



**AMA SUBMISSION TO**

**THE PRODUCTIVITY COMMISSION STUDY ON  
ADMINISTRATIVE AND COMPLIANCE COSTS ASSOCIATED WITH  
COMMONWEALTH PROGRAMS THAT IMPACT SPECIFICALLY ON  
GENERAL PRACTICE**

**“THE REVIEW OF RED TAPE IN GENERAL PRACTICE”**

**August 2002**

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## EXECUTIVE SUMMARY

Australia's general practitioners want to provide high quality health care that meets the needs of their patients. Unnecessary bureaucratic red tape impedes this objective. It consumes important primary health care resources that would be better allocated to the growing health needs of the Australian community. It creates inefficiency and contributes to higher costs.

The AMA does not seek to detail the very large range of policies and programs that are well known to be associated with an inordinate amount of red tape. Instead it seeks to highlight the importance of finding a range of solutions to reducing red tape now and into the future. Further, the AMA is most concerned to highlight red tape as a significant source of dissatisfaction in general practice and an important factor related to broader issues of concern about the delivery of health care in Australia today. These include:

- The GP funding structure as a key source of red tape;
- GP remuneration related to the time and cost of red tape;
- GP costs associated with red tape;
- Workforce shortage where red tape represents one of a range of factors that influence workforce location; and
- Quality – as an opportunity cost of red tape

The AMA is also concerned to ensure that in measuring the costs of red tape that the Productivity Commission take into account and reflect in its methodology the immense diversity within profession and importantly how time is valued as a cost.

There are a range of issues AMA has addressed which do not appear on the Productivity Commission's list of relevant programs and policies that AMA considers of significance for the purposes of the review including information management/technology, privacy and consent, Divisions of General Practice and aged care.

Because the Productivity Commission's study is limited to Commonwealth programs and policies and those that do not impact on business generally, outcomes will represent only a partial story of the impact of red tape on general practice in Australia.

AMA considers it critical that the vast array of State/Territory and local Government compliance and administrative costs on general practice be acknowledged. Further, the impact of Commonwealth imposed red tape specific to general practice must be compared to that imposed on business generally. This is not inconsistent with the terms of reference and serves to place the general practice burden in context.

## 1. INTRODUCTION

The terms of reference for the Review of Compliance Costs in General Practice (the Review) clearly restrict it to Commonwealth policies and programs, although Senator Patterson has indicated that the study will provide information valuable in developing a national approach to addressing the impact of government paperwork on general practice. AMA would stress the significance of the additional impact of State/Territory policies on red tape in medical practice and expresses disappointment that the Productivity Commission will not be engaging State/Territory Governments directly in the review.

While press statements give the impression that the review will focus on paperwork, the terms of reference cover compliance issues but restrict the review to policies and programs that impact on general practice and not on business generally. AMA will seek an assessment of the red tape burden in general practice compared to small business generally.

The AMA is well placed to contribute to the Productivity Commission's review. Data from the 1999 AMA Membership survey identified areas of concern for general practice. Data from the AMA's February 2002 general practice workforce analysis<sup>1</sup> will be particularly valuable to the Review. This analysis identified the exponential increase in red tape related to training, accreditation and administration and their increasing complexity, as one of the key underlying causes of GP dissatisfaction contributing to workforce shortage.

The AMA has consistently identified the red tape burden imposed on general practice by the Commonwealth Government as having significant negative consequences on the profession. This submission seeks to respond to a number of the questions raised in the Productivity Commissions Issues Paper<sup>2</sup> and to highlight where and how the role of red tape has an important impact in other broader areas of critical concern to general practice.

“Thousands and thousands of general practitioners are saying the same thing: workforce conditions in general practice have deteriorated to the stage where many are no longer able to provide quality primary care because of time and financial constraints.”

Results of the 2001 AMA GP Survey by Access Economics, December 2001 – pp. 5

There is currently a shortage of GPs in Australia. In addition to measures Government must take to increase the GP workforce, it is essential that immediate measures be taken that focus on retention of the current workforce. The reasons for the workforce shortage are complex. The fact remains that the workforce shortage is placing GPs under increasingly untenable pressures. The burden of red tape represents a significant source of pressure. Further it is one of the factors that in an environment of workforce shortage impact on the capacity of GPs to provide quality health care.

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<sup>1</sup> An Analysis of the Widening Gap between Community Needs and the Availability of GP Services – A report to the Australian Medical Association by Access Economics Pty Ltd, Canberra, ACT. February 2002.

<sup>2</sup> Productivity Commission Circular of 29 July 2002 – General Practice Compliance Costs – New Research Study.

## **2. RED TAPE AND THE STRUCTURE OF GENERAL PRACTICE FINANCING**

The issue of the burden of red tape is directly related to the general practice funding system that has increasingly been structured around blended payments<sup>3</sup>. A key problem with the expansion in blended payments is that it has not been undertaken within the context of any overall strategic plan.

In the context of the funding structure for general practice a great deal of emphasis has been placed justifiably on the administrative burden created by the Practice Incentive Program (PIP). PIP commenced in 1997 with five elements: information technology, after hours, teaching and rurality and targeted incentives (only immunisation to begin with). By 2002 three additional elements were added – care planning, practice nurses and extra targeted incentives. The targeted incentives are made up of four parts, asthma, diabetes, cervical screening and mental health.

The funding structure, and its associated administrative burden has become even more complex due to the encroachment of added bureaucracy into the fee for service payments through linkage of PIP incentives to Medicare Benefits Schedule (MBS) items. The link to the MBS first occurred in 1999 with the introduction of enhanced primary care items (21 new items grouped into three categories of GP activity). Although not blended payments in the true sense because they are still fee for service, these items marked a departure for the MBS because of the time consuming paperwork attached to them.<sup>4</sup>

The Government's own research into PIP<sup>5</sup> found that the reasons that GPs participate in PIP is to supplement income and to fund maintenance of equipment and facilities. "...GPs say they have to take any money they can get in an attempt to cover rising practice costs and maintain earnings."<sup>6</sup> However, the study found that to the extent payments have been declining as requirements to participate have been increasing, remuneration as it presently stands under PIP is a disappointment and of little advantage. Only a small minority in the focus groups convened as part of this research considered that funding had improved practice or quality of service. In terms of future incentives under PIP GPs demonstrated that they were very wary of anything that is likely to make more demands on their time, or increase administration and

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<sup>3</sup> Blended payments are non-fee for service lump sums in addition to doctors' fees intended to "compensate for the limitations of fee-for-service income". Originally blended payments comprised of the divisions and rural incentives programs until the introduction of the Better Practice Program in 1994 and the subsequent introduction of the Practice Incentive Program in 1998.

<sup>4</sup> More frequently associated with the documentation of business rules that have very little to do with the intent of the item or clinical need.

<sup>5</sup> Review of the Practice Incentives Program (PIP) conducted for the Commonwealth Department of Health and Aged Care, Medicare Benefits Branch by Wendy Bloom and Associates, October – November 2000

<sup>6</sup> Ibid – pp 56

paperwork. The level of complexity, administration and paperwork associated with existing and proposed incentives under PIP is a constant theme throughout this study.

“The time wasted performing mundane routine tasks and paperwork which could be done by less skilled staff.”

“The Government’s increasing complexity of remuneration through time consuming schemes and programs...”

“I feel like a Government employee but without the leave.”

