrars are entitled to access higher Medicare rebates than OMPs.³ However, to maintain access to the higher rebate they are required to undertake certain administrative activities.

- VRGPs must undertake a minimum number of professional development and quality assurance activities, over a three-year period.
- GP registrars must be enrolled in a general practice education and training program, and be working in an approved training placement (appendix D).

In addition, OMPs that work in practices seeking accreditation must show evidence of satisfactory participation in professional development and quality assurance activities (RACGP 2000). Chapter 3 provides more detail on accreditation and the other programs referred to in this chapter.

VRGPs, GP registrars and OMPs can participate in most of the programs covered in this study.

Although GPs operate in a range of settings, about 90 per cent worked in private rooms in 1999 (AIHW 2003). It is mainly these GPs who encounter the programs of interest in this study.

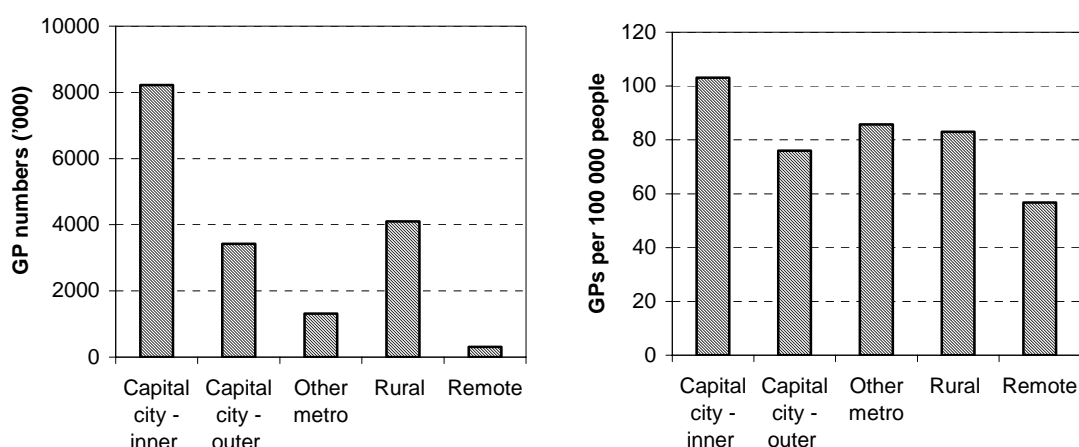
Location

In 2001-02, nearly half of all GPs worked in the inner areas of capital cities (figure 2.1). Differences in the number of GPs between regions are explained by population size and the number of GPs per head of population. Outer areas of capital cities, other metropolitan areas, rural areas and remote areas have lower ratios of GPs per 100 000 people than the inner areas of capital cities.

Location might affect the type and level of administrative activities that GPs undertake. GPs, in areas where there are a relatively large number of social security claimants and relatively few GPs, are likely to complete more forms associated with claims for social security payments and have higher associated administrative costs (chapter 5).

³ OMPs may access the higher rebates if they are willing to practise in areas where there are shortages of GPs, such as remote areas.

Figure 2.1 GPs by region, 2001-02^{a, b}



^a The Department of Health and Ageing's Rural, Remote and Metropolitan Areas classification is adopted to identify regions. This classification normally has seven categories — two metropolitan (capital cities and other metropolitan areas), three rural (large rural centres, small rural centres and other rural areas) and two remote (remote centres and other remote areas). Recently, the capital cities category were separated into inner and outer areas. Where possible, this report presents the data in five categories — capital city-inner, capital city-outer, other metropolitan, rural and remote. ^b This figure relates to 17 363 GPs who conducted more than 1500 non-referred attendances in 2001-02.

Data source: Productivity Commission estimates based on Department of Health and Ageing data (pers. comm., 30 October 2002).

Services

GPs provide most services in their surgery during a consultation. Consultations can also take place in a patient's home, in a nursing home, or over the telephone (Britt et al. 2002).

GPs mainly provide services relating to diagnosing and treating illnesses and injuries, ordering imaging and diagnostic tests, and referring patients to other health professionals and services. Prescribing, advising on or supplying pharmaceuticals is the most common form of service. In 2001-02, GPs prescribed medication in about 58 per cent of all consultations. Other services were provided less frequently: about 40 per cent of consultations involved a non-pharmacological treatment; about 20 per cent involved ordering an investigation; and 10 per cent involved issuing a referral (Britt et al. 2002, p. 42).

The type and mix of services that individual GPs provide is likely to influence the level of participation in programs covered in this study. Female GPs, for example, generally have lower prescribing rates than male GPs (Power 2000), implying that female GPs undertake fewer Pharmaceutical Benefits Scheme authorisations.

Working hours

There is a trend for GPs to work shorter hours. The proportion of GPs working less than 40 hours per week increased from 20 per cent to 31 per cent between 1994-95 and 2002. This trend is partly explained by an increase in the proportion of GPs who are female and who have a stronger preference for part-time work than do male GPs (box 2.1).

Box 2.1 Increasing proportion of female GPs

The proportion of female GPs is increasing. In 2002, 33 per cent of GPs were female, an increase of 4 percentage points since 1994-95 (ABS 1996, 2002a).

This trend is set to continue — in 2002, 51 per cent of GPs in the 35 years and under age group were female (ABS 2002a). Further, in 1998, females represented over 50 per cent of both GP registrars and students commencing undergraduate medical training (AIHW 2000, Power 2000).

In 2002, 60 per cent of female GPs worked less than 40 hours per week, compared with 17 per cent of male GPs (table 2.1). In addition, there is a trend for both males and females to prefer part-time work.

Table 2.1 GP working hours, 1994-95 and 2002^a

	<i>Males</i>				<i>Females</i>			
	<i>1994-95</i>		<i>2002</i>		<i>1994-95</i>		<i>2002</i>	
	no.	%	no.	%	no.	%	no.	%
Less than 40 hours per week	1 021	9	2 110	17	2 314	49	3 742	60
40 or more hours per week	10 656	91	10 513	83	2 388	51	2 503	40
Total	11 677	100	12 623	100	4 702	100	6 245	100

^a Data for 1994-95 refer to a financial year, while data for 2002 refer to a calendar year.

Source: ABS (1996; 2002a).

The trend towards shorter working hours implies that the number of practising GPs needs to increase in order to maintain accessibility to GP services. GPs' overall willingness, or ability, to participate in certain programs might also be affected. Part-time GPs might be less willing, or able, to undertake administrative activities that are complicated and that require them to invest time in training.

2.2 Practice types

Private medical practices differ in terms of size and ownership arrangements. In December 1999, about 19 per cent of GPs worked in solo practices and 66 per cent worked in practices consisting of three or more GPs. GPs in remote areas were more likely to work in practices of two or less GPs, compared with GPs in other areas (table 2.2).

Table 2.2 GPs by practice size and geographic location, 1999

<i>Region of main job</i>	<i>Units</i>	<i>Number of GPs in the practice</i>					Total^a
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5 or more</i>	
Capital city ^b	no.	2 864	2 216	1 987	1 798	5 832	14 697
Other metropolitan	no.	271	252	206	213	584	1 526
Rural	no.	755	619	582	591	1 776	4 322
Remote	no.	131	79	101	46	65	421
Total ^a	no.	4 021	3 166	2 875	2 647	8 256	20 966
Proportion of total GPs	%	19	15	14	13	39	100

^a Totals may not add as a result of rounding. ^b Separate data for inner and outer areas of capital cities are not available.

Source: AIHW (2003).

According to Access Economics (2002), practices with more than one GP have cost advantages. The practice cost per GP falls significantly as the number of GPs increases from one to about eight full-time equivalent GPs. This trend is likely to be reflected in the costs associated with the administrative activities of many of the programs reviewed in this study, such as Practice Incentives Program (PIP) and the Enhanced Primary Care program. Larger practices, for example, might be in a position to engage a practice manager to perform some of the necessary administrative activities more cost effectively than individual GPs (see below).

General practices can be established under a number of ownership models, ranging from practices wholly owned by GPs to those wholly owned by commercial investors (corporate entities) (KPMG 2000). Since 1998, the number of practices owned by corporate entities has increased. In some cases, they have amalgamated general practices with other allied health services to create medical centres (SCRCSSP 2003).

Wholly corporate-owned practices tend to be larger, on average, than practices operating under other ownership models. As for larger practices more generally, GPs in corporate practices are likely to have a higher degree of administrative (and

clinical) support to assist them with the administrative responsibilities associated with government programs.

2.3 Other practice staff

A large proportion of staff employed in general practices are not GPs (table 2.3). In 1995, 33 915 nurses, administrative/support staff and other staff were employed in general practices (about 62 per cent of total employment) (ABS 1997).

Table 2.3 **Total employment in general practices, June 1995**

<i>Employee type</i>	<i>Employment</i>	<i>Proportion of total employment</i>
	no.	%
GPs	20 742	38
Nurses	3 007	6
Administrative/ support staff	25 149	46
Other	5 759	11
Total	54 657	100^a

^a Total might not add as a result of rounding.

Source: ABS (1997, p. 11).

About 30 per cent of general practices have at least one practice nurse (Campbell Research & Consulting 1997; ADGP 2001). Practice nurses assist GPs with the delivery of medical care and can assist them in undertaking administrative activities associated with various government programs.

Nurses are often involved in gathering information for health assessments and population health screening activities (ADGP 2001). In this latter role, a nurse might ensure that all children in a practice are immunised appropriately for their age and that the Australian Childhood Immunisation Register is notified of children's immunisation status. A GP in a focus group discussion noted the involvement of nurses in these administrative activities:

We have a nurse who does the health assessment and fills in the forms for the immunisation. We do the immunisations but she does the paperwork. (St Kilda, 9 September 2002)

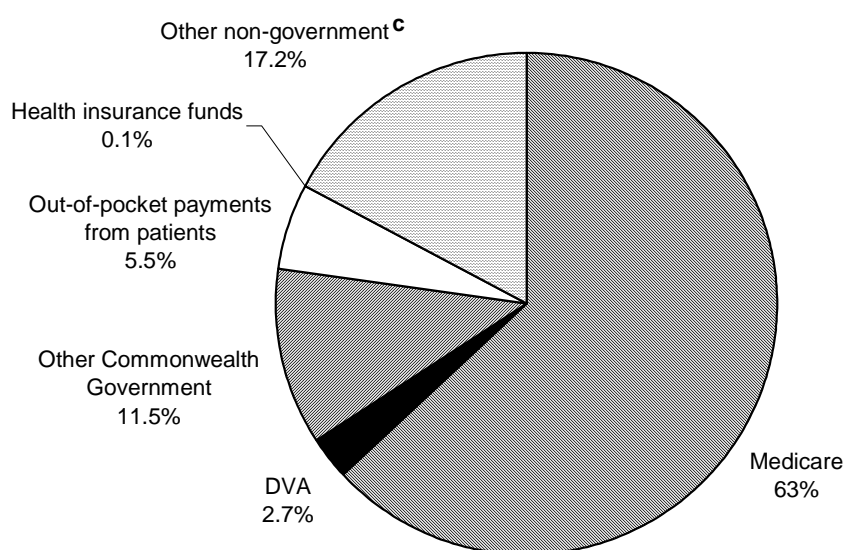
Administrative and support staff assist GPs with the day-to-day running of the practice and more complex aspects of business management. On average, practices have about four administrative staff (Campbell Research & Consulting 1997). Most are medical receptionists, who perform tasks such as coordinating the appointment system, billing patients and reception duties. Other administrative staff include practice managers and bookkeepers.

Administrative and support staff undertake some of the administrative tasks associated with government programs and do so at a lower cost, as they are paid less than GPs. The involvement of administrative staff is likely to be particularly important in relation to PIP (especially the accreditation requirements).

2.4 Sources of revenue

In 1998-99, GPs received about \$4 billion in revenue (about \$4.4 billion in 2001-02 dollars) — this was approximately 8 per cent of total health expenditure. This revenue came from different sources (figure 2.2). The Commonwealth Government contributes revenue towards almost all GP services, principally through Medicare. In 1998-99, Medicare revenue represented about 63 per cent of the total revenue of general practice. The Commonwealth also provided revenue to GPs through the Department of Veterans' Affairs and other programs (including PIP and the General Practice Immunisation Incentives Scheme (appendix D)). In 1998-99, revenue from these sources represented about 14 per cent of total general practice revenue.

Figure 2.2 Sources of revenue for GPs, 1998-99^{a, b}



^a This is the latest year for which data are available. ^b Includes some revenue earned by OMPs who are not principally GPs. ^c Revenue from workers' compensation and compulsory third party motor vehicle insurance schemes.

Data source: SCRCSSP (2003).

Non-government sources contributed about 23 per cent of total revenue, primarily from payments by workers' compensation and third party insurance schemes and by private individuals. State and Territory governments also provided a small amount of revenue for general practice, principally through support services for GPs.

Assistance with housing and relocation, and assistance with employment for spouses of GPs in rural areas, are some examples (SCRCSSP 2003).

Since 1998-99, GP revenue from the Commonwealth has remained relatively stable in real terms, at about \$3.1 billion (in 2001-02 dollars).⁴ In addition, out-of-pocket payments from patients might have increased as a result of the decline in the proportion of GP non-referred attendances that were bulk-billed, from 79 per cent in 1998-99 to 75 per cent in 2001-02 (SCRCSSP 2003).

Structure of government payments

Government payments to GPs are made on a fee-for-service and non-fee-for-service basis. This mix is sometimes referred to as blended payments.

The Commonwealth Government introduced the blended payments system to help achieve goals relating to improving the quality of care provided in general practice (Hynes 2000). In particular, the Health Insurance Commission noted that PIP (one of the key non-fee-for-service programs) aims to:

... compensate for the limitations of fee-for-service arrangements. Under these [fee-for-service] arrangements, practices that provide numerous quick consultations receive higher rewards than those that take the time to look after the ongoing health-care needs of their patients. (HIC 2003)

In 1998-99, fee-for-service payments comprised about 89 per cent of the income of GPs (SCRCSSP 2003).⁵ Most fee-for-service payments are paid to individual GPs for providing clinical services, primarily through Medicare. Under Medicare, GPs can either:

- bill Medicare directly (bulk bill) and receive the Medicare scheduled fee rebate as full payment for the service (the patient makes no out-of-pocket contribution); or
- charge the patient for the medical service (box 2.2).⁶

⁴ Real GP revenue from the Commonwealth Government is a Productivity Commission estimate derived from the expenditure per head of population data (on Medicare, PIP, Department of Veterans' Affairs, divisions of general practice and the General Practice Immunisation Incentives Scheme) in SCRCSSP (2003). The population figure used to derive this revenue estimate was also derived from data in SCRCSSP (2003).

⁵ Fee-for-service payments come from Medicare, Department of Veterans' Affairs, patients (out-of-pocket payments), health insurance funds and other non-government organisations, such as those involved in workers compensation.

⁶ In this case, the patient can either pay the full account and be reimbursed by Medicare (for the Medicare scheduled fee rebate), or can pay the difference between the Medicare scheduled fee rebate and the GP's fee and present the unpaid scheduled fee rebate section of the bill to the HIC, which will forward a 'Pay Doctor' cheque to the patient to pass on to the GP.

Box 2.2 Medicare funding of GP services

The Commonwealth Government introduced Medicare in 1984 to provide Australians with access to free treatment as public patients in public hospitals and free or subsidised medical treatment outside of hospital. The Commonwealth sets the Medicare schedule of fees on which subsidies are based.

General practice services are provided through non-referred attendances (where the patient goes directly to the GP). The scheduled fees associated with each non-referred attendance are set out in the Medicare Benefits Schedule (DoHA 2003).

GPs can charge more than the scheduled fee. However, Medicare only provides a patient subsidy of 85 per cent of the scheduled fee.

In general, the scheduled fees for GP attendances are time, location and content based. Each type of attendance has a specific Medicare Benefits Schedule billing item number with a corresponding fee. Therefore, a GP selects an item number for an attendance according to when and where the service was provided (for example, after hours in a patient's home), the complexity of the patient's problem, and the length of time of the consultation.

Source: DoHA (2003).

Over the last decade, there has been an increase in the number of Commonwealth Government payments that are linked to GPs undertaking certain administrative activities. This has largely occurred through the introduction of programs that provide payments on a non-fee-for-service basis and others that have introduced new Medicare fee-for-service attendance items, where the services to be provided are outlined in the Medicare Benefits Schedule. These new attendance items include those for Enhanced Primary Care (appendix D).

GPs are paid on a fee-for-service basis to undertake certain other activities. The Department of Veterans' Affairs, for example, pays GPs on a per page basis for completing some departmental forms in addition to a consultation fee (chapter 3).

GPs earn a small proportion of their income through non-fee-for-service payments, which are paid mostly to GPs' practices, on a lump sum basis. These are often linked to participation in certain activities, (such as undertaking the majority of the practice's prescriptions electronically), or for reaching certain levels of care of patients (such as the immunisation of a certain proportion of children enrolled in the practice). A number of individual programs provide both fee-for-service and non-fee-for-service funding. PIP is one example (chapter 3).

3 Commonwealth policies and programs

General practitioners (GPs) and other practice staff undertake a range of activities to fulfil government policy and program requirements. The Commission is focusing on Commonwealth Government policies and programs that impact specifically on general practice and not on business generally (chapter 1).

The Commission identified 43 Commonwealth policies and programs that are relevant to this study. This chapter describes these programs, how they affect GPs and what GPs are required to do in order to participate (including the activities intrinsic to the program and paperwork), drawing on the information presented in appendixes B, C and D. The Commission classified these programs into four groups, based on whether the GP is:

- participating in programs that seek to influence the quality and availability of GP services;
- providing information to departments to assist in the assessment of a person's eligibility for support services;
- participating in programs that seek to promote population health; or
- responding to Commonwealth Government surveys (table 3.1).

3.1 Participating in programs to influence the quality and availability of GP services

The Commonwealth Government, in consultation with GP organisations, introduced a range of programs over the past decade to influence the quality and availability of GP services. The purpose of some of these programs is to improve the quality of GP services by influencing the way that general practices are operated. The purpose of others is to influence the services of individual GPs, and address the shortage of GPs, primarily in rural and remote areas.

Table 3.1 **Commonwealth programs included in the study**

<i>Program^a</i>	<i>Department</i>
Participating in programs to influence the quality and availability of GP services	
<i>Programs to influence general practices</i>	
Practice Incentives Program — practice incentive elements	Health and Ageing
<i>Programs to influence GP services</i>	
Enhanced Primary Care	Health and Ageing
Practice Incentives Program — service incentive elements	Health and Ageing
GP access to Medicare — vocational registration and RACGP fellowship	Health and Ageing
Quality Use of Medicines	Veterans' Affairs
<i>Programs to address GP workforce shortages</i>	
Rural programs	Health and Ageing
Aboriginal Community Controlled Health Services	Health and Ageing
Providing information to assist departmental assessments	
<i>Access to payments</i>	
Assistance for people with a disability, illness or injury	Family and Community Services
Assistance for people caring for someone who is frail-aged, ill or has a disability	Family and Community Services
Employment services for people with a disability, illness or injury	Family and Community Services
Disability compensation	Veterans' Affairs
Income support	Veterans' Affairs
Military compensation and rehabilitation	Veterans' Affairs
<i>Access to particular medical products and services</i>	
Pharmaceutical Benefits Scheme	Health and Ageing
Commonwealth Hearing Services	Health and Ageing
Repatriation Comprehensive Care	Veterans' Affairs
Participating in programs to promote population health	
Australian Childhood Immunisation Register	Health and Ageing
General Practice Immunisation Incentives Scheme	Health and Ageing
Responding to Commonwealth Government surveys	Various

^a Some of the 43 programs have been aggregated in the table.

Programs to influence general practice operations

The Commonwealth Government attempts to influence the operations of general practices by providing financial incentives to practices that are accredited and agree to implement certain practice arrangements.

