Australian Divisions of General Practice Ltd.

Submission to the Productivity Commission on the General Practice Compliance Costs Study

1. Introduction

ADGP Ltd. is pleased to make this submission to the Productivity Commission as part of the study of compliance costs in general practice. Many of the issues raised in our feedback will already be known to the Commission, and have been addressed in numerous other submissions to the study. Therefore, in the interests of brevity we have decided to restrict our submission to key comments that were highlighted in the feedback received from our consultation with our members.

In response to concerns raised by Divisions and their GP members, representing approximately 90% of general practitioners in Australia,[1] ADGP has continued to seek solutions to the increasing burden being placed on GPs in complying with government requirements. When the extension to the General Practice Memorandum of Understanding (GP-MoU) was rejected in October 2001, ADGP, together with the Rural Doctors Association of Australia (RDAA), was instrumental in securing the Government's commitment to the review of "red tape" in general practice.[2]

The greatest concern for general practitioners regarding the increasing burden of paperwork and compliance with bureaucratic requirement is the extent to which it detracts from the delivery of care to their patients. There is a strong perception among GPs that many programs do not contribute to the practise of quality medicine, or benefit patients, and in many cases, actively work against it.

2. Issues of compliance with Commonwealth programs

2.1. Enhanced Primary Care, Mental Health MBS Items

Feedback received by ADGP shows that the lack of uptake and recent decline in use of the Enhanced Primary Care (EPC) items, particularly those for Care Planning and Case Conferencing, are due to the complex administrative requirements associated with claiming these items. It would seem that many GPs have determined that the cost-benefit ratio of delivering EPC Care Plans and Case Conferences is not sufficient to warrant the effort entailed in completing the requisite paperwork.

> *To set up a system for Care Plans in our practice took me at least 60 hours. I employ someone for around 10 hours a week to administer it. The doctors all complete the Care Plan paperwork in hometime."*

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[1] Primary Health Care Research and Information Service (2002), *Annual Survey of Divisions 2000-01*, Commonwealth of Australia, 2002.

[2] AGREEMENT ON THE FUNDING OF GP INITIATIVES between the Commonwealth of Australia and Australian Divisions of General Practice and Rural Doctors Association of Australia *28 September 2001 – 30 June 2004*

Many of the new MBS items including EPC and the Mental Health item, are packaged in a different way from traditional attendance items for general practice consultations, and have a considerable number of forms involved in both delivering and claiming the items. The mental health item also includes a requirement for completion of additional training by the GP wishing to claim it. The relatively simple structure of the fee for service system seems to be a key factor in GP support for this method of payment. Some GPs have suggested that introducing higher rebates for chronically ill or disadvantaged patients would compensate for the burden of compliance with initiatives such as EPC.

Much of the criticism of these items is that they are seen as condescending, telling GPs how to do what they have been doing for years as standard care for their patients, as well as placing an additional administrative burden on GPs to claim them. There is apparent resentment by GPs that these "quality" initiatives infer a lack of quality, or concern for quality, in current general practice.

"I often speak with specialists and allied health professionals regarding how patients are going but I couldn't be bothered with the paperwork to claim the item numbers for a care plan."

2.2. Practice Incentive Payments (PIP)

The inadequacy of fee for service to deal with equity and access issues has been documented elsewhere. Many GPs support a "blended" or "additional" payment system, recognising that fee for service supports episodic care, or an "illness model of care", but not the care of those with chronic and complex needs or preventive health, a "health model of care". ADGP is supportive of alternative payment mechanisms that support quality of general practice care and which allow GPs to work as part of a team to deliver quality primary care to their patients, on the proviso that such payment mechanisms do not create an additional burden or compliance cost on GPs.

There appears to have been general initial support for PIP, as a funding mechanism to support the expanding role of GPs in prevention and chronic disease management. However, the feedback received by ADGP indicates that that support for PIP has dropped off considerably with the increasing complexity of registering and maintaining the information requirements for PIP. The tiered payment structure in five initial categories has now grown to include payments for diabetes, care plans, cervical screening and asthma. Indications are it is likely to expand further.

In addition, the allocation of payments at the practice level may be disadvantaging employee or contract GPs, who may be responsible for a substantial proportion of the paperwork but are not remunerated for this. The Government has argued that this is an internal practice issue, however it may be worthwhile considering alternative payment mechanisms to support quality that do not disadvantage non-practice principals. There was also a suggestion that accurate and timely feedback should be provided annually to PIP practices once registered.

"There is approximately one full time staff member employed for dealing with the HIC, and PIP. There is a paucity of accurate written information from the HIC in relation to PIP, and an unfortunate inconsistency in the answers received to questions directed to HIC."