Volunteered responses from GPs on what the problems are to the AMA GP Workforce Survey, 2001.

A recent report on red tape by The Medical Observer<sup>7</sup> noted that changes in Medicare brought on by the introduction of blended payments systems “...has reached the point where the complexity of earning a living in general practice is beginning to turn back the clock. GPs are starting to opt out and simply increase their prices”<sup>8</sup>. Doctors feel that too much of their time, that should be used to practice medicine, is increasingly being allocated to unpaid or inadequately remunerated time to meet bureaucratic requirements. This view is not new as demonstrated in the results of a 1999 AMA Membership survey where political and bureaucratic interference was rated as a significant concern across all medical groups, including general practitioners.

## 2.1 Remuneration/Costs Associated with Red Tape

A survey undertaken by Australian Doctor in May 2002 delivered surprising results in terms of the money some GPs actually receive from blended payments and confirmed the view of the AMA that there is a maldistribution of the funding. 28% of GPs surveyed said they received less than \$1,000 a year and among employees, this proportion almost doubled to 46%. The survey demonstrated, however, that despite 20% of GPs overall earning \$10,000 or more from blended payments and 29% earning \$7,000 or more, 72% of the sample agreed that blended payments should be scrapped and the money used to boost rebates.

The AMA’s 2002 workforce survey<sup>9</sup> indicates that the average Full Time Equivalent general practitioner works an average of 53 hours a week which included non face to face time directly related to provision of primary care (it did not include time allocated to bureaucratic and business processes). The average hourly rate for these hours was \$47.14 before tax.

“I was appalled when I calculated my hourly rate.”

Volunteered comment in GP response to AMA 2001 Workforce Survey

The Australian Doctor survey of May 2002 focused specifically on blended payments only. This indicated that around 49% of GPs spend more than 3 hours or more a week

<sup>7</sup> Medical Observer, 26 July 2002, p.20

<sup>8</sup> This implies a direct link between the increasing complexity of delivering general practice services to the ongoing decline in services that are bulk billed.

<sup>9</sup> An Analysis of the Widening Gap between Community Needs and the Availability of GP Services – A report to the Australian Medical Association by Access Economics Pty Ltd, Canberra, ACT. February 2002.



fighting their way through red tape just associated with blended payments. Based on the mean of four hours derived from this survey the value of this non-remunerated work on blended payments red tape alone would be \$326.10 per week<sup>10</sup>. Combining results of the April 2002 survey<sup>11</sup> that found that one third of GPs were spending more than seven hours a week on paperwork this takes the value of additional non-remunerated hours incurred by GPs to around \$570.64 per week<sup>12</sup>.

In terms of annual income the results of the May 2002 survey found that a mean of 4 hours was spent on blended payments paperwork. Based on this and using an outdated RVS figure of \$70 per hour, the authors suggested that general practitioners should be paid about an extra \$13,000 per year (185.7 hours). However a figure of \$15,139 per annum is the result when the more up to date figure of \$81.52 is applied.

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 AMA General Practice and eHealth Department has been inundated with calls from members facing difficulties with PIP. 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. The practice would have had to employ a third administrative staff member to cope with the increased red tape following the introduction of the new incentives for diabetes, asthma and cervical screening and there would have been additional ongoing costs associated with accreditation required for PIP<sup>13</sup>.

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<sup>10</sup> Based on data from the Relative Value Study (RVS) the average income for GPs in 2002 should be around \$150,000 per annum, after costs. This translates into an hourly rate of \$81.52 which gives the result of 326.10 per week. The hourly rate including practice costs is calculated at \$158.05.

<sup>11</sup> that focused on paperwork, defined as Government imposed bureaucracy such as GST compliance, CME, patient records and referrals and forms for which there was a clear payment, such as immunisation notifications and excluded work essential to the practice such as PIP an accreditation compliance forms, paperwork associated with enhanced primary care MBS items and new disease specific MBS items, Centrelink and other miscellaneous government forms such as for disabled driver licence applications

<sup>12</sup> Based on \$81.52 per hour.

<sup>13</sup> Blended payments also incur significant administrative costs for Government, particularly in the first year of start up. The draft implementation plan for the cervical cancer screening initiative for example, indicated that total costs of \$3.9 million were to be incurred in delivering incentives to GPs worth only \$1.3 million in the first year (includes flow-on costs, administration and DVA). The administration costs alone in the first year were estimated at \$1.6 million – that’s 30% higher than the actual incentive payments of \$1.3 million for the first year

### **3. RED TAPE AND THE GP WORKFORCE SHORTAGE**

Red tape is a significant factor in the important interplay between GP remuneration and hours worked which have been demonstrated to directly impact on the level of the GP workforce and its distribution. Administrative and compliance red tape are significant contributors to the “push and pull” factors linked to GP shortages in many areas of Australia related to the movement of GPs out of rural, remote and outer urban areas to the inner urban areas of Australia.

A 1995 country wide survey of GPs published by the National Centre for Epidemiology and Population Health found 35% said they would leave general practice if they had somewhere else to go and singled out the introduction of blended payments (only introduced three years earlier) as one of the most common sources of dissatisfaction.

A 1998 Medical Journal of Australia study found that paperwork was the second most frequent source of stress for GPs after time pressures to see patients. Paperwork ranked fifth in terms of its place in the severity of stress it caused.

A 1999 AMA Membership survey on Priority Issues sought to gauge “top of the mind” issues by asking survey participants to nominate up to three issues that they wanted the AMA to focus on. The results of the survey showed that political and bureaucratic interference were considered to be of above average importance by all medical groups, including GPs. Importantly these concerns were related to another issue in the top six identified, that of diminishing doctor independence to practice medicine to the highest possible standard and meet patient needs.

#### **3.1 Red Tape as A “Push” Factor**

The February 2002 AMA General Practice Workforce Report<sup>14</sup> identified the increasing complexities and exponential increase of red tape associated with training, accreditation and administration, as one of a number of key issues that relate directly to the overall shortage of GPs in Australia. Problems with administration or management were rated 5<sup>th</sup> in an incidence and ranking of problems identified by dissatisfied GPs.<sup>15</sup>

In rural and remote areas the report found that difficulties associated with running a small business, including red tape were clearly identified as barriers to rural GP supply. Red tape was a significant contributor to the “push” factors of low remuneration and long working hours that has seen a growing shift of the GP

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<sup>14</sup> An Analysis of the Widening Gap between Community Needs and the Availability of GP Services – A report to the Australian Medical Association by Access Economics Pty Ltd, Canberra, ACT. February 2002.

<sup>15</sup> GPs who ranked their satisfaction as 1 to 7 in the 2001 AMA GP Survey Question 8.

workforce from rural, remote and outer urban areas, either out of the workforce altogether or into inner urban areas.

“I have just done 6 months on rural term. It was very isolating, stressful, not well supported and terrible overtime with onerous level of responsibility... It has basically turned me off rural medicine.”

Volunteered comment from the AMA GP Workforce Survey, 2001

Lower remuneration rates in outer urban areas have translated into a reduced incentive to participate in “quality” programs, because of the unpaid additional hours associated with compliance requirements. In fact the survey found that the more frequent response by GPs to the increasingly untenable situation in outer urban areas, where red tape is one of a range of sources of pressure, has been to move to inner urban areas (higher socio-economic locations).