A key program is the Practice Incentives Program (PIP). The objective of PIP is to reward general practices that provide comprehensive and quality care. To meet this objective, this program has been designed, amongst other things, to encourage general practices to become accredited and put in place certain practice

arrangements (practice incentive elements). By August 2002, 4525 general practices were participating in PIP (about 82 per cent of all general practices).

General practices can choose to participate in specific elements of PIP (table 3.2). All participating practices must enrol in the first tier of the three-tier information management and information technology element, with most practices (89 per cent) participating in all three tiers. Almost all practices (98 per cent) have in place arrangements for patients to access after-hours care. However, only 29 per cent provide all after-hours care from within the practice.

Table 3.2 General practices participating in the practice incentive elements of PIP, August 2002^a

<i>Program</i>	<i>Practices participating</i>
Information management and information technology	
Tier 1 — Provide data to the Commonwealth	4 525
Tier 2 — Electronic prescribing	4 027
Tier 3 — Capacity for electronic transfer	4 027
After-hours care ^{b, c}	
Tier 1 — Patient access to after-hours care at all times	4 435
Tier 2 — At least 15 hours of after-hours care per week from within the practice	3 168
Tier 3 — All after-hours care from within the practice	1 312
Teaching	498
Care planning	1 312
Sign-on component — Asthma	3 801
Sign-on component — Cervical screening	3 892
Sign-on component — Diabetes	3 801
Sign-on component — Mental health	na
Additional practice nurses	793
Quality prescribing initiative	1 211
Rurality	na

^a Other than PIP, 3 practices participated in the Quality Innovation Funding Program. ^b Practices enrolled in higher level tiers are also enrolled in lower level tiers. ^c After hours is the time outside the hours of 8am–6pm weekdays and 8am–12pm Saturday. **na** Not available.

Source: Appendix D.

Requirements for participating practices

Practices need to be accredited to receive PIP payments (box 3.1). They also must undertake a variety of activities and tasks to qualify for payments (appendix E).

Some of these activities include completing paperwork and forms. Much of the paperwork associated with PIP (such as the initial application form) is completed on

a one-off basis. Some forms are completed more than once, including the teaching incentives form and the biennial confirmation statement.

Box 3.1 Practice accreditation

To achieve accreditation, practices must meet the Royal Australian College of General Practitioners' standards for general practices. The standards relate to medical services; the rights and needs of patients; quality assurance and education; administration; and the design of, and equipment in, the surgery. Within each standard, there are specific indicators that must be met (two hundred indicators in total).

Accreditation agencies assess practices during a practice visit that takes about four hours. The assessment includes interviewing medical and non-medical staff; reviewing medical records, data and patient comments; and observing the operation of the practice. The practices pay a fee to the accreditation agencies to undertake the survey. Practices must be re-accredited every three years if they wish to continue to receive the incentive payments.

Source: RACGP (2000).

Other activities are more complex and might involve GPs undertaking specific training (such as the new mental health initiative) or changes in practice management, GPs' activities or client care. To participate in the tier two after-hours care practice element, for example, practices must ensure access to 24-hour care for their patients (perhaps through an arrangement with other practices in their division) and provide 15 hours of this care themselves.

Practices are also required to meet physical criteria for accreditation — for instance, the consultation room must be free from extraneous noise (which might involve expenditure on sound proofing) and schedule eight drugs stored in the practice must be safely secured (which might involve expenditure on locks or a safe).

PIP practices also might be audited, in which case they need to provide evidence of their eligibility for payments. This evidence can include documentation (such as a copy of their accreditation certificate) or physical evidence (such as demonstrating their capacity to prescribe electronically if involved in the information management and information technology element).

Programs to influence GP services

The Commonwealth Government attempts to influence the quality of services provided by individual GPs through a number of programs.

Some programs influence quality by prescribing the way GPs deliver particular services or treat particular diseases. Two key programs are the Enhanced Primary Care (EPC) program and PIP (which influences both GP services and general practice operations). Under the EPC program, GPs provide specific services associated with preventative care and care coordination (box 3.2). For PIP, GPs are required to provide prescribed clinical services to treat certain diseases and conditions (asthma, diabetes, cervical cancer and mental health).

Box 3.2 Enhanced Primary Care

EPC was introduced to facilitate the provision of preventative care for older Australians and to coordinate better those GPs and other professionals providing care to people with chronic conditions and complex care needs. These services cover:

- health assessments of older patients — where a patient's medical, physical, psychological and social functions are examined, and any preventative health care and educational activities are recommended;
- care plans for patients with one or more chronic conditions and multidisciplinary care needs — which describe a patient's care needs and related management goals, the kinds of treatment and services to meet these goals, and the arrangements made to access these service; and
- case conferences between health care and care providers to plan care for individual patients with chronic conditions and multidisciplinary care needs.

In return for providing EPC services, GPs can claim specific Medicare payments (accessed by billing a particular item number).

Source: Appendix D.

Other programs encourage GPs to undertake professional training and development by placing conditions on their access to Medicare billing. GPs who are vocationally registered, on the Royal Australian College of General Practitioners (RACGP) fellows list (box 3.3), or who are in an approved GP training placement, receive higher payments for services they provide under Medicare compared to other medical practitioners who have not met these requirements.

GPs participate voluntarily in these programs. Many GPs are undertaking health assessments and care plans under the EPC program. In contrast, there are fewer GPs providing the service incentive elements of PIP (table 3.3).

Box 3.3 Vocational registration and RACGP fellowship

GPs can receive higher Medicare non-referred attendance rebates if they satisfy certain vocational registration requirements or are RACGP fellows. The Health Insurance Commission (HIC) recognises GPs as vocationally registered if the RACGP certified them as eligible for vocational registration before 24 December 1996. The HIC recognises GPs as RACGP fellows if they have:

- completed a vocational training program and passed the RACGP examination;
- completed a specified time in general practice and passed the RACGP assessment process; or
- met RACGP requirements for fellowship via other education or qualification arrangements.

To maintain vocational registration or RACGP fellowship, GPs have to accrue a minimum number of RACGP Quality Assurance and Continuing Professional Development points, over a three-year period. In 2001-02, 13 324 GPs were on the HIC's vocational register, and 5698 GPs were on the HIC's RACGP fellows list.

Source: Appendix D.

Table 3.3 Participation in programs to influence GP services, 2001-02

<i>Program</i>	<i>GPs participating</i>	<i>Services or activities</i>
Department of Health and Ageing		
Enhanced Primary Care		
Health assessments	12 534	164 563
Care plans	10 644	274 510
Case conferences	3 121	10 727
Practice Incentives Program — service incentive payments		
Asthma	2 780	27 670
Cervical screening	4 670	30 144
Diabetes	4 438	76 286
Vocational registration and RACGP fellowship		
GPs on the vocational register	13 324	..
GPs with a RACGP fellowship	5 698	..
GPs in an approved training placement	1 434	..
Domiciliary Medication Management Reviews	940	6 500
Department of Veterans' Affairs		
Local Medical Officer selected health services ^a	14 000	78 437 ^b
Prescriber Intervention and Feedback Program	na	2 882
Local Medical Officer forms	na	1 686 ^c

^a The Department of Veterans' Affairs care plans, case conferences, health assessments and Medication Reviews. ^b Estimate based on 58 828 activities for the period July 2001–March 2002. ^c 918 applications to become a Local Medical Officer and 768 new location forms. .. Not applicable. na Not available.

Sources: Appendix C; appendix D.

Requirements for participating GPs

GPs must meet a number of requirements to be eligible for the payments associated with the programs. Under some programs, GPs are required to complete various activities before they provide a consultation. For an EPC health assessment, care plan or case conference, GPs have to:

- check the patient's eligibility;
- discuss the benefits of the assessment, plan or conference with the patient;
- inform the patient of the need to share information with other providers; and
- obtain and record the patient's consent.

GPs are expected to complete specific activities during a consultation. As part of a health assessment, for example, a GP (possibly with assistance from a practice nurse) must examine prescribed elements of a patient's physical, psychological and social health. Amongst other things, this involves assessing the patient's mobility, alcohol consumption, continence, social support and immunisation status. The GP also usually assesses other relevant elements, including the patient's fitness to drive and safety in the home. Again, as for the service incentive elements of PIP, GPs might also be required to complete paperwork during a consultation.

GPs also might be expected to undertake particular activities outside a consultation. As part of a Domiciliary Medication Management Review, a GP must liaise with a pharmacist outside of a consultation.

GPs also might have to conduct ongoing administrative activities. To remain on the vocational register or RACGP fellowship list, GPs have to continue to participate in Continuing Professional Development and Quality Assurance programs. The activities include clinical audits or participation in educational activities with approved providers, attending conferences, or teaching community groups.

Programs to address shortages of GPs in some regions

The Commonwealth Government has introduced many programs to encourage more GPs to work in outer areas of capital cities as well as in rural and remote areas.

In some of the programs, GPs are given financial incentives or help for relocating and staying in these areas — for example, the Rural and Remote General Practice Program, the Rural Retention Program, the Rural Women's GP Service and the General Practice Registrars Rural Incentives Program. In other programs, access to GP services is sought by other means. An example is the Aboriginal Community Controlled Health Services, which were introduced in order to improve Aboriginal

and Torres Strait Islander communities' access to primary health-care services by allowing the community health service to receive Medicare funds for services provided by their GP employees.

GPs volunteer to participate in these programs. In 2001-02, for example, 2010 GPs received payments under the Rural Retention Program, 400 participated in Aboriginal Community Controlled Health Services and 69 GPs participated in the Royal Women's GP Services. The Com

mission has been unable to obtain information on the number of GPs participating in the Rural and Remote General Practice Program.

The primary requirement for participating GPs is to locate and remain in the designated areas. GPs become eligible for payments under the Rural Retention Program when they meet the qualifying period of continuous active service in their location. Similarly, GP registrars have to be registered in the Rural Training Pathway of the Australian General Practice Training Program and undertaking the majority of their training in a rural and remote area (other than large rural centres) to receive the incentive payments.

GPs also might be required to complete application forms, keep detailed patient records (for instance, the Rural Women's GP Service) and provide the HIC with details to facilitate payment.

3.2 Providing information to assist departmental assessments

The Commonwealth Government provides financial support to certain people with a disability, illness or injury. This support is delivered through various programs administered by the Department of Family and Community Services (FaCS),¹ Department of Health and Ageing (DoHA) and Department of Veterans' Affairs (DVA) (table 3.4).²

Government expenditure on these programs is significant. In 2001-02, FaCS expenditure on such programs was \$15 billion (FaCS 2002a). In the same period, DVA expenditure was \$3.3 billion on health programs, and \$5.5 billion on disability compensation and income support programs (Repatriation Commission 2002).

¹ The responsibility for the delivery of income support payments and services for FaCS' programs has been sub-contracted to Centrelink.

² The HIC administers some programs on behalf of DoHA and DVA.

In view of these large expenditures, considerable care is taken in determining claimant eligibility. To assess a person's eligibility for these programs, departments often require claimants to request GPs to provide information about medical diagnosis, clinical features, symptoms, treatment and length of incapacitation.

Medical information is required for some assessments as eligibility for program benefits depends on an assessed level of medical impairment or medical need. To be eligible for the FaCS/Centrelink Disability Support Pension, a person must, among other things, have a disability, illness or injury which attracts a defined 'impairment rating' and have a continuing inability to work for 30 hours or more per week.

For some programs, the level of support provided depends on the level of impairment, with payments increasing with severity. Pension payments to veterans are made according to a set of system-based tables (*Guide to the Assessment of Rates of Veterans' Pensions*) that assign ratings that reflect the severity of the disability.

During 2001-02, GPs provided information to Commonwealth departments on about 5 million occasions to assist with assessments of eligibility for, and level of support from, programs and services (table 3.4). Most of these were Pharmaceutical Benefits Scheme authorisations (3.3 million), with the majority (94 per cent) completed over the telephone, and the remainder sent either by post or electronically.³ Between 1999-2000 and 2001-02, the number of assessments for FaCS/Centrelink increased by 22.8 per cent, while the number of Pharmaceutical Benefits Scheme authorisations increased by 10.8 per cent. Although the impact on individual GPs might be less marked.

Under legislation relating to health insurance and informed financial consent, GPs are required to provide medical information to private health insurance funds and their members to assist in managing the costs of private health insurance. Programs such as the Pre-existing Ailment Waiting Period and Overnight Certification (which are governed under the *National Health Act 1953* and would be within the scope of the study) require GPs to complete forms and undertake other activities.⁴

³ The HIC is currently trialling the electronic method.

⁴ Despite potentially being within the scope of study, lack of data meant that the Commission could not estimate the GP administrative costs associated with these requirements.

Table 3.4 **Participation in departmental assessments, 1999-2000 to 2001-02**

		<i>Thousands of units</i>	<i>1999-2000</i>	<i>2000-01</i>	<i>2001-02</i>
Programs to provide information to assist departmental assessments					
Access to payments					
<i>Department of Family and Community Services</i>					
Disability Support Pension	no. forms	178.1 ^a	193.1 ^a	217.4 ^a	
Sickness Allowance	no. forms	86.6	88.4	81.1	
Newstart Allowance	no. forms	420.8	514.2	535.7	
Youth Allowance	no. forms	51.4	66.4	68.0	
Mobility Allowance ^b	no. forms	9.5	10.6	12.4	
Carer Payment	no. forms	50.0	50.1	60.0	
Carer Allowance	no. forms	95.6	122.5	121.1	
<i>Department of Veterans' Affairs</i>					
Disability Pension ^c	no. claims	na	na	53.4	
Disability Allowances ^d	no. claims	na	na	0.5	
Service Pension ^e	no. claims	na	na	5.1	
Military Compensation Scheme	no. claims	na	na	1.3	
Access to particular medical products and services					
<i>Department of Health and Ageing</i>					
Pharmaceutical Benefit Scheme	no. auth.	3 023.3	3 118.1	3 349.1	
Commonwealth Hearing Services Program	no. services	61.4	76.6	89.5	
<i>Department of Veterans' Affairs</i>					
Repatriation Pharmaceutical Benefits Scheme	no. services	304.4	318.4	324.9	
Referral to allied health provider	no. services	121.7	108.5	111.3	

^a Includes data for initial and review TDRs completed by non-GPs, which is estimated to be approximately 3 per cent of total forms. ^b Indicative estimates. ^c Indicative estimate. Additional forms are associated with each claim, including additional medical assessments and associated paperwork (such as medical impairment assessment, medical report and diagnostic report). ^d Indicative estimate. ^e Indicative estimate. Each claim requires the GP to provide a medical diagnosis and complete a work-test questionnaire. About 40 per cent of claims also require additional medical assessments. **na** Not available.

Sources: Appendix B; appendix C; appendix D; DoHA (pers. comm., 27 September 2002); HIC (pers. comm., 15 October 2002).

Information requirements from GPs

The amount of information and the frequency with which GPs provide it to Commonwealth departments varies across programs.

The administrative activities are simple for some programs, whereas for others they are complex. A GP might simply be requested to complete a one-page FaCS/Centrelink Medical Certificate, for example, providing a brief diagnosis and certifying a person's inability to work so that they are exempted from the Newstart Allowance 'activity test'. For other programs, more information is required. In the

case of an application by a veteran for the DVA Disability Pension, a detailed assessment of the level of medical impairment and a disability rating are required.

GPs often provide medical information to departments on forms specific to the program, but in some instances can supply information verbally (for example, Pharmaceutical Benefits Scheme authorisations).

Under some programs, GPs provide information regularly, even when the medical condition is permanent and the associated treatment is ongoing (for example, Pharmaceutical Benefits Scheme authorisations). Some departments request GPs to complete regular reports of the diagnosed medical condition (for example, the Newstart Allowance and Youth Allowance). Other programs do not require a regular review of the disability by a GP (for example, the DVA Disability Pension).

In some cases, departments have reduced the amount of information requested of GPs. FaCS/Centrelink, for example, revised a number of its forms in September 2002 as part of the Commonwealth Government's 2001-02 Budget package entitled *Australians Working Together — Helping People to Move Forward*.⁵ The questions contained in the Disability Support Pension Treating Doctor's Report no longer request the GP to assess how the patient's condition would affect his or her ability to work.⁶ The revised form instead asks GPs to provide details about how the diagnosed condition affects the patient's ability to function. FaCS/Centrelink also abolished the three-page review Newstart and Youth Allowance Treating Doctor's Report associated with a claimant's medical review at weeks 40 and 92.

In other cases, the amount of information required and complexity of forms has increased. On 20 September 2002, FaCS/Centrelink changed the Medical Certificate for the Sickness Allowance, Youth Allowance and Newstart Allowance, with medical practitioners asked to provide more information about the patient's temporary incapacity to work (FaCS, sub. 19, p. 8). Additional information is requested on the diagnosis, symptoms, prognosis, and treatment of up to three medical conditions. The impact of introducing new FaCS/Centrelink forms is discussed further in chapter 5.

⁵ The *Australian's Working Together* package outlines a number of Commonwealth Government welfare reform initiatives aimed at reducing the number of people reliant on income support payments (such as the Newstart Allowance) (DEWR 2003).

⁶ This assessment is now undertaken by external work capacity assessors — who are contracted professionals with knowledge of the labour market and the impact of medical conditions on a person's ability to work.

3.3 Participating in programs to promote population health

The Commonwealth Government attempts to promote the primary health care of the community through various programs designed to encourage patients to adopt healthy lifestyles, prevent illness and increase access by particular groups to primary health services. The two key programs that involve GPs in promoting population health are the Australian Childhood Immunisation Register (ACIR) and the General Practice Immunisation Incentives (GPII) scheme.

The ACIR is a national database containing information on the immunisation status of Australian children under seven years of age. The HIC collects information about childhood immunisations from recognised immunisation providers. About half of all such immunisation providers are medical practitioners — predominately GPs. The HIC also uses the ACIR to administer the GPII scheme.

The HIC, through the GPII scheme, provides incentive payments to GPs and general practices that monitor, promote and provide age-appropriate immunisations to children under seven years of age.

GPs participate voluntarily in the ACIR and the GPII scheme. GPs are automatically recognised immunisation providers once they are entitled to bill Medicare (that is, they have a Medicare provider number). Practices enrolled in PIP are automatically enrolled in the GPII scheme, whereas practices not enrolled in PIP must apply to participate in the scheme.

Requirements for participating GPs

A primary requirement for participating GPs is to administer the immunisations. Another important requirement is for GPs to provide information to the HIC regarding a child's immunisation status and history on department-specific forms. GPs sometimes complete other forms for families who access Commonwealth family payments linked to their childrens' immunisation status — for instance, an 'Exemption from Vaccination Because of Conscientious Objection' form.

GPs provide information to the HIC through a variety of means. Depending on the form, information can be provided manually, on-line or via an electronic data interchange system.

In 2001-02, GPs provided information on 1.1 million immunisation encounters to the HIC using the ACIR Immunisation Encounter form. GPs also completed approximately 21 311 other immunisation related forms (table 3.5).

Table 3.5 Participation in programs to promote population health, 1999-2000 to 2001-02

	<i>Units</i>	<i>1999-2000</i>	<i>2000-01</i>	<i>2001-02</i>
Australian Childhood Immunisation Register				
Immunisation encounters	no. forms	1 239 385	1 142 635	1 098 553
Other immunisation-related paperwork ^a	no. forms	41 155	35 980	21 311
General Practice Immunisation Incentives scheme ^b				
	no. practices	3 873	4 640	4 675

^a Includes providing an immunisation history report or forms associated with Commonwealth payments linked to immunisation status. ^b Practices receiving outcome payments, which are less than the number of practices registered for participation.

Source: Appendix D; HIC (pers. comm., 27 September 2002).

3.4 Responding to Government surveys

The Commonwealth Government indirectly requires GPs and practice staff to undertake administrative activities associated with preparing and providing survey information. In 2001-02, around 19 710 GPs were contacted and 6961 (or 35 per cent) participated in seven surveys of GPs on behalf of the Commonwealth Government (table 3.6).