2.3. Accreditation

Practice accreditation is now a prerequisite for receiving PIP. Many practices have become reliant on PIP income and are finding the additional compliance burden associated with accreditation extremely difficult. Accreditation requires a substantial time and money investment by the practice that is not compensated by the additional income from the PIP. As discussed in 2.2 above, PIP also carries its own paperwork requirements, adding to the administrative burden on the practice and the GP. There was also concern raised in feedback to ADGP about the lack of evaluation of the impact of accreditation on general practice, from both quality and administrative perspectives.

While there appears to be general support for the concept of accreditation to maintain minimum quality standards, it may be necessary to ensure additional support for general practices to assist them in attaining accreditation and reaccreditation. This could be provided in a number of ways: through Divisions of General Practice; through accreditation providers, with a focus on ensuring equitable access for all practices; or as infrastructure payments to the practice to enable introduction of the necessary practice systems.

"I took 3 months off from clinical work to complete the requirements for accreditation… It's not that the process was unproductive just that there is not the resource in general practice."

2.4. Health Insurance Commission (HIC) (MBS and PBS)

Many GPs commented on the duplication of information required by the HIC from general practices. For example, the authority forms to register a new doctor with a practice ask for a substantial amount of duplicate information. There is also duplication in the requirement for separate medication reviews within a Health Assessment and for a Home Medication Review (both EPC services); and in requesting a PBS authorisation 6-monthly for a medication for a chronic condition for which the patient has already received a prior authorisation.
Related to the issue of administrative requirements being seen as condescending was a comment that authority prescriptions carry an implication that GPs will not stick to guidelines, or will not act in the best interests of their patients.

The accuracy and timeliness of feedback from the HIC was repeatedly raised as an issue.

2.5. Centrelink

Previous studies have indicated that Centrelink forms are the highest contributor to the paperwork and compliance burden in general practice[3]. The particular issues raised in regard to compliance with Centrelink are:

- Unnecessary duplication of information;
- Repeat assessments e.g. "repeatedly filling out Sickness Benefit Forms for a woman with metastatic breast cancer who will never return to work";

[3] Synavant Foresearch (2002), *GP Paperwork Requirements Research Report*, prepared for Australian Doctor, March 2002.

- Treating Doctor Reports – it was noted that these are not always possible to complete as part of a consultation, and that "as most of these patients are pensioners, most GPs feel obliged to charge less…";
- The burden of completing forms for Centrelink clients is compounded in many cases by a lack of ability in English, which will be concentrated in particular communities.

2.6. Department of Veterans Affairs

There appeared to be slightly less concern about compliance with DVA requirements, possibly as completion of DVA forms is linked to payment for the GP. There were comments made, however, about the decline in the level of DVA remuneration for this purpose.

3. Other issues

3.1. ADGP supports the inclusion of non-Vocationally Recognised GPs and GPs who work in other settings e.g. Aboriginal Medical Services, for the reason that the work requirements are the same, and in some cases more burdensome in these settings. With the severe workforce shortages currently being faced by general practice, paperwork is likely to be a strong contributing factor in the reluctance of GPs to train and/or practice in particular settings.

"The low infrastructure environment e.g. remote indigenous salaried GP has much lower capacity to comply with any systems and tend to take [a] minimum approach to get things done – even signing Medicare forms and path [sic] *forms eat into critical patient care time in overwhelming burden of disease and mortality."*

3.2. ADGP supports differentiating in the study between practices according to their location, including rural, remote, outer urban and inner urban practice. Different regions will reflect different general practice work structures, e.g. GPs working as VMOs will face different requirements in regard to dealing with and working in the (State) hospital system, that will impact on their private practice.

"…Even if the government does introduce measures to reduce GP paperwork overheads, this will probably only be effective in rural areas if the infrastructure services and technology [eg. broadband access] are available at an acceptable cost."

It will also be important to consider the impact of different demographics on GP workload and compliance costs. For example, those GPs who work in areas with higher rates of unemployment, or more employment in manual occupations, may face greater compliance costs with Centrelink/Workcover requirements.

3.3. ADGP also supports differentiating among GPs by the size of the practice in which they work, in order to shed some light on the impact of economies of scale on compliance costs.

3.4. There were numerous comments made in the ADGP feedback regarding the lack of rationale or evidence for the various programs implemented by the Commonwealth. While we do not believe this is necessarily the case, we would suggest that more effort needs to be undertaken by the Government to communicate this information to GPs.