### **3.2 Red Tape as a ‘Pull’ Factor**

The benefits derived from economies of scale are clear “pull” factors in terms of workforce location and distribution. The AMA 2002 workforce survey left no doubt that GPs found practice was “easier” in inner urban areas and in that context they felt they were able to provide quality care with commensurate job satisfaction. The pull factors of inner urban areas (middle to upper income suburban) are directly related to the benefits to be realised from economies of scale not available in rural areas in particular, but also outer urban areas.

It is impossible however to measure the value or significance of the benefits of economies of scale in reducing the red tape burden that lead to individual decisions that contribute to the current workforce distribution<sup>16</sup>. It can be said, however, that a reduction in the administrative and compliance burden is clearly one of a range of significant benefits derived from economies of scale. Slightly more than one third (35%) of practices of five or more doctors employ someone to deal with the PIP associated paperwork.

The AMA GP Workforce Survey identified practice costs as falling significantly from a solo practice to a two doctor practice, and continuing to diminish with increased practice size<sup>17</sup>. Economies of scale not only contribute to relieving the GP of the burden of administration, compliance and other red tape requirements, but generally do so in an environment that remunerates them adequately to practice medicine.

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<sup>16</sup> There are after all other “pull” factors including reduced working hours including after hours and on call, the capacity to balance professional and family life and needs.

<sup>17</sup> Econometric estimation suggested that there were very limited gains in practice expansion past eight Full Time Equivalent GPs.

## **4. THE IMPACT OF RED TAPE ON QUALITY**

The AMA views the issue of “quality” as particularly relevant to section two of the Productivity Commission’s terms of reference in that the study is to have regard to “...the overall objectives of these Commonwealth Programs and the benefits to consumers...”. Importantly GPs see administrative and compliance burdens as one source of pressure on their capacity to deliver quality care. The capacity to maintain “quality” medical care in an environment where time pressures are becoming overwhelming is a constant theme when GPs talk about the impact of red tape.

### **4.1 Blended Payments as a Quality Measure**

The Government’s own research noted that “...the majority of participants in PIP are adamant that the Practice Incentive Payment has made no difference to quality care. Opinion [of GPs] is unanimous that they are providing the same high quality of care that they provided before the advent of PIP”.<sup>18</sup>

The Government has portrayed blended payments as a quality measure. However, one third of GPs now spend more than seven hours every week fighting their way through red tape and 72% believe the impact of paperwork is compromising the treatment they offer their patients. General practitioners generally agree that the burden of the administrative requirements related to the PIP, combined with the compliance costs associated with accreditation as an eligibility criterion, far outweigh any quality outcomes that may be derived. A 2002 survey showed that 65% of respondents thought blended payments had neither influenced the quality of care received for better or worse. 71% had not changed their clinical practice as a result of blended payments.<sup>19</sup>

Further, the structure of some of the PIP incentives actually operates against quality. For example, the information technology incentive is largely based on the use of computer technology for communication and storage. The incentive structure neglects privacy and security - the critical quality elements in the use of information technology and by far the issues of highest concern to patients in terms of the health information. While the incentive was initially intended to increase computerisation in general practice, subsequent changes to the incentive structure focused on cost/price objectives rather than any of the necessary “quality” objectives related to privacy and security. In fact this incentive may have increased security and privacy risks in relation to patients’ health information.

### **4.2 Accreditation**

In the context of the Productivity Commission’s Review AMA wants a clear assessment of the impact of red tape on participation by general practitioners in accreditation. As of January 2002 a general practice must be registered for accreditation to be eligible for PIP. Although an “opt in” system, accreditation is an important element of quality compliance in general practice. That the burden placed

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<sup>18</sup> Review of the Practice Incentives Program (PIP) conducted for the Commonwealth Department of Health and Aged Care, Medicare Benefits Branch by Wendy Bloom and Associates, October – November 2000. PP. 57

<sup>19</sup> Australian Doctor survey undertaken in May 2002 and reported in 12 July 2002 issue.

on general practitioners by the blended payments funding model may be creating negative consequences for this significant quality measure is of concern.

AMA has called for the PIP to be de linked from accreditation. The growing acceptance of accreditation by the profession has the potential to be undermined by the additional administrative burden placed on general practice by linking the two programs. The return from PIP does not cover costs of compliance and general practice cannot readily pass costs to the consumers. The accreditation process should be educative and valued from the beginning by practitioners. It should not be subject to financial incentives.

Many GPs have argued that the costs and complexities of accreditation are simply inefficient. GPs are beginning to undertake cost benefit analyses of the PIP incentives and many are finding that the accreditation costs and “hassles” plus the additional administrative burden associated with the incentives themselves are simply not worth it<sup>20</sup>. Practice size (as one element of economies of scale) is thus a significant factor in attitudes to the quality requirements associated with accreditation. The accreditation link to PIP eligibility is seen as inappropriate by 59% of respondents to the Australian Doctor survey but a further breakdown of the respondents showed that 72% of solo GPs were opposed to this link<sup>21</sup>.

*A letter to the President of the AMA in August 2002 from one practice stated that this practice of 9 doctors supported the AMA's position that accreditation be de-linked from PIP. This practice had two aims in embarking on accreditation, the first to ensure they applied the RACGP standards and second, to access PIP payments. The author added, "our practice manager spent hundreds of hours preparing the practice manual and making sure, in consultation with doctors, that the standards were applied in our every day work. There were few areas where any significant change was made. The whole accreditation exercise has been and is a nightmare."*

*AMA Member – unsolicited comment in correspondence to AMA President, August 2002.*

This is supported by the Review of PIP undertaken by Government in 2000<sup>22</sup> that found that the majority of GPs participating in focus groups voiced strong criticism about accreditation, particularly in relation to PIP. They resented the fact that while a requirement of PIP the cost of accreditation is not reimbursed through PIP.

A May 2002 Australian Doctor survey found that 778 practices have dropped out of the PIP since May 2001. This represents a drop in the number of practices registered of 15% (5260 in the May 2001 payments quarter to 4,482 in the May 2002 quarter). Further, the survey found that there had only been a small increase in the number of practices re-registering for the PIP since April 2002. This was when DoHA announced that 912 practices had dropped out of the program since the beginning of 2002 following the imposition of “registered for accreditation” as a criterion for access to the incentives.

AMA concerns relate to its support for accreditation as a key quality initiative and an apparent decline in accreditation and re-accreditation since the eligibility link to PIP

<sup>20</sup> Documented evidence from one GP practice shows a 37% increase in the cost of accreditation over three years (\$7,157.00 in 1999 to \$9,780.54 in 2002).

<sup>21</sup> Australian Doctor survey undertaken in May 2002 and reported in 12 July 2002 issue.

<sup>22</sup> Review of the Practice Incentives Program (PIP) conducted for the Commonwealth Department of Health and Aged Care, Medicare Benefits Branch by Wendy Bloom and Associates, October – November 2000.

was established. In terms of quality measures AMA's view is that accreditation achieves a measurable level of quality in general practice that benefits both the profession and patients. However, success in achieving quality objectives portrayed as the basis for specific PIP initiatives, is more frequently arguable.<sup>23</sup>

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<sup>23</sup> It is telling that the GP Immunisation Program, which is an incentive program established outside the PIP, is one program that is widely recognised, including among the profession, as a worthwhile and successful initiative that has achieved real and measurable health outcomes.