Table 3.6 Responding to Commonwealth Government surveys, 1999-2000 to 2001-02

	<i>Units</i>	<i>1999-2000</i>	<i>2000-2001</i>	<i>2001-02^a</i>
Total number of surveys	no.	3	14	7
Total number of GPs contacted	no.	7 224	21 726	19 710
Total number of completed surveys	no.	1 776	9 187	6 961
Average time taken per respondent	min.	199	54	60
Total time taken	hours	5 901	8 247	6 935

^a The ABS undertook two large surveys of GPs in 2001-02 — the *Medical Practitioners Survey* (with 2796 participating GPs) and the *Medical Business Survey* (with 3026 participating GPs). However, both surveys are outside the scope of this study because the ABS undertakes surveys of businesses in other industries and not solely of general practices or GPs.

Source: Commission estimates based on Statistical Clearing House data (pers. comm., 6 August 2002).

A key survey conducted on behalf of the Commonwealth Government in 2001-02 was the 'Bettering the Evaluation and Care of Health' survey. This survey is funded by the Commonwealth Government and undertaken annually by the Australian Institute of Health and Welfare and the University of Sydney. Information is collected on the characteristics of GPs, their patients, and the medical services and pharmaceutical prescriptions provided. In 2001-02, 999 GPs participated and spent a total of 5828 hours undertaking this survey.

In addition to the surveys conducted directly for the Commonwealth Government, individual divisions of general practice also conduct surveys of their member GPs. These surveys could be interpreted as Commonwealth surveys, but are not reported in the Statistical Clearing House's data (table 3.6). The divisions receive funding from the Commonwealth Government and are required to report annually to DoHA on their activities. Surveys are used by divisions as an instrument to collect information required for reporting purposes.

Many other organisations (both public and private) seek information from GPs through surveys, including the ABS, State, Territory and local governments, pharmaceutical companies, universities and other researchers. However, these surveys are outside the scope of this study.

3.5 Payments to GPs

GPs and practices are paid to undertake many of the administrative activities associated with the programs covered in this study (table E.2 in appendix E). Information on Commonwealth Government payments to GPs for selected programs is presented in table 3.7.

Remuneration arrangements vary across departments. DVA makes explicit payments to GPs, funded from its own budget and administered by the HIC. GPs are paid 100 per cent of the Medicare Benefits Schedule fee for a consultation (or 110 per cent if they are located in certain rural areas) and for many programs an amount per page. However, they are not allowed to charge veterans a co-payment. GPs undertaking medical examinations of veterans for pension assessment purposes, for example, are paid the appropriate Medicare Benefits Schedule fee for the consultation plus \$11.25 per page of form completed. The HIC undertakes the processing of DVA claims.

DoHA provides incentive payments for GPs and general practices to participate in its programs. Under PIP, for example:

- GPs are paid on a fee-for-service basis to provide prescribed disease-specific clinical services — for example, to claim the cervical screening payment a GP has to provide a pap smear to a woman who has not had a pap smear for four years; and
- practices are paid on a non-fee-for-service basis for having in place certain practice arrangements — for example, agreeing to participate in the cervical screening incentive, where practices receive a one-off payment based on practice load.

In contrast, FaCS/Centrelink does not make explicit payments to GPs from its own budget. GPs are paid by DoHA, through Medicare, an amount per consultation of 85 per cent of the Medicare Benefits Schedule fee.⁷ Completing a FaCS/Centrelink form during a medical consultation (such as when a GP diagnoses or treats a patient) attracts a rebate of \$25.05 (under item 23B, as is the case for any medical examination). If completing the form results in a longer medical consultation, then GPs can legitimately charge for a longer consultation (and receive \$47.60 under item 36C). However, under the requirements for Medicare, where the GP completes a FaCS/Centrelink report in the patient's presence without an accompanying medical examination or other clinically relevant service, or the report is completed in the patient's absence, a Medicare rebate does not apply (HIC, pers. comm., 2 December 2002).

Table 3.7 Selected Commonwealth direct payments to GPs, 2001-02^a

<i>Programs</i>	<i>Payments to GPs</i>
	\$m
Department of Health and Ageing	
Vocational registration	> 493.8 ^b
Practice Incentives Program	193.2
Enhanced Primary Care	62.9
Australian Childhood Immunisation Register	5.0
General Practice Immunisation Incentives Scheme	37.0
Rural Retention Program	14.6
Department of Veterans' Affairs	
Local Medical Officer selected health services ^c	12.6 ^d

^a Direct payments refer to payments from the Commonwealth Government for undertaking the administrative activity. ^b Vocationally registered GPs receive higher rebates under Medicare than other medical practitioners.

^c DVA care plans, case conferences, health assessments and Medication Reviews. ^d Estimate. Expenditure for the period July 2001 to March 2002 was \$9.42 million.

Source: Appendix E.

⁷ Under section 13.3.3 of the Medicare Benefits Schedule, Medicare rebates are available to GPs for completing 'a medical examination which is required to claim eligibility for certain Social Security benefits or allowances' (DoHA 2003).

4 Defining and measuring GP administrative costs

A major focus of this study is the measurement of the private costs that are faced by general practitioners (GPs) and general practices in meeting the requirements of selected Commonwealth Government programs and policies.

This chapter explores the concept of GP administrative costs and how they are defined and measured. In section 4.1, the way in which GP administrative costs fit into evaluations of overall program costs and benefits is discussed. Administrative costs are then defined in section 4.2. The conceptual framework used to measure GP administrative costs is described in section 4.3, and the practical difficulties that can arise in measuring these costs are highlighted in section 4.4.

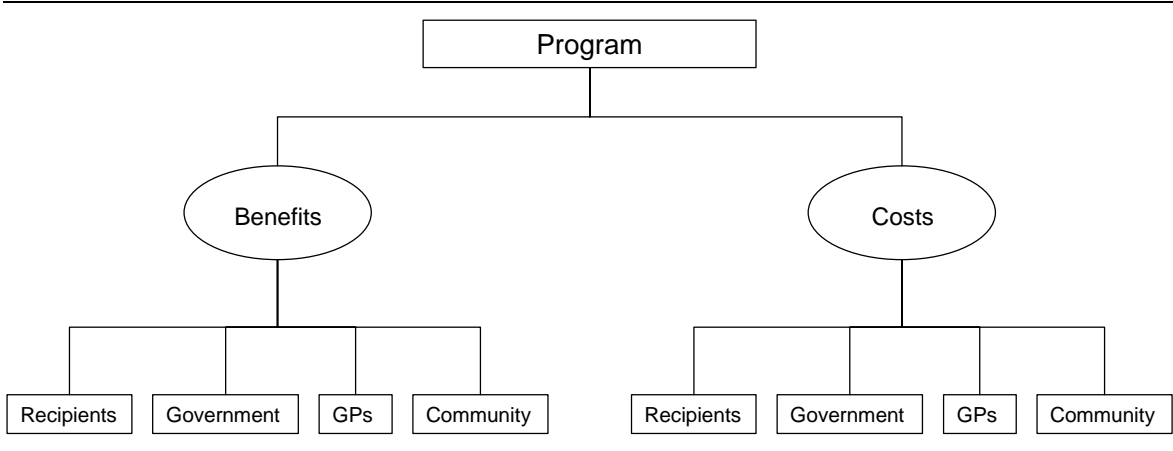
As noted in chapter 1, the term ‘GP administrative costs’ refers to the costs incurred by GPs and general practices in participating in relevant government programs, regardless of whether participation is voluntary or the remuneration arrangements in place. This term covers a range of activities not traditionally classified as ‘administrative costs’, such as training and capital expenditure, and should not be confused with the administrative costs that government departments incur. Since the study’s focus is on costs, it does not take into account or net out payments received by GPs and practices, nor does it take into account the taxation treatment of GPs’ income and costs (such as the ability of GPs to claim costs associated with vocational registration as tax deductions).

4.1 GP administrative costs in context

The benefits of the government policies and programs within the scope of this study are not achieved costlessly — there are costs associated with implementing and administering programs, both for the public and private sectors. An important principle of policy analysis is that the expected benefits to society as a whole from government policy should exceed the costs incurred: ‘When choosing among programs, the best all purpose rule is to choose the one that maximises net social benefits’ (Gramlich 1990). From a societal point of view, benefits and costs to all parties need to be considered when assessing the net benefit of a policy.

Although most benefits from programs accrue to the individuals who receive the treatment or service being provided, other people can also benefit indirectly through the increased health or welfare level of these individuals (figure Error! Not a valid link.). For instance, increasing childhood immunisation rates can slow the transmission of disease. GPs are often remunerated for participating in a program and, as in the case of programs that promote professional development, might receive private benefits themselves. Government might also receive a benefit from a program; for example, through reduced expenditure in other areas.

Figure 4.1 **Benefits and costs of government programs**



The costs associated with programs can be borne by the relevant Commonwealth departments (which design, apply, assess, enforce and audit health policies and programs) and ultimately taxpayers, or by the private sector (including program recipients, GPs and general practices).

Policies can also have second-round effects that impact on other parts of the community by altering behaviour of those directly affected by the program, leading to the reallocation of resources within the economy (Bickerdyke and Lattimore 1997; MED 2001; OECD 2001).¹ There might also be transition costs associated with the commencement of new programs.

GP administrative costs should be taken into account in policy development because they are an element of total program costs. However, they are only part of the costs and, as such, should not be used in isolation to establish whether a policy is desirable.

¹ The Far North Queensland Rural Division of General Practice, for example, suggested that service incentive payments provide ‘perverse incentives to increase the number of visits per patient’ (sub. 9, p. 2).

Mechanisms within Government for assessing program costs and benefits are discussed in section 6.1.

4.2 Defining GP administrative costs

Other studies have used a range of definitions of GP administrative costs. The New Zealand General Practice Test Panel on Compliance Costs (2001) took a broad approach, defining ‘compliance costs’ as those costs attributable to both the underlying policy and the way the policy is operationalised. In contrast, the New Zealand Ministry of Economic Development (MED 2001) defined ‘compliance costs’ more narrowly as the administrative and paperwork costs to business in meeting government requirements. It defined these costs to include staff time, information/training costs and stress, but not other direct costs, such as paying for inspections required by government.

In this study, the Commission’s approach is broadly based on the incremental cost approach used by the OECD (2001). To determine the costs of a policy or program, one should compare any GP and general practice costs associated with a program to those that would be incurred without the program. However, as it is difficult to observe what costs would be in the absence of a program, the most practical way to estimate the cost difference is by identifying the additional activities due to the program and estimating their incremental costs.

Accordingly, this study defined GP administrative costs as the incremental or additional costs to GPs and to their practices of meeting the requirements of certain Commonwealth Government programs. These costs are incremental in the sense that they are:

- above those costs incurred in undertaking the normal activities of a GP; and
- would not have been incurred in the absence of the program.

Incremental costs

Measuring the incremental costs of a policy or program is a commonly used method of economic analysis. Such an approach is valuable because it deals with the marginal impact of a policy. The Commission’s study is required to estimate all of the GP administrative costs associated with GPs’ program participation. A long run incremental cost approach is used, incorporating the incremental use of all labour and non-labour resources associated with participation in the program. Some joint or common overhead costs are not considered to be incremental and are thus omitted from the analysis.

A useful way to consider what constitutes an incremental cost is to answer the following question: what cost savings could be made in running the practice if the program was withdrawn? In this respect, this approach uses the concept of GPs' 'normal' practice activities as a baseline for comparing and measuring such costs.

Sources of incremental costs

Three sources of incremental costs are covered in this study.

- Labour costs — the cost of the additional time it takes the GP and other practice staff to complete the administrative activities.
- Non-labour costs — the cost of purchasing or leasing additional equipment, upgrading surgery facilities, or the costs of materials and services that would not otherwise be required.
- Intangible costs — the cost of additional stress and frustration that might arise from certain administrative activities, such as providing medical information to departments about social welfare claimants.

Labour costs

GPs or other practice staff are required to devote time to undertaking activities to comply with government programs. Staff time might be required to perform a specific service, or to prepare the GP or the practice for participation in a program. An example of an initial requirement to participate in a program is accreditation (such as for the Practice Incentives Program (PIP) — chapter 3). Dr Alison Vickers, for example, found that it took her two days a week for three months to complete the requirements for PIP accreditation (sub. 17).

Other practice staff are sometimes involved in meeting the requirements of a program. Their contribution is highlighted by the 'activity maps' produced in case studies undertaken for the Commission (section E.5 in appendix E). As these practice staff have a lower hourly cost than GPs, shifting administrative activities to them is likely to reduce overall administrative costs for the practice.

Non-labour costs

Non-labour costs might also be incurred in complying with government programs. Examples include the travel and certain training costs associated with vocational registration, and paying accreditation agencies to meet PIP requirements. Capital investments might be necessary, such as soundproofing surgeries or purchasing additional equipment and buildings.

The increased use of computers and the Internet for retrieving and sending information for programs might also warrant an upgrade or purchase of equipment and software. The Far North Queensland Rural Division of General Practice (sub. 9, p. 5) noted that ‘the cost of a reasonable [information management and information technology] system is about \$40 000 [for] 3 years in hardware and about \$5000 per year in maintenance’. However, only incremental information technology costs that are incurred through participation in the program are counted as contributing to GP administrative costs.

Intangible costs

Intangible costs are an important component of administrative costs but are difficult to measure. These include: costs associated with anxiety, stress and frustration due to the accumulation of many government requirements; resentment at having to complete seemingly unnecessary forms; and tensions between the roles they perform on behalf of patients and government departments (Bickerdyke and Lattimore 1997; Cabalu, Doss and Dawkins 1996; MED 2001; Sandford, Godwin and Hardwick 1989).

4.3 Activity-based costing

As noted above, it is difficult to estimate the incremental costs of a program when it is not possible to observe the world in the absence of the program. The Commission’s approach is to identify the additional (or incremental) activities that GPs undertook to participate in the program, and calculate the resources used in performing these activities.

To ensure that the estimate of incremental costs accurately includes not just the costs of GPs’ time, but other costs of undertaking the activities (such as the cost of other staff and equipment) the Commission has used an activity-based costing (ABC) approach. ABC is a technique that is used to relate the amount of each resource used to particular activities. It improves on product costing techniques based on standard accounting information, which tend to make arbitrary allocations of costs to activities or to classify costs as overheads:

A major advantage of using ABC is that it avoids or minimises distortions in product costing that result from arbitrary allocations of indirect [overhead] costs. Unlike more traditional line item budgets which can’t be tied to specific outputs, ABC generates useful information on how money is being spent, if a department is being cost-effective, and how to benchmark (or compare oneself against others) for quality improvement. (OSD Comptroller 2002, p. 3)

In this way, ABC minimises the residual pool of costs considered to be overheads:

ABC applies resource use directly to the output ... based on the actual work activities of the process that produces the output with limited arbitrary allocations of indirect and overhead costs. (US Department of Defense 1995, p. 2)

When using ABC, the appropriate values should be applied to cost each resource used, or else double counting might occur (box 4.1).

Box 4.1 Avoiding double counting

Using an incremental cost framework and ABC, the use of each resource to undertake each activity is individually identified and costed. The GP's average rate of pre-tax earnings, for example, is used to measure the direct cost of his or her time spent on the activity.

In contrast, the Australian Medical Association suggested that the average billing rate be used instead to cost the value of a GP's time (pers. comm., 20 December 2002; sub. PR36, p. 2). Using this, the cost of complying with each program would be equal to the average billing rate per hour charged by the GP for medical consultations, multiplied by the number of billable hours the GP spends undertaking activities for each program. This approach would, however, lead to double counting, since the average billing rate includes an allowance for the costs of other resources (for example, nurses and receptionists) whose time have already been separately costed and attributed to the activity under the ABC approach.

4.4 Distinguishing between normal and incremental costs

A number of issues need to be resolved in determining the incremental costs incurred by practices when meeting government requirements. In particular, it is necessary to establish a baseline with which costs can be compared. A baseline that represents the 'normal' activities of a practice is hard to observe and might vary between practices or move over time.

What is normal?

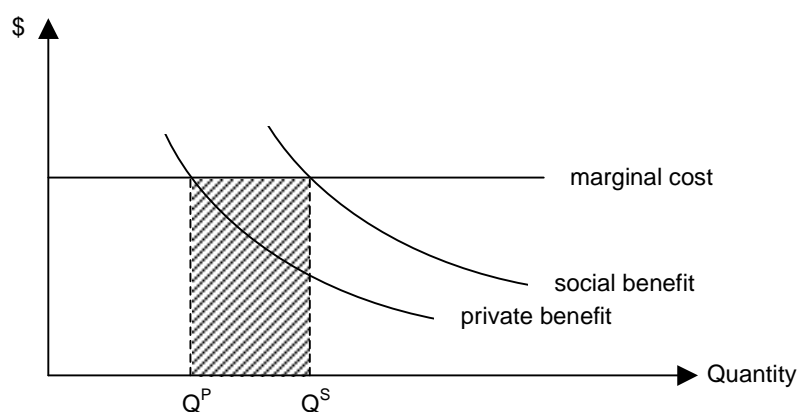
For some programs it is relatively straightforward to establish which activities GPs perform that are in addition to their 'normal' activities — such as completing Department of Family and Community Services/Centrelink or Department of Veterans' Affairs forms. In other cases, the delineation is not so clear because the activities that are supported by the program might be part of 'normal' activities to

some degree, but not always to the level required under the program. The relationship between private and social benefits, and normal and incremental costs is illustrated in box 4.2.

Box 4.2 Private and social benefits vs normal and incremental costs

A GP or general practice would normally perform a given activity up to the point where the private benefits of doing an extra unit cease to outweigh the costs (Q^P). A government program might aim to increase the amount of activity performed above this level — to the point where the cost of an extra unit of service equals the extra benefits it brings to the whole of society (Q^S).

The Government, by implementing the program, induces GPs to increase their participation in an activity from Q^P to Q^S . The incremental costs of the program are the opportunity costs of the extra resources required for the increase (shaded area). Once set, Q^S might be measurable, but it is difficult to determine Q^P as it might not be observable.



In some cases, an activity might not generate any private benefits to the GP or general practice. Under these circumstances, Q^P equals zero and all units performed (Q^S) of the activity would be considered to be incremental.

The challenges of estimating incremental costs are illustrated for vocational registration, practice accreditation for PIP, Enhanced Primary Care (EPC) and information systems. The Commission's assumptions, results and sensitivity analyses are discussed in chapter 5 and appendix F.

Vocational registration

Vocational registration requires participating GPs to undertake at least a minimum level of Continuing Professional Development (CPD), such as teaching and attending conferences. There is debate about the extent to which undertaking CPD is a normal activity of a GP, or is induced by a government requirement, and so

should be considered to be a GP administrative cost. The Royal Australian College of General Practitioners (RACGP), in commenting on the Commission's Progress Report (PC 2003), indicated that it:

... is concerned about the treatment of continuing profession development (CPD) in the Progress Report. The compliance costs associated with the maintenance of GP Recognition that are included in the body of the Progress Report do not represent the RACGP's view of compliance.

The RACGP acknowledges that there is a diversity of opinion in some parts of the profession about the degree to which CPD is a compliance requirement of the Federal Government. Despite this, the RACGP believes that the vast majority of GPs see CPD as a desirable and important part of their profession, not a compliance requirement imposed by the Federal Government. The College developed its CPD program to support the responsibility its members recognised to maintain their knowledge and skills. This occurred well before the Federal Government became involved and imposed its compliance requirements. (sub. PR41, p. 1)

Likewise, the Southern Tasmanian Division of General Practice also disagreed with the Progress Report's treatment of vocational registration (sub. PR44, p. 1).