3.5. "Reform fatigue": the pace and number of new reforms that have been introduced into general practice, particularly in the past four or so years, has been staggering, and has allowed little opportunity for GPs to adapt to or incorporate new processes into their practice before another one is implemented. The Government needs to consider the impact on general practice of simultaneous or successive implementation of multiple programs.

3.6. The costs that must be considered in the study include both GP and staff time for direct compliance (filling out forms, talking through programs with patients), as well as planning time to make the practice functional for compliance (educating self and staff about a new program, installing new systems). In some cases, this has meant the practice employing a new person specifically to deal with compliance issues.

"I spend time assessing all new government initiatives and where appropriate repackaging them to make them efficient and user friendly for the other 4 doctors in our practice."

3.7. Costs must also include consideration of the impingement of bureaucracy on the family life of GPs and practice staff. Many GPs talk about the necessity of using their "time off" (nights, weekends) to complete paperwork, and some have devised imaginative systems to deal with the quantity of work (using a washing basket to take home the daily load of papers for example.)

3.8. Workforce shortages mean that appointments are scarce, waiting times are long, and the time a GP has to spend with individual patients reduced, thereby compounding the effect of complying with administrative requirements. This also has a psychological impact on practice staff that sometimes are required to deal with aggravated patients who are unable to get an appointment or see the doctor of their choice.

3.9. There has been a suggestion that the Divisions of General Practice Program should be included in the study, specifically in regard to the use of GP surveys. Our feedback strongly indicates the opposite, that Divisions have contributed to relieving the red tape burden on GPs, and have provided an alternative source of income for many who are involved in Divisional programs, governance, or management.

Divisions "supply advice, computer training, help with software, assist with immunisation compliance, provide CME, help with provider numbers, [and] assist with hospital credentialing".

3.10. The terms of reference for the study have excluded consideration of compliance with State and Territory programs, however the unique nature of health care administration in Australia, with major crossover between Commonwealth and State programs, affects GPs acutely. Their generalist and longitudinal practice requires that GPs work across numerous settings e.g. aged care facilities, hospitals etc., based on where their patients are being treated, not on who administers the service. EPC of course involves health professionals working in the State system.

Compliance with different institutional requirements often creates an additional time and/or paperwork burden for the GP. This is undertaken in the interests of providing good care to their patients, but is a compounding factor in the levels of stress GPs face in compliance. Anecdotally, there is a declining number of GPs willing to work in residential aged care facilities, which may impose an additional burden on those who continue to do so.

ADGP believes that any study of compliance costs in general practice will be incomplete without a consideration of the compound burden of State/Territory programs.

3.11. The siloed nature of government departments must also be considered as contributing to the compliance load on general practice, where multiple departments, and sections within departments, running different programs, have different and competing (although often duplicated) information and paperwork requirements. Rationalisation of such programs must surely be a critical strategy in finding a solution to the red tape crisis.

3.12. Many GPs have found the introduction of new private sector privacy legislation has increased the time and effort associated with obtaining patient consent, not to mention that needed to understand their obligations under the Regulation. Greater support and education initiatives prior to the introduction of such legislation in the future may go a long way to reducing the compliance burden on GPs.

3.13. GPs have suggested that there needs to be more regard for their clinical opinion rather than just "tick box" forms – 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.

3.14. There were a number of comments about the need for improved clinical software to support GPs in their delivery of programs (eg. diabetes, cervical screening, DMMR, immunisation). There was also some comment received about the seeming contradiction of some programs requiring hand written forms (Centrelink), whilst others are pushing GPs to become fully computerised.

"The ongoing development of IMIT 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..."

3.15. Where possible, many GPs are using practice staff, practice nurses etc. to undertake activities, including the associated paperwork, such as immunisations, health assessments etc. Whilst this may be effective in relieving the burden on the GP, staff time is still a practice cost that must be factored into any review of the burden of compliance.

ADGP strongly supports the use of teams within the practice to assist the GP in the delivery of high quality primary care, and there is a critical need for additional funding to be allocated for this purpose.

Clearly, the costs of complying with administrative and other requirements in general practice is substantial. One GP comment summarises the key issues perfectly:

"Incrementally general practice has accepted more and more bureaucratic requirements for patient management. It remains unclear whether there is an improvement in health outcomes due to this or whether there is an economic benefit in terms of health spending. There is certainly little benefit to the general practitioner doing the work. With good practice support there may be a benefit to the management of an individual practice but this comes at a cost that may not be able to be recouped at this level. GPs need to feel valued for the work they do, not the forms they fill out."

ADGP wishes the Commission well in its undertaking, and looks forward to working with the Commission to find practical solutions to the burden of unnecessary red tape in general practice.

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