## 5. MEASURING THE COSTS OF RED TAPE

### 5.1 Defining a General Practitioner and General Practice

Australian general practice has traditionally been the entry-point to the health system. The underlying strength of the GP resides with his or her capacity to form an ongoing relationship with the patient that produces the personal knowledge and mutual confidence necessary to ensure appropriate services. General practice is also closely involved in the local community, a role that is facilitated by its proximity to places where people live and work though the large numbers of dispersed GP practices.

The World Organisation of Family Doctors also supports this view. In a 1991 statement titled *The Role of the General Practitioner/Family Physician in Health Care Systems*, general practice was described as the “central discipline of medicine around which medical and allied health disciplines are arranged to form a cooperative team for the benefit of the individual, the family and the community”.<sup>24</sup> The Royal Australian College of General Practitioners set up a Presidential Task Force in 1995 to define general practice. The resulting definition stated ‘that general practice is that component of the health care system which provides primary, subsequent and continuing medical care and coordinates services to individuals, families and communities. It integrates current biomedical, psychological and social understandings of health issues.’<sup>25</sup> Above all, GPs have the specific and unique expertise to assess the undifferentiated nature of the problems presented in primary care.<sup>26</sup>

Managing chronic disease, illness and aged care are key areas of the current role of the general practitioner that present a challenge for the immediate future. Thus the current generalist role of the GP is being re-examined and challenged with an opportunity for enhancement.<sup>27</sup> Generalism in primary care continually needs to be re-defined as it is not a default category of non-specialised care. Rather general practice care has several distinct features. It is longitudinal with opportunities for life-long professional and interpersonal relationships between patient, family and medical practitioner. Care is provided through time and this temporal framework can enhance clinical decision making.<sup>28</sup>

“There has been a change in the nature of general practice. I am little more than a pen pusher – most of my skills are lost..”

Comment volunteered in the AMA GP Workforce Survey 2001

<sup>24</sup> WONCA (World Organisation of Family Doctors) 1991. The role of the general practitioner/family physician in health care systems. WONCA. Melbourne

<sup>25</sup> DHFS (1996). *General practice in Australia 1996*. General Practice Branch, Commonwealth Department of Health and Family Services. Canberra

<sup>26</sup> Fugelli P and Heath I (1996). The nature of general practice. *British Medical Journal*: 312

<sup>27</sup> Martin C and Nisa M. (1996). Meeting the needs of children and families in chronic illness and disease. A greater role for the GP? *Australian Family Physician* 25:1273-5, 1277, 1279-81.

<sup>28</sup> McWhinney I. (1996). William Pickles Lecture 1996. The importance of being different. *British Journal of General Practice*, 46(408):433–6.

AMA supports the RACGP definitions of General Practice in Australia and a General Practitioner in Australia as follows:

### ***General Practice***

*General practice is part of the Australian health care system and operates predominantly through private medical practices, which provide universal unreferred access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.*

### ***General Practitioner***

*A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner:*

- *Has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care; and*
- *Maintains professional competence for general practice.*

## **5.2 Target Group**

### ***5.2.1 General Practice Status***

The Productivity Commission posed the question in its Issues Paper as to whether non-vocationally recognised (non-VR) GPs and Registrars should be included in its research.

Non-VR general practitioners are an important section of the primary care work force (9.9%) and are predominantly those GPs who did not or were unable, for a variety of reasons to participate in the “grandfathering” process available when the VR structure was first established. The AMA does not distinguish between non-VR or VR in its recognition of GPs. The Government established this distinction within the MBS. Non-VR GPs undertake continuing medical education and there is no distinction between the quality of care or services provided. Under accreditation a practice which employs a non-VR GP must demonstrate that this GP maintains CME and other requirements imposed on VR GPs in order to maintain their VR status.

GP Registrars should also be included in the study where they are attached either as employees or contracted to a general practice. Registrars are likely to be involved in the day to day activities of running the practice in terms of compliance and administrative requirements.

### ***5.2.2 Employment type***

The apparent differences between principles, partners and “employed” GPs in terms of hours allocated to red tape, and the influence of size of practice, the methodology used by the Productivity Commission for data collection, particularly surveys, should ensure that a distinction can be made as to whether a person is an “employed” GP. For registrars, it could be worthwhile further distinguishing them from the “employed” group. There is otherwise a danger of distorting the research outcomes



given the time Registrars spend on delegated red tape is likely to be influenced by their GP in training status.

### **5.2.3 Location**

The AMA understands that the Productivity Commission is currently considering the use of focus groups, surveys and case studies in undertaking this research. Location of general practice is a variable in terms of access to different Commonwealth programs or specific policies that may impact on different types of locations. While the clear distinction is between rural and urban the AMA would prefer that the location variable be broken down into remote, rural, outer urban and inner urban. A broader distinction than simply urban and rural is also important for the use of focus groups. In analysing the relative ability to manage red tape it is critical to analyse the experience of doctors in very different settings and the impact of red tape on their capacity to deliver clinical services in different communities.

“I wouldn’t no matter what the money...my kids just wouldn’t put up with the time commitment required for rural work.”

“Been there done that – hours and workload were appalling.”

Urban GPs commenting on moving to rural or remote areas from the AMA Workforce Survey, 2001

## **5.3 Time as a Cost**

While information on time allocated to red tape is the key data required to analyse costs, this is not as straightforward as it first appears and must distinguish between:

- non face to face time that is clinically related and that which is not;
- clinically necessary time and allocation of time that is bureaucratically imposed;
- who, in terms of staff within a practice (including GP(s)), is allocating what time;
- remunerated and non remunerated time;
- what time is used – in-hours when patients could be seen, or out of-hours (attempting to measure any implications for clinical time).

### **5.3.1 Valuing Time as a Cost**

“I stopped bulk billing when I ceased feeling guilty about putting a value on my time.”

Volunteered comment in response to AMA GP Workforce Survey 2001.

The AMA is of the view that the Relative Values Study (RVS) should be used as the benchmark to cost GP’s time for the purposes of this study<sup>29</sup>. For general practice, the AMA’s List of Medical Services and Fees, is largely based on the outcomes of the RVS. On the basis of original outcomes of the RVS study, and adjusted for 2002

<sup>29</sup> In a recent letter to the Federal Minister for Health and Ageing (reported in national media on 15/8/02), all State and Territory Health Ministers have requested the Commonwealth Government to re-examine the RVS

prices, the AMA's view is that for the purposes of the Productivity Commission's study an hour of a GP's time should be costed at \$81.52<sup>30</sup>.

The AMA does not support the use of income figures derived from the AMA's 2001 Workforce Study for the purposes of the Productivity Commission's study. This data reflects the harsh reality of general practice not what GPs are worth.

The Government's MBS fee should not be utilised for the purposes of this study as it does not in any way reflect the cost of delivering general practice services to the Australian community. The continual decline in bulk billing services in favour of privately billed services is one of a number of clear indicators that the MBS is meaningless for any purposes that relate to costing the value of a GP's time.

For practice staff other than GPs their hourly rates should be available through reference to the relevant employment Awards.