Similarly, the Department of Health and Ageing (DoHA) suggested that:

In relation to vocational registration, linking the entire cost of participating in the general practice professional development program as a compliance cost to access higher Medicare rebates is not valid. I suggest that continuing professional development is a normal cost of any professional group and therefore should be excluded from the study. (sub. PR43, p. 2)

Nonetheless, DoHA observed that it provides financial support to reward GPs who are vocationally registered, by paying them a higher rate of Medicare benefits than is paid to non vocationally registered GPs. This support is provided to reward vocationally registered GPs for improving their quality of service. As noted by DoHA:

In addition, vocational recognition (including continuing professional development) and practice accreditation are two industry led developments that provide the infrastructure for maintaining and improving the quality of general practice. The Department's programs provide support for these developments through higher MBS rebates and access to PIP incentives respectively. (sub. PR43, p. 2)

Similarly the General Practice Strategy Review Group has argued:

One of the main objectives of vocational registration was to provide incentives for GPs to maintain and improve their skills through participation in continuing medical education and quality assurance programs. (GPSRG 1998, p. 193)

It could be argued that the Government has provided financial incentives and amended the *Health Insurance Act 1973* to give effect to vocational registration.

The need for such action would suggest that more CPD is undertaken for vocational registration than would otherwise be undertaken in the absence of government support.

The contrary argument, that CPD undertaken for vocational registration should be counted as a normal cost of practising as a GP and hence (mostly) excluded from the study, implies that the benefits of CPD, including the community-wide benefit of improved quality of health care, would have been achieved without the program.

If this were the case, then from the community's perspective, the higher Medicare rebates do not generate any incremental benefits with respect to vocational registration. In turn, this suggests that the benefits from the primary health care system could be increased by using at least part of the higher rebates (worth at least \$490 million, see table 5.2) to fund other activities that could yield higher net benefits for the same level of government support.

It is particularly difficult to establish how much CPD would have been undertaken by GPs in the absence of a financial incentive. What cannot be disputed, however, is that GPs use incremental resources to achieve vocational registration and the cost of these resources need to be included in any comprehensive analysis of the costs and benefits of the vocational registration program. Therefore, the incremental costs of vocational registration are relevant to whoever is responsible for the establishment and design of the program, be it the government, the profession or both.

Practice accreditation for PIP

Practice accreditation is an extension of the framework used for vocational registration:

The initiative for accreditation for general practice can be traced back to the 1991 Commonwealth budget. As part of a broad range of policy directions for the reform of general practice, accreditation was seen 'as a natural development of the vocational registration arrangements ... within which many steps could be taken to address quality of care issues in general practice'. (Howe 1991 in Mott, Kidd and Weller 2000, p. 292)

As described in chapter 3 (box 3.1), the RACGP assumed responsibility for establishing standards for accrediting general practices (with support from the Government). The Government requires that practices be accredited as a mandatory prerequisite for participating in PIP. Thus, as noted by DoHA (sub. PR43, p. 2), it provides support for accreditation through access to PIP incentives.

As with vocational registration, it could be argued that government support has been required to implement accreditation. This would suggest that the standard of general

practice and the quality of health care provided by GPs would be higher than without government support for the program.

Once again, what cannot be disputed is that general practices use resources to achieve accreditation and the costs of these need to be recovered. Therefore, the incremental costs of accreditation are relevant to whoever is responsible for establishing the program and setting its standards, be it the government, the profession or both.

Enhanced Primary Care

As discussed in chapter 3, under the EPC program, GPs provide specific services such as health assessments, care plans and case conferences for older people and people with chronic conditions and complex care needs.

DoHA argues that EPC should not be included in the scope of this study, as it is part of the Medicare Benefits Schedule (MBS) fee-for-service system and therefore part of GPs' 'normal' activities (sub. PR43).

The Commission considers EPC to be different and more complex than normal MBS items. Under EPC, the particular services that the Government is seeking to purchase are prescribed and the completion of written plans and records is required. As the Government provides financial incentives to encourage GPs to provide these services, it appears that GPs were not necessarily offering these services through the usual MBS items (at least not in the desired quantities).

Information systems

Maintaining an information system is a cost that practices incur to serve a variety of purposes (Rimmer and Wilson 1996). The question is: how much (if any) of the system cost is attributable to meeting government program requirements?

A well-run general practice will have information systems to maintain patient records, to keep track of the financial position of the practice and to comply with taxation laws. These systems can involve computers, paper files and any back-up systems. The information contained in patient records would be expected to be held for a period of time as one of the practice's normal activities. Therefore, some of the information that GPs are required to provide to comply with government programs would be collected and catalogued whether or not the programs exist. However, additional information required by government programs might involve additional use of the system — such as extra software, an upgraded computer or more information to be held on file.

It is difficult to differentiate between the different types of inter-related uses of information systems. Similarly, it is difficult to determine which features of the system are installed purely for administrative purposes rather than for ‘normal’ activities. Thus, it is not easy to identify the incremental costs associated with information systems in meeting government program requirements.

Diversity among GPs and general practices

There is significant diversity across GPs and general practices in what is considered to be ‘normal’ practice. The nature and magnitude of GP administrative activities (and hence GP administrative costs) will vary between individual practices reflecting, among other things, diversity in practice size, location and service level. This does not change the way in which the conceptual definition of administrative costs is applied. Instead, it means that any estimate of administrative costs per GP will necessarily be an average — there will be some GPs who face higher (and some lower) costs of participating in government programs.

‘Normal’ activities change over time

The professional and public expectations placed on GPs are being continuously re-examined and challenged. What constitutes ‘normal’ will therefore change over time.

The Centre for General Practice Integration Studies identified a number of changes in the community’s expectation of activities performed by GPs:

Areas in which general practice is being increasingly expected to strengthen its role include:

- evidence based management of chronic disease;
- detection and management of risk factors;
- the health of populations (for example, all the patients who attend the practice) and communities, rather than just the individuals who happen to seek services; and
- equity of access to and quality of care.

... These expectations arise in part through increased consumer expectations and in part from mounting evidence about the impact of consistent, evidence based care in improving health. (sub. 16, p. 1)

Such movements in what is considered normal will impact on how administrative costs are measured. Administrative costs are therefore defined for only a specific point in time, and consideration has to be given to issues that can affect the frame of

reference, such as changes that occur in clinical practice, technology or medical knowledge.

4.5 Commission's approach

Most programs covered in this study:

- provide GPs with Government-funded rebates or incentive payments; and/or
- have mandatory prerequisites that might be linked to programs that provide GPs with rebates and incentive payments.

This suggests to the Commission that at least some component of the activity associated with these programs is above the level that would 'normally' be undertaken by GPs or general practice. Otherwise there would be no additional gain to the community from funding higher quality health programs as GPs and general practices would have provided the high quality care without inducement.

Many of the programs covered in this study, such as PIP, vocational registration and EPC, differ from normal Medicare services. The rebates and incentive payments are part of a more prescriptive approach to the way medicine is practised by GPs. Assuming that rebates and incentive payments are paid to induce a higher quality of care than would normally be provided, the programs have been included in the study.

The relevant issue then becomes how much of the activities undertaken by GPs and general practices are induced — that is, above the level that would normally be undertaken in the absence of the program and associated incentive payments. As discussed above, this is difficult to determine with precision in the absence of any evidence on 'before and after' outcomes.

As discussed in the following chapter, the Commission has used case studies to gather information regarding complex programs, such as PIP and EPC. The consultants engaged to undertake the case studies were asked to discuss with GPs what extra costs are incurred (labour and non-labour) to meet the requirements of programs in which they participate (Campbell Research & Consulting 2003). The intention was to elicit from GPs the level of incremental costs incurred to participate in such programs. If a GP reported that he/she did nothing extra or participated in a program without reporting any extra costs, then the Commission has generally assumed a zero value for incremental costs for that activity.

The Commission acknowledges that there is uncertainty associated with its estimates. The Commission's approach to dealing with this uncertainty is to:

- undertake sensitivity analyses of the key drivers of the cost estimates, reflecting views put forward in submissions;
- undertake Monte Carlo simulations in relation to the key drivers of costs; and
- report results in a disaggregated form, so that readers can adjust the Commission's results using different assumptions.

The Commission's approach to estimating GP administrative costs is discussed further in chapter 5 and appendix F.

5 Estimating GP administrative costs

The Commission has attempted to measure administrative costs to general practitioners (GPs) for 2001-02 for as many of the programs within the scope of the study as is practical.

The estimates of GP administrative costs in this chapter are the best that could be produced within the time and information available, but they do have limitations. Various sources of data were used, including government departments, a pilot survey of GPs, focus group discussions attended by GPs, case studies of GPs and submissions. Many of the estimates of staff time and practice costs are based on small samples of GPs and practices. Consequently, this approach yields estimates that are indicative rather than precise and are sensitive to assumptions. The Commission analysed the sensitivity of the estimates to changes in assumptions about key programs (section 5.2 and appendix F). The Commission also examined the effects of the variability in the data from the case studies on the overall estimates (box 5.2 and appendix F).

The estimates of GP administrative costs measure the incremental or additional costs to GPs and to their practices of meeting the requirements of certain Commonwealth Government programs. Nonetheless, there are also intangible costs to GPs (such as stress and frustration) from these activities. These intangible costs have not been quantified, but some qualitative information on intangible costs is discussed in section 5.3.

5.1 Method used to estimate GP administrative costs

The Commission used a method that can be described as an ‘activity-based incremental cost model’ to estimate GP administrative costs. The method used emphasises the importance of identifying the activities and inputs that drive the costs of participating in each program (Drummond et al. 1999, p. 66). Applying this approach involves a number of steps:

- identifying the departmental programs that impact specifically on GPs;

-
- defining the activities (and sub-activities) associated with departmental programs that drive incremental costs;¹
 - defining the categories or components of incremental costs to be used;
 - deriving for each activity an estimate of the incremental costs for each category of cost;
 - summing these estimates of incremental costs to obtain the total incremental costs for each activity; and
 - summing the total incremental costs of all activities to obtain the grand total of incremental costs for all programs and activities.

Defining programs and activities

A four-level hierarchy was used to classify programs and their associated activities, based on department, program, activity and sub-activity.

‘Activity’ refers to administrative activities and ‘sub-activity’ refers to the processes used to undertake the activity in question. Consider the Department of Health and Ageing’s (DoHA’s) Australian Childhood Immunisation Register as an example. One of the activities in this program is immunisation notification. This activity can be undertaken in one of two ways (by electronic data interchange or manually), which are identified as sub-activities.

Defining incremental cost categories

Different types of costs are incurred by GPs and general practices participating in the programs covered in this study.

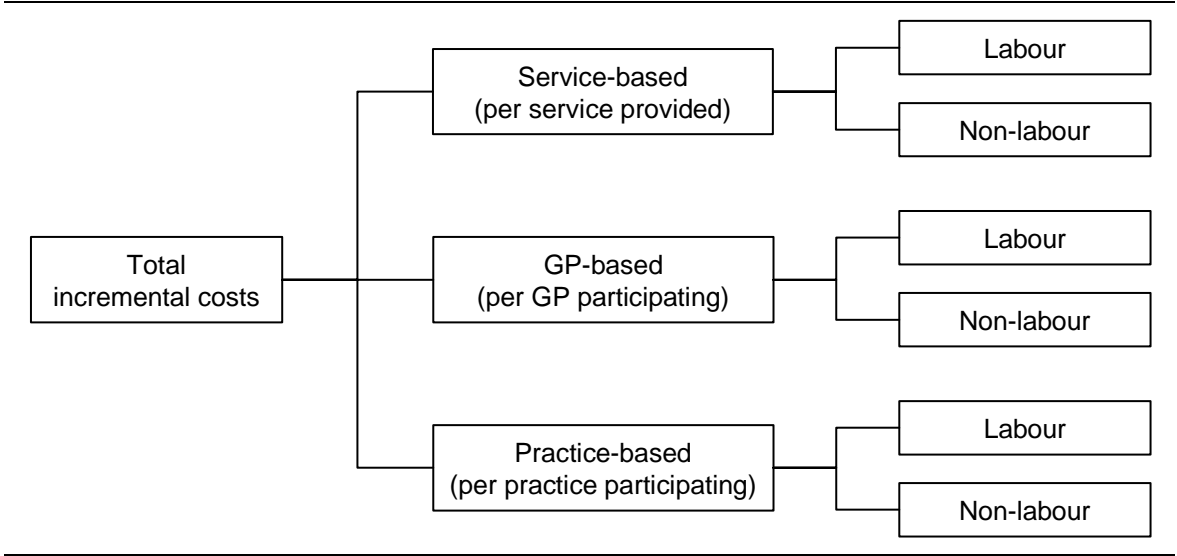
Some of these GP administrative costs depend on the number of patient services provided (figure 5.1) — such as completing a Treating Doctor’s Report (TDR) for a client of the Department of Family and Community Services (FaCS)/Centrelink or undertaking an Enhanced Primary Care (EPC) health assessment. The overall estimate of GP administrative costs for these services is obtained by multiplying the administrative cost of a service by the number of services provided nationally.

Programs can also have administrative costs that are viewed by the GP or general practice as the ‘fixed’ costs of participating in programs (that is, these costs do not

¹ Campbell Research & Consulting (2003) developed activity maps for key programs as part of the case studies conducted for this study. These maps set out who undertakes each of the activities that make up the process, what order the activities take place and other resources that might be required to complete the process. These are reproduced in appendix E.

vary with the number of services provided). The incremental cost of maintaining vocational registration is an example of fixed costs incurred by GPs. The overall estimate of costs for this activity is obtained by multiplying the incremental cost of vocational registration by the number of GPs who are vocationally registered nationally. Similarly, the costs of a practice maintaining its accreditation is an example of the fixed costs incurred by general practices. The overall estimate of the cost of accreditation is obtained by multiplying the incremental cost of accreditation per practice by the number of practices accredited nationally.

Figure 5.1 Incremental cost categories



Each of the three types of costs (service-based, GP-based and practice-based) can be disaggregated into labour and non-labour costs. Labour costs are the estimated costs of practice staff (GPs, nurses, practice managers and receptionists). Practice managers and receptionists, for example, might assist the GP to maintain vocational registration (such as assisting with clinical audits, setting up meetings and lodging or renewing GPs’ vocational registration). Non-labour costs include purchasing or leasing additional equipment, upgrading surgery facilities, and the costs of materials and services.

Some programs might have more than one of these types of costs. GP administrative costs for EPC care plans, for example, include service-based labour costs incurred each time a care plan is undertaken (the time taken to complete the care plan) and GP-based ‘fixed’ labour and non-labour costs incurred each year to set up the program for that year.

For some programs, either labour or non-labour costs can be incurred periodically rather than in each year. These periodic costs have been amortised over the ‘life’ of the ‘investment’ (such as three years for accreditation and ten years for a major

capital improvement), using an appropriate discount rate. That is, the Commission converted the periodic costs into equivalent annual values. Further detail on the Commission's approach is included in appendix F.

Illustrations of the method used to calculate GP administrative costs are provided in box 5.1.

Box 5.1 **Estimating GP administrative costs — some examples**

Two examples of Commission estimates of GP administrative costs are presented below. (Other examples are included in appendix F.) Costs for the first example (completing FaCS/Centrelink Disability Support Pension Treating Doctor's Report (TDR)) vary with the number of activities (that is, forms completed). Costs for the second (vocational registration) are fixed per GP.

FaCS/Centrelink Disability Support Pension TDRs (pre September 2002 forms)

The estimate of the cost of completing a FaCS/Centrelink Disability Support Pension TDR depends only on the time taken to complete the form. For each TDR, the estimated average time taken by each GP is 17.2 minutes. Assuming an average hourly wage of \$63.84, the average cost of the GP's time is \$18.30 per TDR. Similarly, the average cost for the receptionist's time (for photocopying the form, where undertaken) is \$0.10. Together these result in an average cost of \$18.40 per TDR (or a total cost of \$2.4 million, for all 129 972 TDRs completed in 2001-02).

<i>Cost category</i>	<i>Average time per form</i>	<i>Hourly earnings</i>	<i>Average cost per TDR</i>	<i>TDRs</i>	<i>Total annual costs^a</i>
	minutes	\$ per hour	\$	no. per annum	\$
Labour costs					
GP	17.2	63.84	18.3	129 972	2 380 792
Nurse	0.0	19.34	0.0	129 972	0
Practice manager	0.0	20.10	0.0	129 972	0
Receptionist	0.4	15.64	0.1	129 972	12 548
Total labour costs					2 393 340
Non-labour costs	0	129 972	0
Total			18.4	129 972	2 393 340

^a Totals may not add as a result of rounding. .. Not applicable.

Vocational registration

Vocational registration, which is a prerequisite for higher Medicare rebates, involves both labour and non-labour costs. For GPs, the estimated average time assumed taken in a year to maintain vocational registration (in the base case), above what they would have spent in the absence of the scheme, is 2958 minutes (or about 49.3 hours per

(Continued next page)

Box 5.1 (continued)

year). (The RACGP view about GP administrative costs attributable to vocational registration is presented in the sensitivity analysis.) Assuming an average earning rate of \$63.84 per hour, the annual incremental cost to a GP to maintain vocational registration is \$3147. (Similar calculations are made for the time costs for practice managers and receptionists who might assist the GP with maintaining their registration.) GPs also incur incremental non-labour costs of \$737 per year to maintain their vocational registration (such as travel costs and RACGP annual fees). Using these assumptions, the total annual incremental cost of a GP maintaining vocational registration is estimated to be \$3900 per year (or a total cost of \$74.2 million for all 19 022 vocationally registered GPs (VRGPs) in 2001-02).

<i>Cost category</i>	<i>Average time per annum</i>	<i>Hourly earnings</i>	<i>Annual cost per VRGP</i>	<i>VRGPs</i>	<i>Total annual costs^a</i>
	minutes	\$ per hour	\$	no.	\$
Labour costs					
GP	2 958	63.84	3 147	19 022	59 866 482
Nurse	0	19.34	0	19 022	0
Practice manager ^b	40	20.10	13	19 022	254 894
Receptionist ^b	10	15.64	3	19 022	49 586
Total labour costs			3 163	19 022	60 170 963
Non-labour costs	737	19 022	14 012 873
Total costs			3 900	19 022	74 183 836

^a Totals may not add as a result of rounding. ^b Practice managers and receptionists might assist GPs to maintain registration (such as assisting with clinical audits, setting up meetings, and lodging or renewing GPs' vocational registration). Therefore, the cost of their time is multiplied by the number of VRGPs to derive their contribution to the costs of GPs maintaining vocational registration. .. Not applicable.

Source: Productivity Commission estimates.

Sources of data

The Commission obtained data to estimate GP administrative costs from a variety of sources, including:

- Commonwealth Government departments — DoHA, Department of Veterans' Affairs (DVA), FaCS/Centrelink and the Health Insurance Commission provided data on the number of activities (or services) and GPs participating in each program (chapter 3 and appendixes B, C, D and E);
- a pilot survey of GPs, conducted by Millward Brown Australia for this study, provided some data on the time it takes GPs and practice staff to undertake administrative activities (appendix E);

-
- focus group discussions attended by GPs, conducted by Millward Brown Australia for this study, also provided data on the time it takes GPs and practice staff to undertake administrative activities (appendix E);
 - case studies of 13 GPs, conducted by Campbell Research & Consulting for this study, provided estimates of the labour and non-labour costs of complying with some of the complex programs (appendix E); and
 - other miscellaneous sources, such as the ABS (2000) and the Relative Value Study,² were used to obtain estimates of other variables such as earnings (appendix F).

The Commission's original intention was to conduct a survey of GPs to yield statistically significant national estimates of administrative costs. However, a pilot survey, conducted in October 2002, revealed several methodological and practical problems:

- a low response rate by GPs to the survey;
- the low frequency with which GPs encountered forms during a one-week survey period;
- the difficulty GPs have in recognising the various types of forms; and
- 45 per cent of GPs could not be contacted, primarily due to missing or incorrect phone numbers and/or addresses in the database provided by DoHA (Millward Brown Australia 2002b).

Taking into account these problems, and advice from the consultant and the Commonwealth Government's Statistical Clearing House (appendix E), the Commission decided against conducting the main survey and instead undertook a series of focus group discussions with GPs in a variety of locations.