#### **5.4 Other Costs**

Calculation of costs must be based on an estimated and fair hourly rate for general practitioners and each member of staff. In this context analysis must address costs associated with:

- Costs of time allocated to red tape by every member of staff in the practice (including GP(s));
- Estimated cost of non remunerated time by any staff, including the GP(s);
- Opportunity costs – lost remuneration or income because time (at a specific cost) has been allocated to red tape rather than clinical tasks;
- Additional costs incurred, including staff, associated infrastructure (computers, phones etc), training, education and support

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<sup>30</sup> If practice costs were included this hourly rate would in fact be costed at \$158.05.

## 6. PROGRAM AND POLICIES FOR REVIEW

AMA notes the list of programs and policies developed by the Productivity Commission for consideration of the GP Compliance Costs Study Advisory Committee Roundtable of 15 August 2002<sup>31</sup>. The following seeks to:

- outline additional Commonwealth programs or policies that AMA believes are consistent with the Commission's Terms of Reference for the Review; and
- to highlight specific issues related to a number of the programs and policies that the Commission has already identified.

### 6.1 Practice Incentives Program

#### 6.1.1 *Single Whole Patient Equivalent (SWPE) and Whole Patient Equivalents (WPE) Calculations*

PIP payments are calculated using SWPE or WPE. If a patient visits different practitioners over a year this will influence the calculation of incentives payments. In this context the SWPE is used to calculate pro rata payments of the specific incentive. The calculations used to calculate the SWPE are complex and GPs are not privy to the information that forms the basis of the calculation as the SWPE calculation involves patient information that is confidential. A GP is unable to contest the calculation made or check that the information provided, or the actual payment made, is correct.

#### **SWPE IN REALITY** (names have been changed)

Dr Smith and his practice worked hard to provide Care Plans to eligible patients in their practice, and calculated that they had performed 100 care plans. As there are 90 patients in their practice over the age of 65, the practice calculated that they had performed more than the 10% requirement for the care plan initiative, and should therefore receive the PIP payment for care plans.

The practice received their PIP statement that identified that they had performed 96 care plans, and when the SWPE was calculated, this turned into 83 Care plans. This therefore meant that they had not reached their 10% target, and did not receive their CPI payment.

The practice queried this with the HIC, asking for a review of the initial number of care plans calculated. The HIC later reported that 4 Care plans for DVA patients had been missed in the HIC calculation. The practice therefore had performed the 100 care plans as originally thought. However the SWPE care plans were still below the 10% requirement.

As the practice is the only practice in this area, they also queried why the SWPE calculation was so low, as their patients do not regularly see other doctors. This information CANNOT be divulged by the HIC, meaning that the practice could not compare HIC data with their own. This practice did not, and will not receive the payment for the care plan incentive.

#### 6.1.2 *Recording of Accreditation Status*

The linking of Accreditation to PIP as an eligibility criterion has numerous problems, some of which have already been outlined. A specific problem, that has created

<sup>31</sup> See Attachment A at pages 31-33 for the Productivity Commission's list of relevant programs and the AMA's list of additional programs and policies.

mayhem since the linking of the two programs came into force, has arisen where HIC has failed to correctly record the practice's accreditation status. A practice recorded as not accredited or not registered for accreditation is removed as a practice eligible for PIP. A further complication has arisen due to pressures on accrediting bodies that meant that many practices were unable to organise an accreditation survey visit prior to the end of 2001. In May 2002 164 practices had their PIP payments held by HIC under special arrangements for practices who sought to be subject to an accreditation survey but were unable to arrange a survey visit prior to the end of 2001 due to demands on the accrediting bodies. The uncertainties to which these complexities give rise illustrate a lack of forward thinking by the Commonwealth Government in relation to its policy of linking the accreditation and PIP programs. This has consequently contributed to a significant level of stress, frustration and administrative work by general practitioners and their representative groups to seek solutions.

## 6.2 Information Management/Information Technology

The development of the Commonwealth's information management and information technology (IM/IT) agenda is guided by its Health Online Policy<sup>32</sup>. The Health Information Action Plan sets out its guiding principles.<sup>33</sup> In the context of the Productivity Commission's Review one of the significant principles is:

*“Information needed for research, policy or planning purposes should be generated as a by product of operational systems that are designed primarily for other purposes – such as achieving better health outcomes for individuals, groups and communities, or organising payments.”*

Current initiatives being developed and implemented by the Commonwealth Government reflect this principle which has significant implications because it results in:

- Imposition of a data and information collection role on general practitioners that is “additional” to that already undertaken with no compensation for that additional role;
- Imposition of a “policing” role on general practitioners in relation to issues such as health care entitlements, accuracy of HIC records. In relation to entitlements this has already been implemented for pharmacists who now bear the cost if they fail to check the entitlement or make a mistake. It is currently proposed under the Better Medication Management System (BMMS)<sup>34</sup>;
- Imposition of a higher level of responsibility for “informed consent” on general practitioners that extends beyond their clinical role through the collection of personal patient information beyond the primary purpose. The higher level and more complex role in “informed consent” is implicit in this broader information and data collection role, consistent with the Privacy Act provisions related to the use of information collected from a patient for purposes other than the primary or a secondary related purpose. In this context the higher level of “risk” established

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<sup>32</sup> Health Online – A health Information Action Plan for Australia, Second Edition, September 2001. National Health Information Advisory Council and A Health Information Network for Australia, July 2000, National Electronic Health Records Taskforce.

<sup>33</sup> Health Online – a Health Information Action Plan for Australia, Second Edition, September 2001, pp. 11.

<sup>34</sup> An electronic medication record currently under development and scheduled for field trials in 2003.

in such a role is also a matter for consideration. The costs incurred in avoiding any risks associated with responsibility for a higher and more complex process of informed consent is imposed on the general practitioner<sup>35</sup>.

General practitioners are beginning to recognise that under the guise of benefits to general practice, particularly improved health outcomes, many of these IM/IT initiatives in fact create a greater burden for general practice with the associated benefits flowing directly to Government. The burden is manifested in both additional infrastructure, maintenance, support, education and training costs and changes to and increases in administrative work practices. This is a real example of cost shifting. The fact that the implied cost savings benefits from a range of initiatives are not shared with general practice, which has done the work and invested in the necessary infrastructure, GPs will be more reluctant to take up Commonwealth IM/IT initiatives in the future.

### **6.2.1 The Business Case**

The Commonwealth quite rightly develops a business case for specific initiatives that it intends to introduce into general practice. In this context the Business Case establishes the “good” business reasons for the use of Commonwealth investment in specific initiatives. The Commonwealth consistently, however, fails to undertake research on a Business Case for general practice. It must be realised that while the Commonwealth makes decisions based on the likely benefits of specific initiatives, based on proposed inputs and estimated outcomes, so do general practices. The Commonwealth consistently demonstrates a view that GPs derive benefits from initiatives that bring improved patient outcomes only. There is a point, however, where the cost of investment in any initiative being introduced is analysed in the context of a general practice as a business. GPs welcome initiatives that contribute to improved health outcomes but they must do so in terms of a cost benefit analysis of their own business. AMA continues to argue that without developing a specific business case for general practice for individual programs and initiatives their design reflects a disproportionate allocation of costs to GPs with the benefits flowing to patients and Government.

“Our practice, which is rural, and abandoned bulk billing a year ago (all pensioners now pay a co-payment, and no discount is provided after hours), has calculated that our current fee for 3 level C visits is worth more to us than the current rebate and SIP payment under this scheme. All this with no extra paper work! The idea that GPs need to attend a 2hr training session to learn how to implement the items was rejected by every GP in our practice (waste of time, sooner spend with family etc).”

AMA member unsolicited comment on Mental Health Initiative

### **6.3 Privacy and Consent Compliance**

Privacy and consent compliance requirements impact across the range of Commonwealth programs and policies and in terms of the Productivity Commission’s work must be seen as an important cross cutting issue that impacts on GP compliance and administrative costs.

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<sup>35</sup> The may include expensive legal advice.

The fragmentation of Privacy legislation has imposed a specific burden on general practice. It is widely acknowledged that consumers have particular and significant concerns about the protection of their personal health information compared to other types of personal information. The Commonwealth has acknowledged the “special” nature of privacy related to personal health information case through the development of a draft National Health Privacy Code<sup>36</sup>. General practitioners are bound by an array of privacy provisions and while some are State/Territory based the existence of separate Commonwealth legislation creates additional burden and complexity to compliance. The array of privacy provisions to which a general practitioner is bound include:

- Commonwealth Privacy Act – including its National Privacy Principles and their interpretation as they related to the health sector;
- Separate existing and proposed State/Territory legislation – ACT, NSW and Victoria have separate privacy legislation;
- Proposed National Health Privacy Code;
- Proposed separate legislation for the Better Medication Management System<sup>37</sup> which will establish separate privacy provisions, consent process and requirements, complaints mechanisms, offences and penalties;
- Proposed separate legislation for HealthConnect that will establish separate privacy provisions, consent processes and requirements, complaints mechanism, offences and penalties.
- A range of State/Territory privacy guidelines and codes;
- Professional privacy codes.

This fragmented approach to privacy in the health sector is inefficient in that it has created a vast and complex array of bureaucratic and legislative requirements, that subjects general practitioners to unnecessary compliance and administrative costs. The AMA has consistently argued that there is a need to simplify and standardise privacy requirements that respond to the specific issues in the health sector and most particularly in relation to electronic handling of health information. The AMA’s position is that this could be achieved by specific National Health Privacy legislation.

### ***6.3.1 Consent as a Compliance Measure***

Consent processes represent a significant compliance cost and are related to the level of complexity of the consent required in particular circumstances or under particular jurisdictions. The cost is related to the time a GP must incur to gain consent, particularly “informed” consent.

Of particular concern, in relation to the Productivity Commission’s study, is the cost of consent processes and the additional burden this imposes upon general practitioners. While the AMA supports the principle of consent, the lack of a standard means that GPs must balance the array of requirements to which they are bound either

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<sup>36</sup> Draft National Health Privacy Code produced by the National Health Privacy Working Group under the Australian Health Ministers’ Advisory Council – issued for consultation with the Working Group by the Department of Health and Ageing on 12 July 2002.

<sup>37</sup> A draft of the BMMS legislation, which was rejected by stakeholders in 2001 in its present form, remains on the table for revision following field tests. This is a public document available on the Department’s website which also includes submissions from stakeholders invited to comment on the draft legislation.

legally or professionally. Difficulties arise in terms of analysing which legislation has precedent. The fact is that in some cases the State/Territory legislation raises the bar and in relation to a particular issue that legislation will apply over Commonwealth legislation. Where the Commonwealth legislation has raised the bar above State/Territory legislation it takes precedence. As an example, there are some significant differences between Commonwealth and State/Territory legislation in relation to a patient's access to their medical records and in terms of definitions and provisions related to consent. The various interpretations of what informed consent means and whether in terms of risk doctors should seek written consent, create a level of uncertainty which in turn leads to unnecessarily complex and time consuming risk avoidance processes.

### **CONSENT GONE MAD**

In relation to the BMMS the general practitioner will, for each patient that is not currently registered or for whom they do not have consent to access the patient record undertake the following:

At some time during a normal consultation the GP will ask the patient if they are registered with BMMS. If not the GP will be required to provide an explanation of what is a very complex system, answer initial questions and provide the patient with written information we assume will be developed by the Government. The patient will take the information away and return to register – whether this is done as a consultation is not clear but would be done as part of a normal consultation if that occurred at the same time the patient wanted to register.

The doctor registers the patient through the electronic registration only available on his or her desktop and linked to PKI. In registering the patient the doctor also undertakes a separate agreement where the patient consents to:

- participate in the BMMS;
- uses of the information in the medication record beyond that required for the patient doctor event;
- whether the patient consents to emergency access override; and
- whether the consent is event based or standing consent.

In implementing this consent process the GP will also be required to explain the patients rights and obligations and particularly their responsibilities should they decide at some point in time that they wish part of the record suppressed. It is also recommended that the GP maintain a signed paper copy of consent from each patient.

In this consultation, should the GP determine that a referral to a specialist and some pathology is required, he or she must obtain the consent of the patient to provide necessary clinical information to the specialist and pathologists. Under proposed informed financial consent provisions a GP would also be required to attempt to accurately advise a patient of the costs of a specific specialist service. At this point the patient also has the right to deny access of the specialist to any part of the BMMS record.

For subsequent consultations a participating doctor will have to ask each patient if they are registered and electronically check and acknowledge consent of the patient for the GP to use the record. Patients have a right to determine the actual wording of some elements of the record and therefore the doctor must show the patient what they have written and patients also have the right to suppress certain events that they do not wish anyone else to see. Further patients are permitted to seek copies of their current record from their doctor (though this is likely to be limited to four times per year). However, given access to the current BMMS is only available to the doctor this means the doctor alone will be responsible for going into the record and printing it off. Patients are also permitted to amend or annotate the record and they need to do this with the doctor.

In some cases the risks associated with a breach to legislation, Commonwealth or State, may require doctors to seek expensive legal advice. The BMMS draft legislation for example provided for criminal offences with up to two years prison in relation to a number of privacy breaches. The Commonwealth Privacy Act, however, adopts a mediation approach and incorporates no offence. The AMA's experience is that amendments to the Privacy Act alone have created uncertainty and concern for members in terms of their compliance and risks.

#### **6.4 Divisions of General Practice**

Analysis of the impact of red tape costs associated with programs managed by the 123 Divisions of General Practice throughout Australia fall clearly and directly within the Productivity Commission's terms of reference for the purposes of this Review. All Divisions of General Practice are private companies, governed by Corporate Law and are contracted with, and funded by the Commonwealth to implement, monitor and evaluate Government policies and programs. The activities of the Divisions in relation to general practice are, for all intents and purposes, Commonwealth programs guided by Commonwealth policies.

Divisions of General Practice were established as a joint initiative between the Commonwealth Government and GPs beginning in 1992. In 1997 and 1998 all Divisions moved to Outcomes Based Block Grant Funding (OBF). Under this model Divisions receive funds on the basis of the size and demographics of the geographically defined patient population which their GP-members serve, in exchange for which Divisions agree to meet defined health outcomes in a number of performance areas. Divisions report to the Commonwealth on their performance targets and use of Commonwealth funds every six months. No formal assessment of compliance with performance indicators and targets appears to be undertaken. However, in implementing Government programs and policies and particularly through their monitoring and evaluation requirements Divisions impose red tape on general practice. The level of red tape imposed by Divisions is one issue. Another is whether this 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. Further, Divisions may also contract for external funding to undertake specific research or implement clinical trials through members or member practices.