5.2 Measurable costs

In the tables and figures below, administrative costs are presented on a disaggregated basis. The estimates of incremental costs depend on many assumptions, of which the most important relate to:

- GPs' earnings;

² The Relative Value Study consisted of several reports commissioned by the Medicare Schedule Review Board. It included reports by Healthcare Management Advisors (2000); the National Centre for Classification in Health (2000); and PricewaterhouseCoopers (2000).

-
- the amount of incremental time GPs spent maintaining their vocational registration (that is, the amount of time above what they would have spent on professional development in the absence of the Government program); and
 - whether undertaking health assessments and care plans for EPC and accreditation for the Practice Incentives Program (PIP) are normal activities of GPs.

Apart from the results presented in table 5.5, all results are based on the FaCS/Centrelink forms being used prior to September 2002.

National results

The Commission estimated GP administrative costs using the following ‘base case’ assumptions:

- GPs earn, on average, a pre-tax rate of \$63.84 per hour (and average hourly rates for practice nurses, practice managers and reception staff of \$19.34, \$20.10 and \$15.64, respectively);
- GPs spend, on average, about 49.3 more hours per annum on professional development to maintain their vocational registration than they would in the absence of the vocational registration scheme;
- GPs would spend no time on health assessments and care plans if there were no EPC program; and
- general practices would not have undertaken the incremental activities to comply with accreditation if there was no PIP.

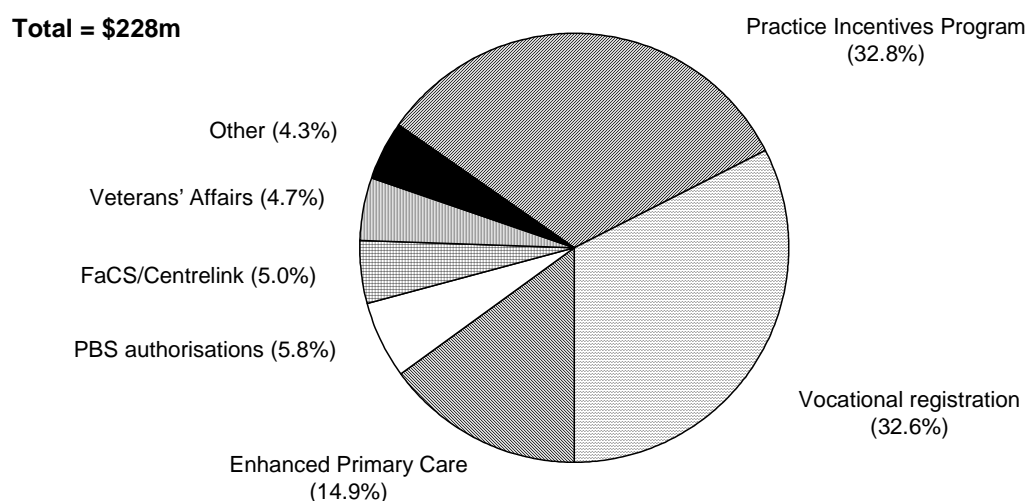
Using these assumptions, GP administrative costs resulting from Commonwealth policies and programs are estimated to have been about \$228 million in 2001-02 (about 5 per cent of GPs’ estimated total income from public and private sources³). This is equivalent to an average of about \$13 100 per GP who works at least one day per week (this is discussed further below).

³ The Commission estimates that GPs’ total income from public and private sources was about \$4.4 billion in 2001-02. This estimate is based on indexing for inflation the most recent data on GPs’ total income from public and private sources — \$4.0 billion in 1998-99 (SCRCSSP 2003) — using the ABS *Wage Cost Index* (2002b). This estimate includes some revenue from other medical practitioners who are not principally GPs. GPs’ total income is used as a proxy for total costs, due to the lack of national data on total costs.

Administrative costs by program

In figure 5.2, results are provided for the programs for which the Commission was able to derive estimates. (Detailed results for individual programs are presented in appendix F.)

Figure 5.2 Estimated GP administrative costs by program, 2001-02^a



^a Data relate to the base case earnings, vocational registration and EPC assumptions.

Data source: Productivity Commission estimates.

Some key results for individual programs include:

- PIP, with an estimated administrative cost of about \$75 million, accounted for a third of total GP administrative costs in 2001-02. Accreditation for PIP accounted for \$49 million of this cost and service incentive payments and other requirements the remainder;
- vocational registration (\$74 million) was the next highest cost (box 5.1 contains the data used to derive this estimate);
- the EPC program was the third largest, with GP administrative costs of \$34 million; and
- FaCS/Centrelink programs accounted for a relatively small share (just over \$11 million or 5.0 per cent), as did DVA programs (just under \$11 million or 4.7 per cent). This is largely due to the small average number of forms completed per GP.

These results primarily reflect the relative time intensities of the activities.

Sensitivity analyses

Before discussing these results further, it is important to understand the nature of the Commission's estimates. For some programs it is difficult to establish which activities GPs perform that are in addition to their 'normal' activities, as the activities that are supported by the program might be part of 'normal' activities to some degree, but not always to the level required under the program (chapter 4). Further, the Commission's estimates are indicative rather than precise.

Alternative assumptions

The Commission's base case assumes that some of the activities of GPs and general practice for vocational registration, EPC health assessments and care plans, and accreditation for PIP are not 'normal' activities. That is, GPs or practices would not have undertaken the incremental activities in the absence of these programs. The alternative view is that many of these are 'normal' activities, and GPs or practices would have incurred these incremental costs even if the program did not exist (chapter 4). There are also different views about the earnings rate for GPs that should be used in the analysis.

The Commission conducted sensitivity analyses to indicate how the national estimates of total administrative costs might vary with changes in the most important assumptions (table 5.1). The analyses are reported in detail in appendix F.

- If the AMA's preferred earnings assumption of \$100 per hour for GPs (based on their proposed rate of \$200 per hour (sub. PR36, p. 2) taking into account practice costs) were used instead of the Commission's estimated level of \$63.84, for example, and all other assumptions were unchanged, the estimate of GP administrative costs would increase from \$228 million to \$305 million.
- If the RACGP's suggested approach for vocational registration (only including the time spent *undertaking* Continuing Professional Development for 5 per cent of GPs and the time and cost of *reporting* Continuing Professional Development for all GPs) were adopted, and EPC health assessments and care plans and accreditation for PIP were assumed to be normal activities, the cost estimate would fall from \$228 million to \$85 million. FaCS/Centrelink programs account for a larger share of total GP administrative costs (13 per cent) under this approach.

FINDING 5.1

Under the Commission's base case, the estimated administrative costs for general practitioners and general practice resulting from Commonwealth policies and programs were about \$228 million (or 5 per cent of GPs' estimated total income from public and private sources) in 2001-02. This is equivalent to an average of about \$13 100 for a GP who works at least one day per week.

Table 5.1 Total GP administrative costs by earnings and other assumptions, 2001-02^a

\$ million

Other assumptions	Earnings assumption		
	Productivity Commission estimate (base case)	Relative Value Study	AMA recommendation
<i>Base case</i>			
Vocational registration	74.2	85.3	108.1
EPC — care plans	17.7	20.6	26.2
EPC — health assessments	13.0	14.5	16.5
PIP — accreditation	48.7	52.0	52.1
Other	74.0	84.4	101.9
Total	227.6	256.8	304.8
<i>Alternative</i>			
Vocational registration	7.8	8.6	10.2
EPC — care plans	1.7	1.9	2.0
EPC — health assessments	1.2	1.3	1.3
PIP — accreditation	0.0	0.0	0.0
Other	74.0	84.4	101.9
Total	84.6	96.2	115.4

^a Assumptions are listed in appendix F (earnings assumptions in table F.10 and other assumptions in table F.11).

Source: Productivity Commission estimates.

FINDING 5.2

Based on an alternative assumption that some activities associated with certain Commonwealth policies and programs would be undertaken by GPs anyway, administrative costs could be as low as \$85 million (or 2 per cent of GPs' estimated total income from public and private sources) in 2001-02. This is equivalent to an average of about \$4900 for a GP who works at least one day per week.

FINDING 5.3

Under the Commission's base case, three programs aimed at promoting high quality care — Practice Incentives Program, vocational registration and Enhanced Primary Care — accounted for over three-quarters of measurable GP administrative costs in 2001-02. Administrative costs arising from GPs completing forms for the Department of Veterans' Affairs and the Department of Family and Community Services/Centrelink accounted for much smaller shares.

As discussed in chapter 4, regardless of which approach is used to measuring GP administrative costs, it is important to recognise that GPs and general practices use resources when undertaking these activities and the costs of these resources need to be recovered.

Monte Carlo simulations

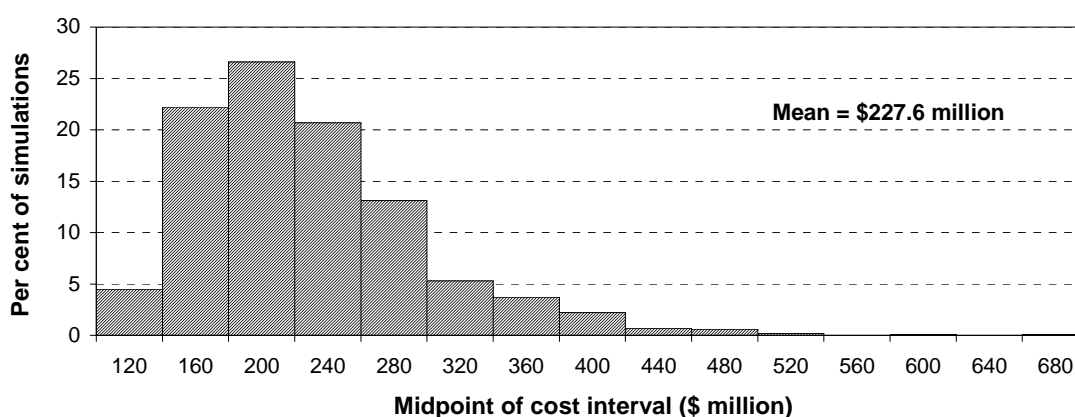
The Commission's estimates are indicative rather than precise, as some data were obtained from small samples and there is variability in the data. To illustrate the indicative nature of the results for the Commission's base case, a Monte Carlo simulation analysis was undertaken to generate a frequency distribution of the estimates of total GP administrative costs (box 5.2). These simulations generated a broad range of estimates, with 70 per cent of simulations being between \$140–\$260 million.

Box 5.2 Variation of estimates

The Commission used data from a wide range of sources (appendix E). Some data were obtained from small samples and there is variability in the data. Only 13 case studies were conducted, and a number of case study practices did not participate in all of the activities; for example, only six were involved in care planning for Enhanced Primary Care (EPC). There was also variation in the costs between case studies (which was expected given differences in their size, location and ownership arrangements).

To understand how this variability might affect estimates of total GP administrative costs, a Monte Carlo simulation analysis was conducted to generate a frequency distribution of the estimates of total GP administrative costs. The key time and cost parameters of vocational registration, EPC, the Practice Incentives Program and GP earnings were repeatedly sampled from distributions estimated for each of the relevant variables. These values were then used to calculate GP administrative costs repeatedly. The distribution, based on 1000 simulations, illustrates the indicative nature of the estimates. There was a broad range of estimates, with 70 per cent of simulations being between \$140–\$260 million. Further details of these simulations are provided in appendix F.

Distribution of estimates of total GP administrative costs^a



^a Based on 1000 Monte Carlo simulations. Each cost interval has a width of \$40 million.

Source: Productivity Commission estimates.

Payments to GPs

GPs are remunerated through rebates or incentive payments for undertaking many of the administrative activities associated with the programs covered in this study (as indicated in chapter 3 and appendix E). For many of the programs where there is information on both payments and estimates of administrative costs, payments exceed estimated GP administrative costs. In 2001-02, using the base case assumptions, GP administrative costs for the three programs for which those costs were largest (PIP, vocational registration and EPC) were less than 25 per cent of the total payments to GPs (table 5.2). Using the alternative assumptions, GP administrative costs for these programs were about 5 per cent of total payments.

The Commission has not formed a view about whether the payments to GPs were too high or too low. The level of payments to GPs for these programs could be designed to meet a range of objectives, including meeting GP administrative costs, providing incentives to GPs to meet certain program requirements and/or to supplement conventional fee-for-service payments via blended payments.

As noted in chapter 1, this study is not designed to assess whether GPs are adequately remunerated for the costs associated with particular programs. Such conclusions are properly the domain of program evaluations, where the objectives, total costs and benefits, and level of remuneration can be considered as a policy package.

FINDING 5.4

For many of the programs for which information is available, GPs receive Government payments that exceed measurable GP administrative costs.

Table 5.2 **Selected GP administrative costs and direct payments to GPs, 2001-02**

Programs	Estimated GP administrative costs		Payments to GPs
	Base case assumptions	Alternative assumptions	
	\$m	\$m	\$m
Practice Incentives Program	74.6	25.8	193.2
Vocational registration	74.2	7.8	> 493.8
Enhanced Primary Care	33.9	6.1	62.9
Total	182.7	39.7	749.9

Source: Productivity Commission estimates; table 3.7.

Administrative costs per GP

The discussion throughout the remainder of the chapter relates to the Commission's base case assumptions. The national GP administrative costs estimate of about \$228 million can be divided by the number of GPs to provide an indication of the costs incurred by an 'average' GP. However, this average estimate will depend upon the definition and consequent number of GPs. For GPs working at least one day per week (17 400 in 2001-02), the national GP administrative costs estimate is equivalent to an average of about \$13 100 per GP. If the number of GPs is adjusted for workload (there were about 14 100 full-time equivalent GPs in 2001-02), the estimate is equivalent to about \$16 100 per GP.

Given that the number of GPs participating in each program varies, choosing a single number by which to divide total costs is problematic. In addition, the administrative costs faced by individual GPs are likely to vary from this average for a number of reasons, which will also influence the rate at which they participate in various activities (such as vocational registration or EPC).

For example, variations in the efficiency of GPs (and their practices) in undertaking administrative activities will influence individual GP administrative costs. The size of a general practice and the level of administrative support are also likely to influence these costs. Campbell Research & Consulting commented:

Larger practices (group or corporate practices) are able to benefit from more extensive and cost effective administrative and clinical support. For programs such as the PIP or EPC, this support is critical to be able to establish systems and procedures that are essential to program participation. ...

Larger practices are also better positioned to participate in the PIP and EPC program because their size allows for economies of scale. The PIP and EPC program require initial investment (in terms of time and capital) that yield better return if they are used by a large number of GPs. (2003, vol. 1, p. 9)

A GP interviewed for one of the case studies considered that he:

... does not encounter difficulties when complying with the programs. This is because he is able to rely on systems and procedures developed by the practice administration staff and because the practice employs several nurses ... (Campbell Research & Consulting 2003, vol. 2, p. 3)

Further, Campbell Research & Consulting noted that 'the presence of a practice manager appears to be a critical factor to the level of participation in, and optimisation of, major programs (PIP)' (2003, vol. 1, pp. ii-iii).

The Canning Division of General Practice also stated:

... GPs in a solo practice or small group practice are less likely to have such support [nurses or administrative staff] and probably bear an even greater administrative burden. (sub. 11, p. 1)

Similarly, the ownership structure of the practice might influence administrative costs. GPs have indicated that one advantage of working in a corporate practice is that there is more administrative and clinical support. This means that GPs in corporate practices might undertake fewer administrative activities than other GPs. Campbell Research & Consulting reported that one of the GPs interviewed in the case studies conducted for this study:

... confirmed that his decision to join a corporate practice was partly motivated by the desire to reduce the amount of paperwork that had become 'intolerable'. He particularly enjoys not having any paperwork to do at the ... practice. (2003, vol. 2, p. 102)

This administrative and clinical support might also influence GPs' willingness to participate in programs considered to be administratively onerous. Campbell Research & Consulting noted that one GP interviewed:

... believed that health assessments could be beneficial but require too much preparation, as the practice did not yet employ a practice nurse... 'Health assessments are beneficial to corporate GPs who have support, and to GPs who don't mind leaving acute patients waiting for care'. (2003, vol. 2, p. 21)

Other factors that might influence the administrative costs faced by particular GPs include the characteristics of their patients (such as their socio-economic status or age) and location of the practice.

The Commission disaggregated the costs that GPs face in complying with some programs, to see whether the level of administrative costs per GP varies between locations — both for regions and for socio-economic status of the resident population of an area. These estimates are presented below. The Commission was unable to disaggregate costs for other characteristics that might influence individual GP's administrative costs.

Administrative costs per GP by region

The incidence of administrative costs is likely to vary between GPs because of differences across regions in the rate at which they undertake various activities. The Commission originally intended to test this assumption by producing administrative cost estimates disaggregated into the Rural, Remote and Metropolitan Areas classification (RRMA). However, disaggregated data for some programs, such as vocational registration, were not available (table 5.3).

Table 5.3 Total GP administrative costs by region and department, 2001-02^a
\$'000

<i>RRMA classification</i>	<i>DoHA</i>	<i>DVA</i>	<i>FaCS</i>	<i>Surveys</i>	<i>Total^b</i>
Data not provided by RRMA	84 324 ^c	10 530	na	443	95 297
Unknown RRMA ^d	0	0	13	0	14
Inner capital city	53 688	na	4 203	na	57 891
Outer capital city	23 024	56	2 592	na	25 672
Other metropolitan areas	10 385	29	1 053	na	11 467
Large rural centre	7 891	15	782	na	8 688
Small rural centre	8 346	42	871	na	9 259
Other rural areas	14 935	34	1 532	na	16 501
Remote	2 616	na	238	na	2 854
Total	205 210	10 707	11 283	443	227 643

^a Data relate to the base case earnings, vocational registration and EPC assumptions. ^b Totals may not add as a result of rounding ^c \$74 million of this estimate is for vocational registration. ^d Data provided by RRMA, but RRMA category unclear due to limitations in the concordance table used to match postcode areas into RRMA areas. **na** Not available.

Source: Productivity Commission estimates.

Regionally disaggregated data were available for the FaCS/Centrelink programs, enabling the Commission to estimate the administrative costs per GP on a regional basis (figure 5.3). In the case of FaCS/Centrelink programs, administrative costs per GP could be expected to differ across regions, reflecting the ratio of social welfare claimants to GPs. Several different measures of the number of GPs are represented in figure 5.3 to take into account full-time and part-time work.

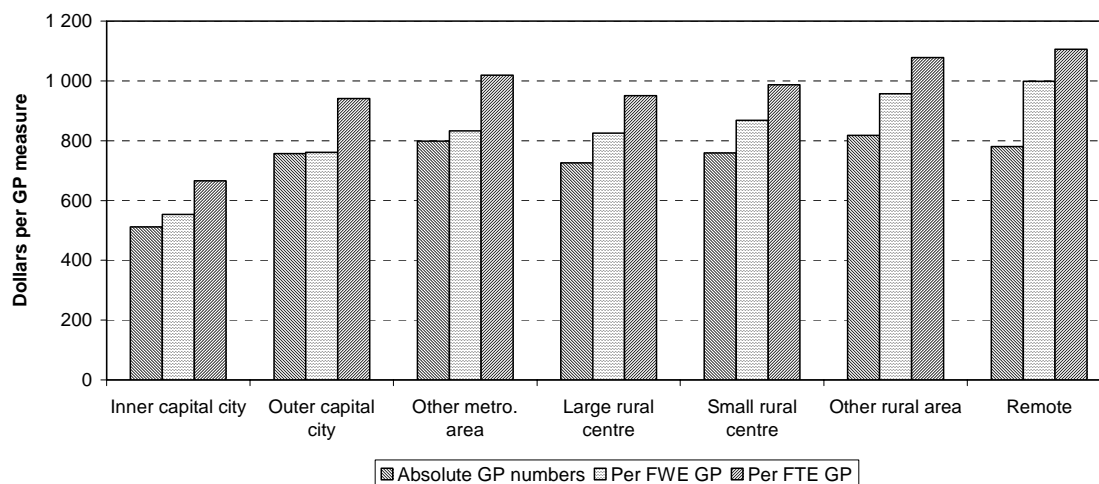
There appears to be a general trend to higher administrative costs per GP for FaCS/Centrelink programs as population density decreases. That is, costs are lowest in inner capital cities, higher in rural areas and highest in remote areas.

FINDING 5.5

Administrative costs per GP for the Department of Family and Community Services/Centrelink programs differ across regions. They are lowest in inner capital cities and highest in remote areas.

Regionally disaggregated data were also available for PIP accreditation. GP administrative costs for accreditation are incurred by each participating practice. Again there appears to be a general trend to higher administrative costs per GP for PIP accreditation as population density decreases (figure 5.4).

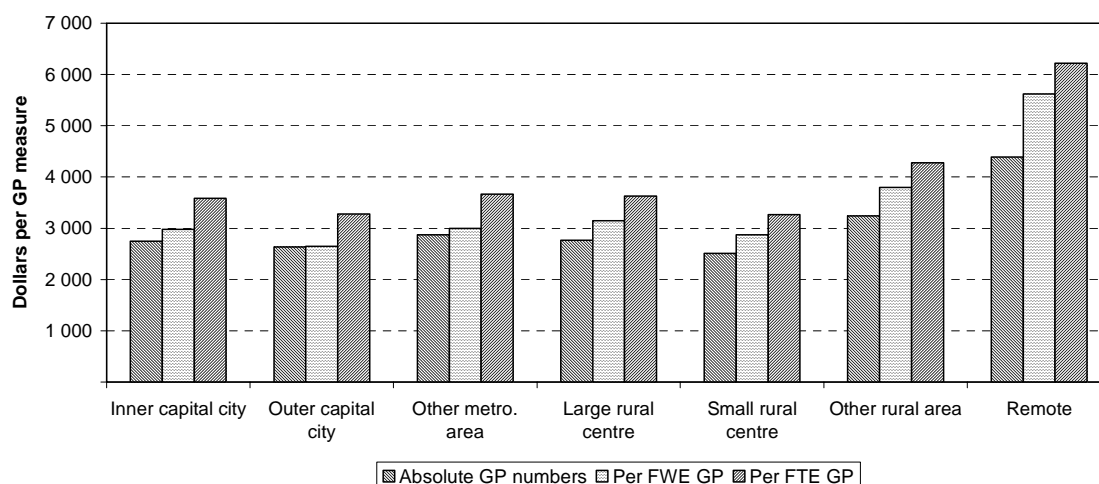
Figure 5.3 Administrative costs per GP for FaCS/Centrelink programs, by region, 2001-02^{a, b}



^a Data relate to the base case earnings, vocational registration and EPC assumptions. ^b Absolute GP numbers is the number of GPs who undertook more than 1500 total non-referred attendances in 2001-02. Numbers for full-time equivalent (FTE) and full-time working equivalent (FWE) GPs are calculated by dividing each GP's Medicare billing by the average billing of GPs who are deemed to be full-time in 2001-02 (the method adopted by DoHA). However, GPs who bill Medicare above the average billing rate are treated differently for each measure. For FTE numbers, GPs who bill Medicare above the average are counted as one. For FWE numbers, GPs who bill Medicare above the average are counted as the ratio of their billing to the average. (For example, a GP who bills Medicare for twice as much as the average is counted as two.)

Data source: Productivity Commission estimates.

Figure 5.4 Administrative costs per GP for PIP accreditation, by region, 2001-02^{a, b}



^a Data relate to the base case earnings, vocational registration and EPC assumptions. ^b An explanation of how absolute GP numbers, FTE and FWE GPs are calculated is included in figure 5.3 (note b).

Data source: Productivity Commission estimates.

The number of GPs per practice in other rural and remote areas is generally lower than for practices in other areas. In addition, rural and remote practices might also be more likely to participate in PIP due to the rurality loading provided under the program, which allows for payments to increase with the extent of remoteness (DoHA, sub. 23, p. 7). The higher participation rates by rural practices, together with the smaller number of GPs per practice, are likely explanations for the higher cost of accreditation per GP in other rural and remote areas.

The Commission also disaggregated the estimates for some other programs (such as Pharmaceutical Benefits Scheme authorisations and EPC care plans, case conferences and health assessments). For these programs there were no obvious trends in the estimates across regions.

Administrative costs per GP by socio-economic status

Administrative costs would also be expected to differ according to the socio-economic status of the population being serviced by the GP. Such variations are likely to be most evident for activities associated with the social welfare programs administered by FaCS/Centrelink. Recipients of social welfare support are more likely to live in lower socioeconomic areas.

Millward Brown Australia reported that GPs in the focus group discussions conducted for this study noted:

... in low income areas there generally is a large quantity of forms for disability pension, carer pension and medical certificates. These areas may also inherently have literacy and language issues, which require further support and time from the doctor in filling out their portion, as well as the patient's part of the applications. (2002a, p.14)

As for the regional analysis, the Commission was able to obtain data for some programs disaggregated according to the ABS Socio-Economic Indexes for Areas index of relative disadvantage (referred to here as SEIFA) (table 5.4). This index summarises, in a single measure, a large number of variables, such as low-income families, households renting public housing, unemployed people, people without educational qualifications and various other indicators of disadvantage. The lowest classification corresponds to areas that are the most disadvantaged, and the highest to the least disadvantaged.

Table 5.4 Total GP administrative costs, by SEIFA classification and department, 2001-02^a

\$'000

<i>SEIFA classification^b</i>	<i>DoHA</i>	<i>DVA</i>	<i>FaCS</i>	<i>Surveys</i>	<i>Total</i>
Data not provided by SEIFA	84 324	10 530	na	443	95 297
Unknown SEIFA ^c	732	2	119	na	853
Lowest	8 734	10	1 318	na	10 062
-4	11 733	38	1 576	na	13 347
-3	11 163	33	1 231	na	12 427
-2	9 827	43	946	na	10 816
-1	11 066	12	1 037	na	12 115
0	10 084	8	1 067	na	11 159
1	11 258	3	921	na	12 181
2	9 381	17	822	na	10 220
3	10 579	na	856	na	11 435
4	13 064	9	830	na	13 903
Highest	13 526	2	560	na	14 088
Total	205 471	10 707	11 283	443	227 903^d

^a Data relate to the base case earnings, vocational registration and EPC assumptions. ^b Eleven SEIFA categories were derived by DoHA by sorting postcodes into ascending order according to the value of the SEIFA index. Postcodes were then assigned into 11 groups, each with equal numbers. ^c Data provided by SEIFA, but SEIFA category unclear due to limitations in the concordance table used to match postcode areas into SEIFA areas. ^d Total for SEIFA does not equal the total for RRMA because of the DoHA data classification for the EPC program. **na** Not available.

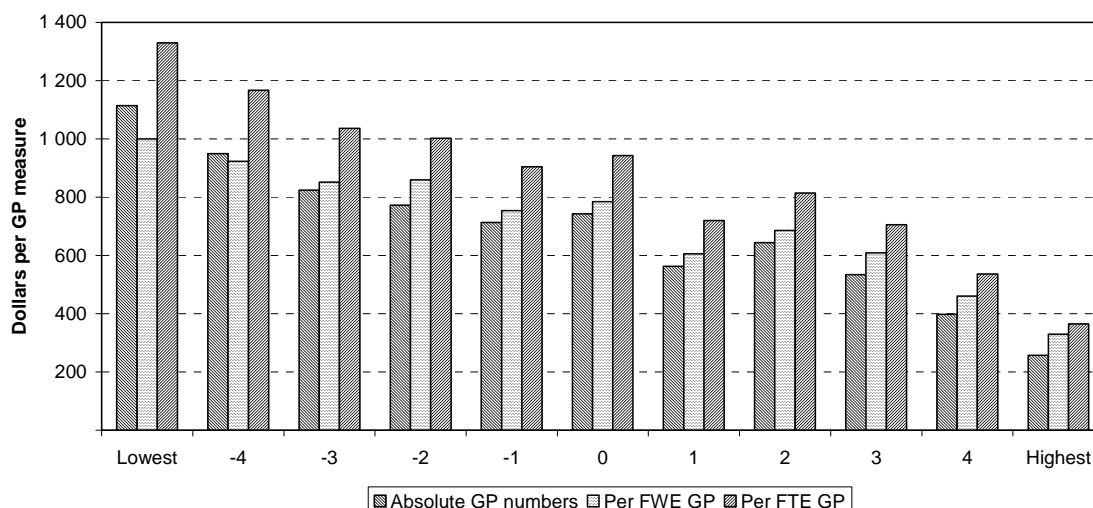
Source: Productivity Commission estimates.

Once again the analysis focused on FaCS/Centrelink programs for which such disaggregation was possible. The costs for other programs could not be disaggregated. The administrative costs per GP by SEIFA for FaCS/Centrelink programs are indicated in figure 5.5. The costs per GP are highest for those located in areas with a lower SEIFA index and vice versa. A plausible explanation is that GPs in these areas might have more patients who require them to complete FaCS/Centrelink forms. This result again indicates that the cost of complying with FaCS/Centrelink requirements is not uniform across all GPs, but varies depending upon the location of the practice. This conclusion cannot be extrapolated to other programs.

FINDING 5.6

Administrative costs per GP for the Department of Family and Community Services/Centrelink programs differ according to the socio-economic status of the population in the area in which GPs practise, increasing as the socio-economic status decreases.

Figure 5.5 Administrative costs per GP for FaCS/Centrelink programs, by socio-economic area classification, 2001-02^{a, b}



^a Data relate to the base case earnings, vocational registration and EPC assumptions. ^b An explanation of how absolute GP numbers, FTE and FWE GPs are calculated is included in figure 5.3 (note b).

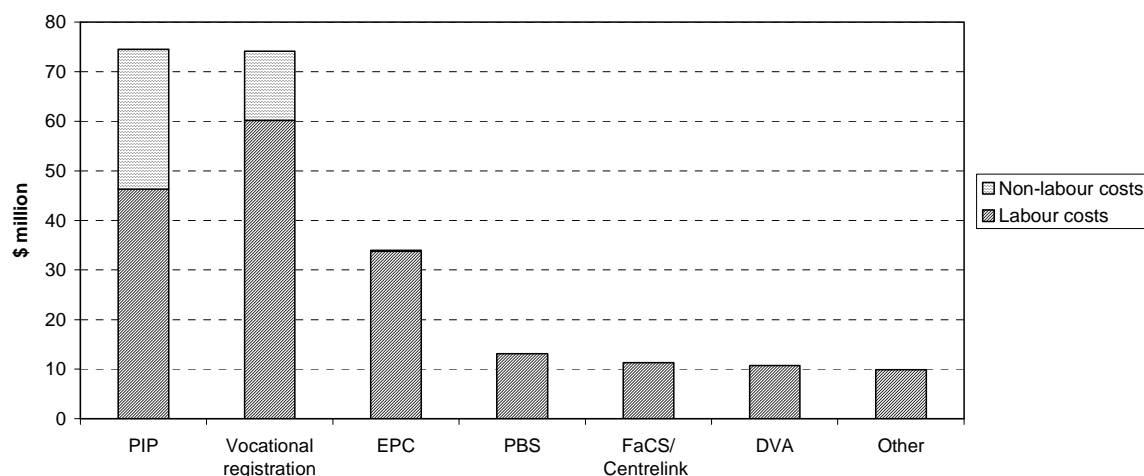
Data source: Productivity Commission estimates.

Components of GP administrative costs

Estimates of administrative costs can also be disaggregated into labour costs (for GPs, practice nurses, practice managers and reception staff) and non-labour costs (such as capital expenditure).

Labour costs dominate, accounting for about 81 per cent of the \$228 million total administrative costs (figure 5.6). For DVA programs, FaCS/Centrelink programs and Pharmaceutical Benefits Scheme authorisations, there are only labour costs. For most other programs, labour costs are at least three-quarters of total costs. The only exception is PIP, where non-labour costs are about 38 per cent of total costs. These costs are largely associated with PIP accreditation.

Figure 5.6 GP administrative costs for key programs by type of costs, 2001-02^a



^a Data relate to the base case earnings, vocational registration and EPC assumptions.

Data source: Productivity Commission estimates.

Comparing old and new FaCS/Centrelink forms

In September 2002, FaCS/Centrelink introduced a number of changes to the Disability Support Pension TDR and review TDR and the Medical Certificate for Newstart Allowance, Sickness Allowance and Youth Allowance. These changes were part of the Commonwealth Government's 2001-02 Budget package entitled *Australians Working Together — Helping People to Move Forward* (appendix B).

These changes related to the content and format of the forms, and are likely to have influenced the time taken to complete these forms. The Commission obtained some limited information from focus group discussions on the time taken by GPs to complete the new forms introduced by FaCS/Centrelink and estimated the resulting administrative costs with the two time estimates (table 5.5). In the absence of more recent data, the table show how administrative costs would have changed in 2001-02, if the number of forms stayed the same.

Although the data and results in table 5.5 are highly qualified due to the small sample of GPs and the limited time the new forms have been in place, the results indicate that the incremental costs of completing the new TDR for the Disability Support Pension have increased, compared with the previous forms. The costs associated with review TDRs appear to have decreased. The costs associated with the forms for Newstart, Youth and Sickness Allowances all appear to have increased.

Table 5.5 Comparison of annual GP administrative costs for selected FaCS/Centrelink forms, 2001-02^a

\$'000

<i>Program</i>	<i>Activity</i>	<i>Pre September 2002 forms</i>	<i>New forms</i>
Disability Support Pension	TDR	2 393 ^b	2 845 ^c
Disability Support Pension	Review TDR	2 176 ^d	1 418 ^e
Newstart Allowance	Forms ^f	3 203 ^g	3 924 ^h
Youth Allowance	Forms ^f	406 ^g	498 ^h
Sickness Allowance	Forms ^f	502 ⁱ	594 ^h
Total		8 682	9 279

^a Data relate to the base case earnings, vocational registration and EPC assumptions. ^b GP time per form estimated to be 17.22 minutes and receptionist time per form estimated to be 0.37 minutes. ^c GP time 20.5 minutes. ^d GP time 23.38 minutes and receptionist time 0.07 minutes. ^e GP time 15.2 minutes. ^f Medical Certificates and review Treating Doctor's Reports. ^g GP time 5.62 minutes. ^h GP time 6.9 minutes. ⁱ GP time 5.82 minutes.

Source: Productivity Commission estimates.

The changes in September 2002 might also result in a reduction in the number of forms completed in future years. FaCS/Centrelink changed the requirement for GPs to complete the review TDR for Newstart Allowance and Youth Allowance in September 2002. FaCS/Centrelink expects this to lead to a decrease of about 67 100 forms that GPs need to complete (sub. 19, p. 9).

The differences in cost estimates in table 5.5 only reflect differences in the estimated time taken to complete the forms, as the Commission has not been able to obtain recent data on the number of new forms that GPs have completed. If the number of forms for Newstart Allowance and Youth Allowance completed by GPs are reduced, this would be offset to some degree the increased time needed to complete the Medical Certificates.

5.3 Intangible costs

In addition to the measurable costs of these programs, there are also intangible costs arising from the stress and frustration involved in undertaking activities, such as providing medical information to departments about social welfare claimants (chapter 4).

A number of participants expressed concerns about the stress associated with completing forms. For example, the Far North Queensland Rural Division of General Practice commented on the effects of paperwork:

There is no doubt that the cost is not only monetary and in time, but also the psychological impact. One of the great frustrations of general practice is the paperwork. (sub. 9, p. 5)

Similarly, the Medical Board of South Australia commented that:

The administrative burden of 'paperwork requirement' is a source of complaint, the time it takes to meet these requirements is now beginning to seriously 'eat into' time which should be spent on patient care and consultations. If paperwork requirements are not met during normal consulting hours, these matters have to be attended to out of consulting hours, which contributes to 'burn out', ill health and stress related issues. (sub. 1, p. 1)

Dr Ratner also noted:

... having one's professional opinion assessed by a non-medical person via a form which has to be filled out using particular wording is demeaning and results in anger and frustration. It is not possible to measure psychological costs quantitatively but failure to take up some of the less complicated initiatives such as EPC items must reflect confusion on the part of GPs who are already doing the work anyway. (sub. 7, p. 1)

Another GP also reflected on the personal impact of paperwork requirements:

I am overburdened with paperwork as well as patients to the point that I don't enjoy my work half as much as I used to. I feel that some paperwork is necessary and I have to do that. We are taken for granted by a lot of people that our paperwork is just box ticking and signature and there is no responsibility associated to it so therefore just get the doctor to do it. That is wrong particularly in the days of medical litigation and personal responsibility. I find it very stressful. (Millward Brown Australia 2002a, p. 14)

Millward Brown Australia reported from focus group discussions with GPs:

Amongst GPs there were mixed perceptions of the burden placed on their profession by Commonwealth forms. Certainly, there were individuals who felt the forms were an enormous frustration while for others they were inconsequential and simply part of their responsibility. However, there was consensus in the feeling that Commonwealth forms were just one area of the various range of compliance tasks enforced upon GPs. The greatest frustration was the sheer number of forms for every type of government program. (Millward Brown Australia 2002a, p. 13)

However, most GPs in the focus group discussions (95 per cent) considered that the paperwork associated with government policies and programs had increased over the last two years.

In the discussions, GPs were asked qualitative questions about selected forms they encounter. Although GPs considered these forms were a minor part of overall government requirements, they considered there were areas of significant frustration relating to the processes and forms themselves (Millward Brown Australia 2002a, p. 4). In relation to individual forms, GPs expressed the most frustration with the FaCS/Centrelink's Disability Support Pension TDR and review TDR, with about 80 per cent of GPs considering them 'fairly' to 'very frustrating' (table 5.6).

Table 5.6 Qualitative information from GPs on selected forms^a

Form	Sample size	Time spent completing form		Level of difficulty		Level of frustration	
		Somewhat to very reasonable	Somewhat to very unreasonable	Fairly to very	Not very to not at all	Fairly to very	Not very to not at all
	no.	%	%	%	%	%	%
FaCS/Centrelink forms							
DSP TDR							
Pre-Sept 2002 form	33	30	70	64	36	85	15
New form	29	31	69	76	24	76	24
DSP review TDR							
Pre-Sept 2002 form	21	19	81	71	29	95	5
New form	9	44	56	44	56	44	56
Medical Certificate ^b							
Pre-Sept 2002 form	41	78	22	20	80	24	76
New form	13	62	38	15	85	62	38
Carer allowance ^c	3	33	67	67	33	67	33
Carer payment/allowance ^d	8	100	0	13	88	13	88
DVA forms							
Disability Pension Claim Form	5	20	80	60	40	60	40
GARP forms	15	53	47	47	53	67	33
DoHA forms							
PBS/RPBS authorisations ^e	62	72	28	14	86	36	63
ACIR immunisation notification	24	83	17	0	100	8	92
Hearing services application	4	100	0	0	100	0	100

^a Abbreviations listed at the front of the report. ^b For Sickness Allowance, Newstart Allowance and Youth Allowance. ^c Where the person being cared for is aged less than 16 years. ^d Where the person being cared for is aged 16 years or over. ^e Pharmaceutical Benefit Scheme or Repatriation Pharmaceutical Benefit Scheme.

Source: Unpublished data from Millward Brown Australia (2002a).

Some GPs considered the TDR ‘to have little value, thus increasing the frustration with having to fill it out’ (Millward Brown Australia 2002a, p. 23). Over two-thirds of the focus group GPs also considered that the time spent completing these forms was ‘somewhat’ to ‘very unreasonable’ and more than half of them considered the forms ‘fairly’ to ‘very difficult to complete’. In contrast, 92 per cent of the focus group GPs considered that DoHA’s ACIR immunisation notification to be ‘not very’ or ‘not at all frustrating’ and all GPs considered it ‘not very’ or ‘not at all difficult to complete’.