#### **Surveys – A Disproportionate Load for GPs**

Commonwealth Government Statistical Clearing House (SCH) representatives note that while in terms of a business community of 800,000, general practitioners represented only about 2%, they were subjected to a disproportionate percentage of the total survey load. Of a total of 132 surveys directed to the business community 22 (or 17%) were directed to general practitioners.<sup>38</sup>

Comment of SCH representative, 14 August 2002

As an example of the significant use of time consuming surveys by Divisions in fulfilling their contracted role to the Commonwealth, the 1999/2000 report on the Annual Survey of Divisions, indicated that all 123 Divisions used surveys, medical

<sup>38</sup> Commonwealth Government's Statistical Clearing House convened a cross portfolio and stakeholders forum to discuss Surveys on Doctors on 14 August 2002.



audits, registers or data to evaluate and monitor their activities. The most common evaluation method, however, was GP surveys which 122 Divisions reported using. Further Divisions reported that GP surveys were considered the most useful method for planning and implementing their programs and activities.<sup>39</sup>

## **6.5 GP Services in Residential Aged Care Facilities**

The well-developed health service and residential aged care (RAC) systems in Australia can be characterised as funding and bureaucratic “silos”.

The Commonwealth sets the regulatory environment for residential aged care facilities, regulating standards of service provision and all income streams/funding.

The current Australian aged care subsidy and accreditation systems purport to fund and assure a quality multi-disciplinary care service but result in a "pseudo-stand-alone" system. Doctors have no formal relationship or responsibility to the residential aged care facilities. For example, for quite some time there have been large barriers facing general practitioners who attend patients in Residential Aged Care Facilities.

For example, while doctors are legally and ethically responsible for the care management of their patients, the enormous amount of paperwork required within residential aged care facilities act as major disincentives for doctors to provide medical consultations and treatment within facilities. These barriers include:

- The adversarial approach of the Department of Health and Ageing’s Resident Classification Scale (RCS) validation system which monitors and determines the care level classification (and thus funding level) of all residents in aged care.
- The inspectorial approach of the Aged Care Standards and Accreditation Agency. There is enormous paperwork involved in residential aged care facilities’ complying with the standards and expected outcomes set by the Agency, including in medical areas such as medical care, medication management, and restraint. Failure to comply can result in sanctions on the facilities, including closure.

Much of the red tape for these two inspectorial regimes are duplicated across the two requirements.

The Health Insurance Commission has also “considered it necessary” to question some GPs in relation to their increased number of visits being undertaken to residential aged care residents/patients.

An analysis of Health Insurance Commission data indicates that in 1998 there were 129,403 residents in Aged Care Facilities and 1,557,570 attendances by GPs to the facilities. In 2000 the number of residents increased to 130,316 while the number of attendances by GPs to the facilities dropped to 1,519,301.

While this looming crisis in service provision to residential aged care facilities by GPs is largely related to funding issues, it also indicates the failure of the funding structure

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<sup>39</sup> Distinct Divisions: report on the 1999/2000 Annual Survey of Divisions of General Practice in Australia, C. Modra, E. Kalucy, E. McIntyre – Department of Health and Aged Care and the National Information Service, 2001.

to take into account the level of non face to face time spent by GPs involved in red tape associated with providing care in a system that is highly regulated.

For example, a GP who takes over the care of a new patient from another GP in a residential aged care facility is required to develop a Comprehensive Medical Assessment Care Plan. This involves what amounts to patient assessment, information collection and review and care plan development over a period of around two to three weeks<sup>40</sup>. The high dependency level of residents in aged care facilities and their associated complex and chronic health problems ensure that this process is not straightforward. Participation of the GP in this process involves substantial non face-to-face time attempting to develop a plan within a structure that is fragmented and remunerated at a level which makes participation in such an exercise uneconomic, inefficient and carries with it high opportunity cost.

## **6.6 Centrelink and Department of Veterans Affairs**

The AMA understands that the Productivity Commission will be closely examining the extensive administrative burdens placed on medical practitioners through programs administered by Centrelink, the Department of Family and Community Services and the Department of Veterans' Affairs. In a study conducted by Synavant Foresearch<sup>41</sup> for the Australian Doctor magazine in April 2002, general practitioners identified Centrelink as the single agency placing the most onerous demands on them in terms of unpaid paperwork and administrative requirements.

The administrative requirements of programs administered by the Department of Veterans Affairs place similar burdens on medical practitioners. Despite undertakings from the Department of Veterans Affairs to review these requirements with the objective of reducing the burden of unpaid paperwork placed on medical practitioners, no such review has taken place.

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<sup>40</sup> The collection and clarification of historical data – discussion with the patient and/or relatives or legal guardian as appropriate, accessing a previous GP, phoning specialists and contacting a hospital – is often necessary. This is time consuming but extremely important for provision of continuity of care and prospective quality medical care.

<sup>41</sup> GP Paperwork Requirements Research Report, PISA 2/02 March 2002 Prepared by Synavant Foresearch for Australian Doctor.

## **7. GP SURVEYS – OPTIONS FOR REDUCING THE SURVEY LOAD**

Over the course of recent meetings, including the half day Productivity Commission's Advisory Committee Roundtable on this study and a full day forum on Surveys of GPs, convened by the Commonwealth Government's Statistical Clearing House, a number of options were raised. AMA acknowledges that these options were raised informally but considers it important to provide comment at the earliest stage on these proposals.

### **7.2 *Integration of Commonwealth Government surveys***

During the Forum on Surveys of Doctors (14 August 2002) representatives of Government Departments that participated recognised and acknowledged the problems of duplication of survey questions both across and within Departments. A logical response was consideration of how to “piggy back” questions that respond to what would have been a number of surveys and allow the sharing of “common” data. The development of an omnibus survey that covered a number of different agencies requirements was proposed.

The AMA representative expressed the view that such an approach may constitute a breach of the Privacy Act and where it did not it would, however, have the effect of increasing the informed consent burden and associated risk, particularly where the information required is based on patient records. Key issues related to a “mixed” purpose for data collection and the potential for agencies to have available to them “opportunistic” data (data they would not have normally collected). Further such a proposal raised concerns about data linkage. The Productivity Commission and the Commonwealth's Statistical Clearing House in considering such remedies must pay strong regard to the red tape implications that privacy provisions now impose on GPs, particularly in terms of consent.

### **7.3 *Improved Internal Management***

Some Departmental representatives acknowledge the frequent silo approach to survey implementation and the absence of any monitoring or coordination within specific Commonwealth Departments. While there was general agreement that this was a common problem that led to duplication in particular, there was little that could be done about it. This was an issue for the larger Departments such as Health and Ageing. AMA's representative disagreed and noted this was a “management” issue. It simply required a structure that ensured co-ordination and monitoring of survey activities that was aimed at reducing duplication in particular. Current technology provided the tools but the management structure and the specific role had to be established in the first instance. While duplication of data collection across a range of different Departments was more difficult the management of this problem within Departments is relatively straightforward to resolve.

### **7.4 *Delegation of Survey Requirements***

It was suggested that surveys normally directed to GPs could be directed to other staff within the practice for completion. While surveys were consistently addressed to the GP, it is not always necessary that the GP personally complete the forms. The AMA representative pointed out that regardless of where the time was allocated within a

practice to complete a Government survey, the cost of that time was a cost to the GP. Such a process was not a real solution and would simply represent a burden and cost shift within a general practice. This may be worth considering, however, in the context of a range of measures aimed at reducing the overall burden of surveys imposed on GPs.