GPs appear to consider that the new Disability Support Pension TDR is more difficult to complete than the previous one. In contrast, the level of frustration associated with the new form appears to be lower and views on the time spent to complete the two forms were similar. The new forms were introduced only two

months before the focus group discussions, so GPs might not have been as familiar with the new forms.

While participants' comments on intangible costs have tended to focus more on requirements to complete forms, some participants also have strong views on other programs, such as PIP.

The Australian Medical Association argued that issues arising from linking accreditation and PIP:

... contributed to a significant level of stress, frustration and administrative work by GPs and their representative groups to seek solutions. (sub. 13, p. 19)

As discussed above and later in chapter 6, some GPs have indicated growing frustration and stress associated with:

- completing forms and undertaking administratively complex program requirements;
- the increasing accumulation of forms and programs (section 6.3); and
- facing conflicting priorities (section 6.6).

FINDING 5.7

Intangible costs arise from stress and frustration experienced by GPs in completing forms and meeting program requirements, but they are difficult to quantify and have not been included in the Commission's estimates.

6 Reducing GP administrative costs

Under the terms of reference, the Commission is required to report on ways to reduce administrative costs to general practitioners (GPs), having regard to the overall objectives of the relevant Commonwealth Government programs and the benefits to consumers. In this chapter, the Commission highlights the main issues faced by GPs relating to administrative costs, and provides recommendations on ways in which the Commonwealth might be able to reduce these costs.

As discussed in chapter 5, the Commission's estimates of GP administrative costs are large for some programs, such as Practice Incentives Program (PIP), vocational registration and Enhanced Primary Care (EPC). Such programs have been designed to 'support the provision of high quality general practice services to the community' (Department of Health and Ageing, sub. PR43, p. 1). The activities that result in the bulk of GP administrative costs are an integral part of these programs, although some paperwork may also be required.

Typically, these programs have been either developed by the Department of Health and Ageing (DoHA) in consultation with GPs, or by GP representatives with DoHA support. DoHA encourages GPs to participate in each program by offering them rebates or incentive payments (sub. PR43).

Some participants have raised concerns about the PIP and EPC programs in particular. The Australian Medical Association (AMA) commented, in relation to PIP, that:

There is no doubt that the costs and complexities are contributing to a rejection of PIP altogether by general practice, particularly noticeable when the link to accreditation was established. ... The constant theme has been that PIP is just too costly and complex and just not worth the trouble. For example, one practice 'ditched' PIP after calculating that administration costs were likely to swallow \$25 000–\$30 000 of gross income about the same amount the practice estimated it would earn with PIP. (sub. 13, p. 8)

In relation to EPC, Campbell Research & Consulting stated that the main concern of a number of GPs interviewed for the case studies was that the activities:

... are complex to set up and to carry out, and require developed systems and procedures that are more accessible to larger, urban practices. (2003, vol. 1, p. 20)

The Commission found it difficult to identify ways to reduce GP administrative costs for these programs that potentially would not impinge on their underlying objectives. Indeed, an analysis of whether GP administrative costs could be reduced for these programs would involve considering whether there are more effective and efficient ways to achieve their objectives, such as modifying the systems, procedures and standards for each program. However, such an evaluation was not within the Commission's terms of reference. Instead, the Commission has made recommendations on ways in which the issues raised by participants could be more effectively taken into account in program evaluations and review processes.

Some other recommendations focus on programs with relatively low estimates of GP administrative costs. As noted in chapter 5, however, these programs (such as completing forms for clients of the Department of Family and Community Services (FaCS)/Centrelink) are a significant source of frustration and stress.

In making its recommendations, the Commission is making no judgments about the net benefits to the community from the programs covered in the study. As discussed in chapter 1, this report is not about evaluating the costs and benefits of the programs covered.

The recommendations for reducing GP administrative costs relate to a number of broad areas:

- assessing program costs and benefits;
- remunerating GPs;
- monitoring cumulative GP administrative costs;
- improving information collection;
- using information technology; and
- addressing conflicting priorities facing GPs.

6.1 Assessing program costs and benefits

It is good practice to assess the costs and benefits of both new and ongoing programs, to ensure that they deliver net benefits overall. Programs that impact on GPs result in an increased use of resources, which ultimately need to be recovered through Medicare rebates, incentive payments or patient co-payments. From a community-wide perspective, it is important that the benefits to the community from a program are compared to the costs of all resources consumed to implement it. This principle holds, whether it is the government, the profession or both that are responsible for introducing the program.

Assessing the costs and benefits of a program might have additional advantages, including:

- suggesting ways to reduce the costs associated with the program, which might in turn encourage participation in the program; and
- assisting departments to set an appropriate level and structure of remuneration, if remuneration is involved (as it is for some of the programs covered in this study).

New or amended Commonwealth programs involving regulation are usually accompanied by a Regulation Impact Statement (RIS). The RIS process is intended to improve the quality of regulations by ensuring that new and amended regulations achieve their objectives in an effective and efficient manner (PC 2002). To achieve this, a RIS will include an assessment of the benefits and costs of regulation for businesses, where the costs include the costs to businesses in complying with and/or reporting on regulatory requirements (ORR 1998).

However, a RIS is not required for programs:

- that are voluntary or where there is no expectation by the Government that business should comply with these programs; or
- where the Government provides financial incentives to encourage participation or compliance.

As most of the programs covered in this study are voluntary and GPs are remunerated for their participation (section 1.1), RISs have not been required.

FINDING 6.1

Many programs within the scope of this study are voluntary, with GPs (or general practices) being remunerated for participation. Departments and agencies have accordingly not been required to prepare a Regulation Impact Statement in developing these programs.

Program evaluations are another mechanism for assessing the benefits and costs of Government programs. While such program evaluations are not compulsory, departments are nevertheless expected to evaluate new and existing programs. The performance management framework endorsed by the Commonwealth Government emphasises the need for evaluation and ongoing performance monitoring (Mackay 1998). In addition, chief executives are required under the *Financial Management Accountability Act 1997* to manage a department in a way that promotes efficient, effective and ethical use of Commonwealth resources.

To the best of the Commission's knowledge, however, most departmental evaluations of the programs covered in this study have not included the costs of resources used by GPs to fulfil the requirements of the program when assessing costs. This would suggest that such evaluations have not been undertaken from a community-wide perspective that would reveal whether a program has a net benefit for society as a whole.

FINDING 6.2

Departments and agencies seem to give little or no consideration to GP administrative costs in their evaluations of most of the programs covered in this study.

For a comprehensive assessment of costs and benefits, GP administrative costs should be included regardless of whether:

- departments remunerate GPs; or
- whether participation by GPs in programs is voluntary.

The Commission's experience, described in chapter 5, indicates that it can be difficult to estimate GP administrative costs. Nevertheless, unless these costs are insignificant, it is worth persevering with measurement, to ensure that the program's objectives are being achieved effectively and efficiently.

Estimating such costs could be done using a method similar to that used by the Commission in chapters 4 and 5. It would be inappropriate, as a short cut, to use departments' payments to GPs for participating in the program as a proxy for administrative costs. This point has been made by Drummond et al. in the context of evaluating health programs:

... cost refers to the sacrifice (of benefits) made when a given resource is consumed in a program or treatment. Therefore, it is important not to confine one's attention to expenditures, but to consider also resources, the consumption of which is not adequately reflected in market prices [program payments] ... (1999, p. 54)

Estimates of GP administrative costs could be informed by discussion with GP organisations. According to DoHA, it does consult with GP organisations, on an ongoing basis, in relation to programs such as PIP, the EPC and the General Practice Immunisation Incentives scheme, although there are no formal processes in place to discuss administrative costs (pers. comm., 19 December 2002).

FINDING 6.3

Although departments and agencies appear to consult with GP organisations about the details of programs, there appears to have been little discussion on the likely nature and magnitude of GP administrative costs.

When conducting program evaluations (for programs within the scope of this study), departments and agencies should include GP administrative costs associated with participation in the program (regardless of whether GPs are explicitly remunerated or their participation is voluntary), unless they can show that these costs are insignificant. Estimates of these costs should be developed after discussions with GP organisations.

As noted above, GP administrative costs do not appear to have been included in evaluations of programs affecting GPs, including the three programs for which these costs are particularly large (PIP, vocational registration and EPC). This would suggest a case for reviewing these administrative costs. Indeed, DoHA appears to have accepted that there is a case for revisiting some sources of administrative costs:

... there have been some concerns raised about the complexity of these items, and ... it is important for this department to work closely with professional groups to resolve this issue. (sub. PR43, p. 2)

However, as noted earlier, administrative costs are often integral to the program with which they are associated, and as such probably cannot be altered without affecting the capacity of the program to achieve its objectives. This suggests that a review of these costs would need to be incorporated in a review of the program as a whole.

Conducting such reviews is, however, beyond the terms of reference for this study. The Commission's view is therefore that the best way forward is for DoHA to undertake evaluations of PIP, vocational registration and EPC.

The Department of Health and Ageing should conduct program evaluations (accounting for the administrative costs to GPs) of the Practice Incentives Program, vocational registration, and Enhanced Primary Care program.

6.2 Remunerating GPs for providing medical information

Participants have raised issues about differences in the ways GPs are remunerated for providing medical information to Department of Veterans' Affairs (DVA) and FaCS/Centrelink, as described in section 3.5.

To summarise, DVA sets the remuneration level and structure (including payments on a per page basis), funds the payments out of its own budget and uses the Health Insurance Commission (HIC) to administer its payments. On the other hand, GPs are permitted to claim for a standard Medicare billing item where they complete a FaCS/Centrelink form during a medical consultation.

FINDING 6.4

The Department of Family and Community Services/Centrelink and the Department of Veterans' Affairs differ in their approach to remunerating GPs for similar tasks, particularly in relation to the preparation of medical reports.

Who should fund payments?

The fact that FaCS/Centrelink does not pay explicitly, and that GPs can claim under a standard Medicare consultation, creates confusion amongst GPs about whether they are paid for completing FaCS/Centrelink forms. The Osborne Division of General Practice, for example, noted that:

The amount of paperwork is not excessive, it's just that Centrelink will not pay GPs to complete it. (sub. 8, p. 2)

One GP in the focus group discussions noted that: '[Centrelink] pay us nothing' (Brisbane, 15 November 2002). Similarly, GPs attending the focus group discussions were confused as to whether they are eligible for a Medicare rebate. One GP had informed patients that they 'have to be charged this privately because it's illegal to charge Medicare' (focus group discussion, Bendigo, 11 September 2002).

On the other hand, others considered that they were eligible for a Medicare rebate: 'if you do something medical in that consultation, and you've done the Centrelink form, it's not illegal to [charge Medicare]' (focus group discussion, Bendigo, 11 September 2002). Another GP in the same focus group discussion remarked: 'you can't charge for filling in a medical report for Centrelink, and it's only relevant if you check the blood pressure ...'.

FINDING 6.5

There is confusion among some GPs regarding eligibility for payment to complete Department of Family and Community Services/Centrelink forms.

FaCS argued that the different ways GPs are remunerated (appropriately) reflect differences between the departments in their rationale for providing benefits to their clients:

... it is important to note that DVA payments are in the nature of compensation for injury arising from war service for which the Government has accepted responsibility. In providing social security payments the Commonwealth is not assuming a compensatory role, rather it is providing a safety net to people who are in need of support. (sub. PR37, p. 1)

Regardless of these different rationales, GPs perform similar tasks for each department, providing detailed medical information so that the relevant department can assess eligibility for benefits. Thus, in the Commission's view, the underlying rationale for the payment is irrelevant to whether an individual department makes explicit payments to GPs for completing forms required under its programs. The Government has already made an implicit decision as to who should pay — the Government rather than the patient in most instances. In the case of DVA, the Government meets all the costs. In the case of FaCS/Centrelink, the Government meets most of the costs, as GPs generally bill Medicare for consultations involving the completion of forms.¹

Given that the Government has largely assumed responsibility for remunerating GPs for providing medical information, it would be appropriate for departments seeking the information to pay GPs from their own budgets. This approach would encourage departments to constrain administrative costs imposed on GPs as it would strengthen their incentive to take these costs into account. In response to clear incentives, for example, a department might reduce the amount of information sought or expand the use of information technology to collect the information. As well as internalising the administrative costs within departments, it might also limit cost shifting to GPs or to other departments.

Thus, FaCS/Centrelink, like DVA, should fund GP remuneration arrangements out of its own budget, rather than relying on GPs to charge Medicare for a standard consultation. Administration could still be undertaken by HIC on behalf of FaCS/Centrelink, as currently applies to the administration of DVA payments.

RECOMMENDATION 6.3

To the extent that the Government chooses to remunerate GPs for providing medical information, the relevant department or agency should fund the payments out of its own budget.

¹ In some cases, GPs might also receive a co-payment from patients. As FaCS noted: 'GPs also receive the "gap" from patients where they do not bulk bill' (sub. PR37, p. 1).

Should payments be uniform across departments?

Another issue relates to the payment structures adopted by departments. As discussed in section 3.5, GPs generally receive 85 per cent of the Medicare Benefits Schedule fee for consultations in which they complete a FaCS/Centrelink form. However, they receive 100 per cent of the Medicare Benefits Schedule consultation fee and an amount per page for completing DVA forms. The question arises as to the efficiency of each approach.

A payment arrangement, such as that applied by DVA, that separates payment for forms and payment for consultations would enable GPs to complete forms outside of normal consultation hours and receive a payment for the form, consequently increasing the time available for direct patient care.

Overall, a well designed payments structure has the potential to promote both departmental efficiency and the efficient provision of high quality information by GPs. Many factors might influence the appropriate payment structure so it need not be the same between departments.

RECOMMENDATION 6.4

Consistent principles for remunerating GPs should be adopted between (and within) departments and agencies. This does not require identical payment schedules.

Implications for government expenditures

Adopting consistent remuneration arrangements and ensuring that departments bear their own costs would have budgetary implications for individual departments. For example, if FaCS/Centrelink were to adopt remuneration arrangements similar to those of DVA, its expenditure would need to increase to fund both consultations and additional payments (such as payments per page).

This increase in expenditure might be offset to the extent that the new incentives encourage FaCS/Centrelink to find cost savings by reducing GP administrative costs (such as decreasing information requirements or expanding the use of information technology to collect the information).

The increase in FaCS/Centrelink expenditure would be partially offset by a decrease in DoHA's expenditure on Medicare. The decrease in DoHA's expenditure would depend on the number of GPs currently claiming a consultation fee for completing these forms.

The aggregate budgetary impact for the Government as a whole would depend on the balance of these factors.

6.3 Cumulative GP administrative costs

GPs face cumulative administrative costs when participating in Commonwealth Government programs, reflecting a large number of programs administered within and across departments. As the Australian Divisions of General Practice noted:

The problem of uncoordinated implementation of programs is one not only between departments, but within departments. Since 1999 GPs have experienced the introduction of at least 40 new item number services (that is EPC, PIP, SIP, DMMR, Mental Health, Discharge Planning etc). (sub. PR40, p. 5)

Many Commonwealth policies and programs impact specifically on GPs and on the ways general practices are managed and operated — the Commission has identified 43 programs that fall within the scope of this study. These programs are administered by a number of Commonwealth Government departments, and have a cumulative effect on GPs.

FINDING 6.6

Departments and agencies appear to implement their programs independently, with little consideration given to the cumulative level of GP administrative activity and costs created by these programs.

Although GPs might find the administrative costs of complying with individual programs reasonable, the cumulative effect of all programs might be significant. GPs have indicated a growing frustration with the increasing accumulation of GP administrative activities and costs as new programs are added to existing ones. As Campbell Research & Consulting noted:

There is a cumulative effect of paperwork on GPs' frustration levels. Each paperwork activity may be justified and would not raise much concern by itself. However when added together, GPs feel that they spend an increasing amount of time away from what they see as their core function, patient clinical care. (2003, vol. 1, p. 11)

Similarly, Millward Brown Australia noted:

... there were serious areas of frustration relating to various processes and forms and the ongoing proliferation of forms of every type from all agencies was seen to be the core issue for GPs. (2002a, p. 4)

One of the GPs in the Bendigo focus group discussion stated:

I think that some of the big problems is that we get a lot of surveys. Most of the surveys we receive we are never actually asked whether we would like to receive the survey in the first place ... (11 September 2002, p. 25)

FINDING 6.7

Even if the GP administrative costs associated with an individual program might be considered small, the cumulative impact of all programs can be large. This appears to have led to frustration among GPs.

A possible mechanism for constraining the increasing cumulative costs is to establish a departmental coordination group, consisting of representatives of those departments responsible for administering programs impacting on GPs, such as DoHA, DVA, FaCS/Centrelink and the HIC.

This group could facilitate communication across the relevant departments, and consult with GP organisations where required, with the aim of:

- encouraging departments, when developing new (or evaluating existing) programs, to consult with GPs (or their organisations) regarding the potential magnitude and impact of GP administrative costs (section 6.1); and
- monitoring, and reporting publicly on, the expected cumulative impact on GPs of administrative activities and costs across Commonwealth programs, ensuring that only the minimum necessary requirements to achieve each program's objectives are implemented.

DoHA could be responsible for reporting publicly, in its annual report, on the cumulative impact on GPs of administrative activities and costs across Commonwealth Government programs.

RECOMMENDATION 6.5

A departmental coordination group should be established to monitor changes in cumulative GP administrative costs over time. The Department of Health and Ageing should report these costs publicly.

While this study focuses on Commonwealth policies and programs, non-Commonwealth programs also generate GP administrative costs and might be a source of frustration to GPs. As Millward Brown Australia noted:

... Commonwealth forms were just one area of the various range of compliance tasks enforced upon GPs. The greatest frustration was the sheer number of forms for every type of government program.

... GPs most wanted to communicate ... that [Commonwealth forms were] just one small area and simply another addition to the various other types of programs, legal requirements and compliance matters GPs must undertake to meet regulations and ensure they are providing a valuable service to their patients. (2002a, p. 13)

Similarly, Campbell Research & Consulting noted:

One has to add the activities relating to State-specific programs, information sent by GPs' representative organisations ..., and professional journals to the activities necessary to comply with the Commonwealth programs examined for this research project. (2003, vol. 1, p. 11)

The requirements of State, Territory and local government policies and programs are outside the scope of this study. Nonetheless, the coordination group should recognise the cumulative costs associated with programs across all levels of government.

The AMA supported this view:

... the Productivity Commission notes that in assessing the cumulative administrative costs and activities there are also State and Territory, and local government policies and programs that should be recognised ... AMA acknowledges the limitations of the Productivity Commission's terms of reference for this current study. However, the recommendations of the Productivity Commission must be implemented in a manner that recognises and takes account of the non-Commonwealth programs and policies that contribute to overall compliance and administrative costs. (sub. PR36, p. 1)

Assessing the cumulative costs of programs across all levels of government would not be straightforward. Nonetheless, the Commonwealth Government's leadership in establishing a coordination group to consider cumulative costs might demonstrate the benefits of such an approach to other levels of government.

6.4 Information collection

GPs have raised issues regarding the way information is collected by Commonwealth departments, particularly regarding the completion of forms. These include:

- unnecessary repetition across forms and activities;
- duplication of surveys;
- lack of clarity and simplicity in the design and wording of some forms;
- frequent changes, leading to confusion, for example, as to which are current forms;
- lack of input from GPs into designing forms;
- lack of relevance of questions in forms; and
- lack of feedback about completed forms (box 6.1).