## **8. COMMONWEALTH PROGRAMS/POLICIES FOR REVIEW**

**Attachment A** to this submission provides the list of Commonwealth Programs that the Productivity Commission developed and provided on 15 August 2002 to representatives of the Advisory Group (including AMA) for this study.

The AMA has appended a list of policies and programs that are additional to those already identified by the Productivity Commission. These appear under the heading “Additional Commonwealth Programs and Policies”.

## 9. RESOURCES

AMA recommends the Productivity Commission refer to the following resources in undertaking its study:

- Report to the AMA by Access Economics, February 2002 – “An Analysis of the Widening Gap between Community Needs and the Availability of GP Services.
- The General Practice Workforce in Australia, Results of the 2001 AMA GP Survey, prepared for the AMA by Access Economics Pty Ltd, December 2001
- Review of the Practice Incentives Program conducted for the Commonwealth Department of Health and Aged Care, Medicare Benefits Branch by Wendy Bloom and Associates – October-November 2000.
- The Relative Values Study – a six year joint study by the Commonwealth Department of Health and Ageing and the AMA.
- Bettering the Evaluation and Care of Health (BEACH) – an ongoing national data collection undertaken by Department of General Practice, University of Sydney at Westmead Hospital. BEACH is financially supported by the Commonwealth Department of Health and Aged Care, the Department of Veteran’s Affairs, the National Occupational Health and Safety Commission, Astra Pharmaceuticals, Roche Products and Rhone-Poulenc Rorer Australia Pty Ltd.
- Evaluation of the General Practice Immunisation Scheme prepared by KPMG for the Commonwealth Department of Health and Aged Care, November 2000 and submissions to Government in response to that study.
- General Practice in Australia: 2000, Department of Health and Aged Care, May 2000.
- Distinct Divisions: Report on the 1999/2000 Annual Survey of Divisions of General Practice in Australia. Modra, C, Kalucy, E, McIntyre E. 2001. National Information Service and the Department of Health and Aged Care.
- AMA Privacy Resource Handbook – For All Medical Practitioners in the Private Sector, AMA 2002
- An Analysis of Forms in General Practice – Final Report, September 1996, Dr Peter Schattner, Department of Community Medicine and General Practice, Monash University
- GP Paperwork Requirements Research Report, March 2002. Prepared by SYNAVANT FORESEARCH for Australian Doctor, April 2002

## **10. AMA RESOLUTIONS**

The AMA has passed a number of resolutions in relation to red tape.

The AMA Council of General Practice (AMACGP), 6-7 July 2002, passed the following resolution:

That AMACGP, recognising the increasing and unacceptable burden of red tape imposed by Federal, State and Territory Governments on general practice, supports an AMA campaign that seeks to reduce the burden of red tape in general practice, including through participation in consultation processes associated with the Federal Government's review of red tape.

The AMA Executive Council passed the following resolution on 11 July 2002:

*That Executive Council, recognising the increasing and unacceptable burden of red tape imposed by Federal, State and Territory governments on general practice, support:*

- *An AMA campaign that seeks to reduce the burden of red tape in general practice; and*
- *Participation in consultation processes associated with the Productivity Commission's review of red tape in general practice.*

### **Previous AMACGP Resolutions**

#### **2001**

*The AMACGP urge all general practice accrediting bodies to review their operations to ensure minimisation of cost and bureaucratic imposition to practices, maximisation of openness and communication and clearly demonstrated relevance to general practice.*

*That AMACGP support the user pay principle in that whenever a report is requested the party that actually makes the request, be it a government department or private organisation should be responsible for the appropriate payment for the service.*

## ATTACHMENT A

### RELEVANT COMMONWEALTH PROGRAMS

#### **Family and Community Services programs**

Disability Support Pension	FACS/Centrelink
Sickness Allowance	FACS/Centrelink
Newstart Allowance	FACS/Centrelink
Youth Allowance	FACS/Centrelink
Mobility Allowance	FACS/Centrelink
Carer Payment	FACS/Centrelink
Carer Allowance (child and adult)	FACS/Centrelink
Child care Supplementary Services (SUPS) Program	FACS
Child care Special Needs Subsidy Scheme (SNSS)	FACS

#### **Veterans programs**

Health DVA/HIC

- Repatriation Comprehensive Care Scheme
- Application to be a local medical officer (LMO)
- Procedural requirements for LMO consultations (LMO Notes)
- Enhanced primary care initiative
- Veteran's Home Care
- Repatriation Pharmaceutical Benefits Scheme (RPBS)
- Prescriber Intervention and Feedback Program

Income Support DVA

- Service Pension (Invalidity)
- Income Support Supplement

Disability Compensation DVA

- Disability Pension
- Disability Allowances
  - Attendant Allowance
  - Clothing Allowance
  - Loss of Earnings Allowance
- War Widow/Widower's Pension and Orphan's Pension
- Veterans' Children Education Scheme

Military Compensation and Rehabilitation Service DVA/MCRS

#### **Health programs**

Australian Childhood Immunisation Register DOHA/HIC

Medicare Benefits Schedule Eligibility of Providers: HIC

- Eligibility to access higher Medicare rebates:
  - Vocational register of GPs
  - Fellows List
  - Rural Remote Area Placement
  - Temporary Resident Other Medical Practitioners
  - Approved Medical Deputising Service
  - Rural Locum Relief
  - RACGP Registrars
  - General Practice Education and Training Registrars
  - Rural Other Medical Practitioners



- Australian College of Sports Physicians Fellows
- Australian College of Sports Physicians Registrars
- Remote Area Exceptions

Medicare Benefits Schedule Billing Items:

- Enhanced Primary Care
- Home Medicines Review DOHA/HIC

Pharmaceutical Benefits Scheme (PBS):

- □ PBS authorisations DOHA/HIC

Practice Incentives Program DOHA/HIC

General Practice Immunisation Incentives Scheme DOHA/HIC

General Practice Registrars Rural Incentive Payments Scheme DOHA/HIC

Rural Retention Program:

- Central payments
- Flexible payments DOHA/HIC/RWA

Rural and Remote General Practice Program DOHA/RWA

Rural Women's GP Service DOHA

Rural Other Medical Practitioners Program DOHA/HIC

Quality Innovations Funding Program For Medical Deputising Services DOHA

Aboriginal Community Controlled Health Services (ACCHS) receiving MBS Funding DOHA

Pre-Existing Ailment Waiting Period DOHA

Overnight Certification DOHA

3B Certificates DOHA

Informed Financial Consent DOHA

More Doctors For Outer Metropolitan Areas DOHA

3 GA Program DOHA

19 A(B) Exemptions DOHA

Sharing Health Care Initiative DOHA

Commonwealth Hearing Service DOHA

## **ADDITIONAL COMMONWEALTH PROGRAMS AND POLICIES**

- Disease Registers
  - Cancer
  - Diabetes
  - Immunisation
  
- Residential Aged Care Facilities
  - Accreditation
  - Assisted Care forms (6 monthly to provide GST exemption for residents)
  
- Treating Doctor Reports Centrelink
  
- Information Technology
  - Data collection for Government
  - Policing role
  - Consent
  
- Privacy
  - Legislative complexity/compliance
  - Security compliance
  - Consent issues
  
- Practice Incentives Program
  - Single Whole Patient and Whole Patient Equivalent Calculations