Box 6.1 Comments on information collection

Unnecessary repetition across forms and activities

Examining FaCS/Centrelink forms, GPs in the focus group discussions stated:

They're increasing in length and in the good old days, they were always the same so you copied them every three months, but then they're changing them ... The forms are very repetitive ... You just keep filling the same form out, or a different version, same questions. (Bendigo, 11 September 2002, p. 4)

Other GPs questioned the objectives of several different types of forms, originating from one department. Commenting on the DVA forms, Millward Brown Australia noted:

The set of forms ... were perceived as repetitive, with a number of GPs not necessarily understanding the difference in objective between each of the Medical Report, Medical Impairment Assessment and Diagnostic Report. (2002a, p. 67)

GPs consider that some activities are repetitive. Regarding the ongoing Pharmaceutical Benefits Scheme (PBS) authorisation for prescribing restricted medication for an unchanging chronic condition, Millward Brown Australia noted:

The procedure of gaining authority from the HIC for a repeat script was raised as a frustration amongst a number of GPs ... especially where chronic or terminal illnesses are concerned. (2002a, p. 87)

GPs also commented on the inefficiencies of regularly completing Treating Doctor's Report (TDR) forms for patients with permanent disabilities (Millward Brown Australia 2002a, p. 29).

Duplication of surveys

Commenting on the requirements of the divisions of general practice (some of which are undertaken under the auspices of the Commonwealth Government), the AMA noted:

Another is whether [the divisions' monitoring and evaluation requirements] represents duplication, particularly when seen in the context of the overall amount of surveying of GPs undertaken by the Australian Bureau of Statistics, the Commonwealth health portfolio and a range of other Commonwealth departments. (sub. 13, p. 23)

The AMA also stated that during a forum on surveys of doctors (in August 2002), representatives from government departments 'recognised and acknowledged the problems of duplication of survey questions both across and within departments' (sub. 13, p. 26).

Lack of clarity and simplicity in form design

Some GPs find it difficult to complete certain forms quickly and efficiently because of the lack of simplicity in the form design. Concerns regarding poor form design were echoed in a review of six forms undertaken for the Commission by a professional editor (Doyle 2002). The forms fall short of best practice in a number of ways, including:

The forms are not standardised in terms of their overall look, font sizes and styles ... [making it] difficult to read ... The forms are not written in plain, simple and grammatical English ... [The] words 'doctor', 'treating doctor', 'practitioner', 'medical practitioner', and 'provider' are used interchangeably ... distracting for the reader ... (Doyle 2002, pp. 2–3)

(Continued next page)

Box 6.1 (continued)

Frequent changes to forms

Dr Merrington stated that a major cause of confusion caused by immunisation forms and new published immunisation schedules, is the absence of a clearly marked date of printing, raising the question of whether the forms are current (sub. 24, p. 1).

Millward Brown Australia noted that there was significant confusion and uncertainty amongst GPs about the new FaCS/Centrelink forms and whether older versions would still be accepted. Further, some GPs felt that these forms changed too frequently (2002a, p. 19).

Lack of input from GPs into form design

A number of GPs commented on the lack of opportunity to provide input into designing forms. According to the Australian Divisions of General Practice:

... there is resentment and frustration among GPs that their expertise is apparently not valued, and their opinion or feedback frequently questioned by non-clinical clerical staff. Ensuring GP input into the design of such forms may resolve some of these issues. (sub. 22, p. 6)

The Osborne Division of General Practice stated:

It is important that GPs ... have input into the design of forms. (sub. 8, p. 2)

Lack of relevance of questions

The relevance of certain questions in forms is an issue raised by some GPs. A GP in one of the focus group discussions commented (in relation to FaCS/Centrelink forms):

... for some of the questions ... they specifically ask in these forms 'Is the disability permanent?' — you tick 'yes'. Yet three months later you've got the same form again for the same patient, which really contradicts the purpose of the form. (Bendigo, 11 September 2002, p. 7)

Another GP in the focus group discussions stated that:

In my personal opinion the Sickness Benefit ... ask really strange questions. Inappropriate. And you try to fit your patient's thing to the questions they ask. (Wantirna, 10 September 2002, p. 10)

Lack of feedback from departments

Some GPs indicated that they would like to receive some feedback on how the information they provide on forms is used by departments. Regarding the TDR, Millward Brown Australia noted that:

The general lack of communication to the GPs from Centrelink about their processes, expectations and feedback in relation to patients has created a devaluation of the TDR ... [leading] to a decreasing amount of information and quality of reporting through the form. (2002a, p. 25)

Commonwealth departments do not seem to apply a common, ‘standard’ approach when collecting information from GPs. As an illustration, the Commission compared FaCS/Centrelink’s Disability Support Pension Treating Doctor’s Report (TDR) with DVA’s Claim for Disability Pension form (box 6.2). The type of information and the detail required from GPs varied between these two forms.

Further, the processes in place for requesting information differs between the two forms. In the case of FaCS/Centrelink, the GP completes a six-page form, which provides information about the patient’s medical condition. In the case of DVA, the GP is required to provide a provisional diagnosis on a condition and, in some cases, might be required to complete additional forms from DVA seeking more specific information on some medical conditions.

Box 6.2 Illustrative comparison of two forms

Information required from GPs

FaCS/Centrelink’s Disability Support Pension Treating Doctor’s Report^a

The GP provides:

- clinical details, including information on diagnosis, related medical history, current symptoms, treatment (current, past and planned) and impact on the patient’s ability to function;
- additional information, including any other medical condition that causes limited impact on the patient’s ability to function and other relevant specialist reports; and
- certification of the information.

DVA’s Claim for Disability Pension form

The GP provides:

- information on the medical diagnosis; and
- when the veteran first consulted the GP for this condition.

The veteran provides information on the disability in question, and the related signs and symptoms.

The GP is required to provide more information on FaCS/Centrelink’s form than on DVA’s form. However, DVA might request further information from the GP on some medical conditions using additional forms, such as:

- medical impairment forms (for various conditions);
- diagnostic reports (for various conditions); and
- medical reports (for various conditions).

^a Form introduced in September 2002.

In some instances, differences in data collected might be due to information requirements prescribed in legislation.

FINDING 6.8

There does not appear to be a standard approach by departments and agencies to designing forms and collecting information from GPs.

Improving information collection

Some departments have implemented processes to address concerns about the varying, and often poor, standards applied to form design. In 2000, FaCS/Centrelink established a working group consisting of representatives from FaCS/Centrelink, the AMA, Royal Australian College of General Practitioners (RACGP) and DoHA. The group's responsibilities included examining the goals of the TDR and the role of GPs, examining options to streamline the medical assessment process, and considering possible quality assurance mechanisms (sub. 19, p. 4).

FaCS, in discussing the need to improve clarity of the TDR, noted:

The working group noted that often there was a lack of transparency in questions contained in the TDR, and that the complexity of the forms made them difficult to complete. ... changes were made to the format of the TDR in response to issues raised at the working group. (sub. 19, p. 5)

Recommendations of this working group were adopted in the revised TDR and other forms introduced in September 2002.

Doyle (2002) suggests ways to improve the clarity and simplicity of certain forms (appendix E). Implementing these could help GPs to complete forms more quickly, accurately and efficiently, and enhance departments' ability to collate the responses.

Informing GPs about the purpose of certain forms and activities should reduce the frustration felt by GPs, provided that the information itself is not so extensive as to be perceived by GPs as unhelpful rather than useful. FaCS/Centrelink recently identified a number of strategies to address this issue, such as:

- writing to GPs advising them of the forthcoming changes to forms;
- providing an information kit to explain the purpose and meaning of questions on the TDR and FaCS/Centrelink medical certificates; and
- providing a helpline and email address dedicated to GPs to answer their questions about the new forms and processes (sub. 19, p. 7).

Apart from improving GPs' understanding of the processes of certain forms and activities, there might also be some benefits from training departmental staff, as suggested by Mavis Hoy:

The distinction between medical evidence and medical opinion is significant. Departmental officers might benefit from training to better recognise the basis of their requests for information. (sub. PR38, p. 1)

Departments should also look for ways to reduce duplication of information collection, by examining whether existing data sources can replace information currently collected from GPs. For example, FaCS/Centrelink no longer requires the TDR for the Disability Support Pension when sufficient information is available from other sources (for example, customers who are blind and do not have any other medical conditions, are able to provide a report from an ophthalmologist) (sub. 19, p. 6). There might also be scope to reduce the information required from GPs in certain FaCS/Centrelink forms — especially if each patient is linked to a FaCS/Centrelink identification number. Thus, for a patient receiving a specific allowance on an ongoing basis, the GP might only need to provide an identification number in the section of the form relating to the patient's medical history. The onus would then be on FaCS/Centrelink to use this identification number to access stored patient medical history (collected from past forms) from its database.

The AMA pointed out that when using existing data sources, departments need to be aware of patient confidentiality (sub. 13, p. 26). The *Privacy Act 1988* includes principles that govern the conduct of Commonwealth departments in the collection, management and use of data containing personal information.

Although some improvements to information collection and form design have been implemented, guidelines could usefully be developed to assist departments to standardise their information collection and form design as a whole. This would help to constrain administrative costs by encouraging departments to:

- assess what information needs to be collected, and whether there are other available data sources;
- assess whether or how often it is necessary to repeat the collection of information;
- assess the most appropriate method of information collection (for example, by computer, telephone, paper or a combination of these);
- assess the types of questions to include in a form and how to structure them to ensure they are clear and precise; and
- test the forms on GPs and incorporate, where appropriate, their feedback.

The task of developing these guidelines could be assigned to a particular department (such as DoHA), which would liaise with other relevant departments and GP organisations when required.

RECOMMENDATION 6.6

A set of guidelines should be developed (possibly by the Department of Health and Ageing) to facilitate, when appropriate, the standardisation of information collection and form design across departments and agencies.

6.5 Use of information technology

Commonwealth and State governments have been facilitating the adoption of information technology. Some strategies are aimed at the ‘whole of government’ level, encompassing many businesses and departments, whereas others focus specifically on GPs.

DoHA has made available up to \$9 million to the General Practice Computing Group (GPCG) for the period 2001-02 to 2003-04 to encourage standards development, the practical use of information management to support initiatives relating to chronic disease management and other GPCG projects (GPCG 2001). The Government also provided \$126 million (over four years beginning in 2002-03) for HIC’s business improvement program — which focuses on using the advantages of new channel technologies, particularly the Internet, combined with the introduction of improved electronic information security measures to protect health sector data (HIC, pers. comm., 20 February 2003).

Information technology could be integrated into information provision processes in four broad stages, enabling GPs to:

- download forms from discs provided by the department or from a Government website;
- complete forms electronically on a computer program that is not linked to other GP software, giving GPs an electronic record that is easy to update for later reviews;
- complete forms on a computer program that is integrated into a GP’s database of medical records, using software that is compatible with existing, commonly used programs; and
- submit forms to the relevant department using the Internet.

FaCS/Centrelink has provided GPs with software that is not linked to other clinical software, to enable them to complete medical certificates. It is also trialing

completing these certificates using programs integrated into GPs' medical databases (Centrelink, pers. comm., 16 January 2003). Australian Childhood Immunisation Register notification forms can currently be completed and submitted electronically.

Nevertheless, most government programs in the scope of this study still appear to rely heavily on paper-based systems. Relatively few appear to allow GPs to complete or submit forms electronically. Of the more than 80 forms considered in this study, the Commission is aware of only six that could be completed electronically and five that could be submitted electronically.

Further, there is varying uptake of information management and information technology by general practices. In the focus group discussions, some GPs commented that they made use of information technology in all aspects of their practice: 'In my practice, everything is computerised' (St Kilda, 9 September 2002). Within the same focus group, another GP noted that his practice made little use of information technology and that the staff 'just does it manually ... couldn't do it on the computer'. The Australian Divisions of General Practice suggested that 'between 7 per cent and 20 per cent of general practices maintain quality electronic patient records and practice management systems' (sub. PR40, p. 6).

FINDING 6.9

The extent to which information technology is used for GP administrative activities differs among Commonwealth departments and agencies, and among GP practices. The reliance on paper-based systems is still extensive.

Some GPs have suggested that accelerating the use of information technology to aid completing and submitting forms could reduce GP administrative costs. One GP commented that 'the way you can speed [the forms] up is with a template on the computer' (Millward Brown Australia 2002a, p. 48). The Far North Queensland Rural Division of General Practice Association Inc. noted:

The ongoing development of [information management and information technology] systems and services has a significant potential to reduce work done by GPs and practice staff, especially if it occurs automatically as a result of normal patient management through the practice software, for example HIC initiatives such as HIC Online. (sub. 9, p. 4)

In regard to DoHA's Domiciliary Medication Management Review (DMMR), the Australian Divisions of General Practice reported:

A practice that has since developed its own active electronic templates estimated after testing with nine GPs that the paper referral form for DMMR takes a minimum of 23 minutes to complete, whereas the electronic template takes six minutes. (sub. PR40, p. 6)

FaCS/Centrelink aims to develop electronic formats of all its forms over the next 12 months (Centrelink, pers. comm., 2 December 2002). As noted, the medical certificate can already be completed on a computer.

GPs in rural and remote areas might have limited (or lower quality) access to Internet-based systems. This is likely to influence the extent to which increased use of the Internet can yield reductions in administrative costs for these GPs.

It is important to point out that even if Government does introduce measures to reduce GP paperwork overheads, this will probably only be effective in rural areas if the infrastructure services and technology are available at an acceptable cost. (Far North Queensland Rural Division of General Practice Association Inc., sub. 9, p. 4)

Integrating departmental information requirements with existing medical software (integrated information systems) might improve the quality of information provided.

Templates of all forms required by the government bodies could be included in the medical director program. These could then be filled out using already existing information from the patient records which are kept up-to-date after each visit or hospitalisation, pathology report etc. This would increase the clarity of information with better detail, because the information is up-to-date. (unpublished response to Millward Brown Australia 2002b)

The electronic submission of completed forms could facilitate a less constrained approach to appraisal by GPs. However, it could limit the patient's ability to decide whether to proceed with the claim contingent on the GP's evaluation if he or she is unable to view the GP's comments. There might also be concerns about confidentiality and security.

RECOMMENDATION 6.7

Departments and agencies should examine options to accelerate the use of information technology in reporting by GPs, including integrating forms into computer software used by GPs, and allowing more forms to be submitted electronically when there is a net benefit.

Introducing more direct funding and remuneration arrangements, as discussed in section 6.2, could accelerate the uptake of information technology. Meanwhile, more could be done to achieve short-run benefits. The advisory committee suggested that most of the benefits are likely to be derived from options that can be implemented in the short term, such as increased electronic completion of forms. A longer term goal could be to attain greater integration between GPs and departments to achieve electronic submission of information.

The AMA suggested that the National Health Information Management Advisory Council should play a significant role in a nationally ‘coordinated strategy related to the efficient and effective use of information technology’ (sub. PR36, p. 1).

The GPCG suggested that developing standard protocols to exchange information would aid the uptake of information technology:

... achieving a degree of uniformity of systems will contribute to a reduction in the reliance on, if not use of, paper-based systems. (sub. PR42, p. 2)

It also noted that to achieve such standardisation:

... consideration needs to be given to the underlying infrastructure issues. These include development of a standard vocabulary and terminology for use by GPs and agencies to ensure collected data is capable of transmission at all. Other standards and encryption issues also need to be addressed to ensure the integrity of the data, security of information and protection of privacy. (GPCG, sub. PR42, p. 2)

Work to develop these standards has already commenced. For example:

The GPCG has established a special Task Group to examine the nature of forms currently in use for the provision of information to departments and agencies by general practice. The Task Group brings together key GPCG stakeholders and experts.

... the GPCG Task Group[’s] ... principal mandate initially is to develop a standard form of information collection from GPs. (GPCG, sub. PR42, p. 2)

Developing protocols for information exchange would accelerate the development of integrated information systems for both GPs and departments. However, developing standards and integrating information systems can be expensive. Further, the benefits and costs of these developments can accrue to different groups. GPCG commented:

... many of the Government’s [information management and information technology] initiatives have created a greater burden for general practice with the associated benefits flowing directly to Government. The burden is seen through the need for additional and upgraded infrastructure, maintenance, support, education and training costs and changes to and increases in administrative work practices. This cost shifting ... will also have a longer term impact on the willingness of GPs to embrace and actively take up Commonwealth [information management and information technology] initiatives in the future. (GPCG, sub. PR42, p. 3)

GPs might be willing to pay for software enhancements which reduce their costs, but they might not necessarily wish to pay if they perceive that the cost savings go to government departments.

6.6 Addressing conflicting priorities

GPs have a duty of care to their patients. However, some government departments' requirements could strain this relationship. For example, FaCS/Centrelink and the DVA disability assessments sometimes require GPs to assess the effect of a medical condition on a person's ability to work or study. Some GPs perceive that they are becoming 'screeners' for government departments and in some cases are required to make judgments extending beyond the clinical evidence available (Millward Brown Australia 2002a, p. 25).

Some assessments can cause tensions for GPs between the duty of care to their patients and program requirements. For instance, patients might place pressure on their GP to help them gain (or retain) social security benefits. In some cases this pressure would appear to have 'involved physical threats of violence' (Millward Brown Australia 2002a, p. 44). Indirect pressure to make an assessment in the patient's favour might arise given the possibility of losing the patient's (and family's) future business. Other GPs do not consider it a significant issue: 'some GPs indicated they were happy to make the decision' (Millward Brown Australia 2002a, p. 26).

The conflicting roles faced by GPs is not a new issue. In 1976, Hoy found that 'only one doctor [of the 15 surveyed] considered he could supply certificates without difficulty or conflict for himself' (1976, p. 202).

A study in the United Kingdom also questioned the objectivity of the resulting information that a GP provides:

... the GP role of patient advocate has important implications for those seeking verification of a claimed illness or disability. GPs are not independent, objective observers. They have a relationship with their patients which leads them to give their patients the benefit of the doubt in most circumstances, [that is] they believe what the patient says unless they have good clinical reasons not to do so. (UK Cabinet Office Public Sector Team and Department of Health 2001, p. 14)

This sentiment was echoed by a GP in one of the focus group discussions.

Sometimes when you know a patient for a long time there might be a slight bias towards a patient. I wonder whether it's a good idea for another doctor to do the form or assess the patient. (Millward Brown Australia 2002a, p. 26)

FINDING 6.10

Some GPs can face a tension between discharging a duty of care to their patients, retaining their patients and meeting the requirements of some programs. This can be a source of stress and anxiety for these GPs.

The intangible costs that arise from tensions between some GPs and their patients are less likely to arise if the information required is restricted to medical diagnoses based on clinical evidence, rather than seeking, for example, GPs' opinions about when a person will be fit to return to work.

RECOMMENDATION 6.8

When a department or agency is asking GPs to supply information, it should focus its requirements on medical diagnoses based on clinical evidence.

FaCS/Centrelink revised a number of its forms in September 2002. The questions contained in the Disability Support Pension TDR no longer ask the GP to assess how the patient's condition would affect his or her ability to work. Instead, GPs are asked to provide details about how the diagnosed condition affects the patient's ability to function (box 6.2).

Allowing GPs to submit information directly to the department by electronic means, as proposed earlier, could give GPs the opportunity to provide information based on clinical evidence that they consider might not necessarily be in the interests of the patient to see. However, freedom of information provisions might mean that this information is still accessible to the patient upon request.

Tensions could be avoided if assessments were to be provided by other medical professionals in a less familiar relationship with the patient. Further, Mavis Hoy suggested that GPs might not be best placed to provide some information:

In some instances, other service professionals might be more effective in providing individual reports (for example, occupational therapists are trained to assess driving ability but GPs are inappropriately asked to report on the driving ability of elderly patients). (sub. PR38, p. 1)

To reduce the emphasis on GP assessments, FaCS/Centrelink already 'undertakes a secondary assessment of eligibility using internal and external experts' (FaCS, sub. PR37, p. 1). In 2001-02, \$21 million was spent on these medical assessments.

6.7 Summary

There is scope to reduce GP administrative costs. The Commission has made a number of recommendations aimed at encouraging Commonwealth departments to consider GP administrative costs in their program evaluations, and reduce requirements to the minimum necessary. Adopting these recommendations would help to reduce GP administrative costs, without compromising the community-wide benefits that these programs deliver.