10 March 2003

Ms Helen Owens
Commissioner
Productivity Commission
Locked Bag 2, Collins St East
MELBOURNE VIC 8003

Dear Ms Owens

I am please to provide ADGP's submission to the Commission's *Progress Report on the GP Administrative and Compliance Costs Study 10 February 2003*.

ADGP has made a range of comments and suggestions against the reports draft findings and recommendations and would welcome the opportunity to discuss these further with the Commission prior to conclusion of the study.

ADGP is particularly keen to present a case study to the Commission demonstrating the reduction in administrative and compliance costs associated with EPC and related evidenced based MBS items through the innovative use of GP desk top software and the maintenance of complete, integrated electronic patient notes. ADGP feels that such a demonstration would assist the Commission to add weight to recommendation 6 and 7 of its draft report.

ADGP officers will contact the Commission following presentation of the ADGP submission to pursue this matter.

Whilst there remain concerns regarding the scope of the Commission's Terms of Reference (ie exclusion of costs associated with State/Territory government administrative and compliance costs) and the accuracy of the Commission's assumptions regarding average hourly pre-tax earnings, ADGP commends the Commission's efforts in undertaking this study and looks forward to supporting the implementation of many of its recommendations.

Please contact Ian Krebs or Kerry Ungerer on 6228 0800 should you wish to discuss any aspect of ADGP's submission.

Yours sincerely

Steve Clark (Dr)
Chief Executive Officer

AUSTRALIAN DIVISIONS OF GENERAL PRACTICE LTD

Response to the

Productivity Commission
General Practice Administrative and Compliance Costs Study
Progress Report 10 February 2003

DRAFT FINDING 1

Incremental administrative costs for general practitioners and general practice resulting from Commonwealth policies and programs are estimated to be about $230 million in 2001-02, just under 6 per cent of GPs' total income from public and private sources. This is equivalent to an average of about $9500 per GP. GPs receive government payments above incremental costs for most programs.

Comment:

While ADGP understands the Commission's terms of reference require it to report on costs only, ADGP believes it would be both useful and provide a more accurate picture of the relative costs and benefits of such programs to report both the incremental administrative costs and the payments received by GPs in incurring these costs. Cost figures alone may have a negative impact on GP uptake and/or continued use of important quality service models such as DMMR, EPC, Mental Health Plan etc.

DRAFT FINDING 2

Three programs — vocational registration, the Practice Incentives Program (including Service Incentive Payments) and Enhanced Primary Care — accounted for over three-quarters of GP administrative costs. Administrative costs arising from GPs completing forms for the Department of Veterans' Affairs and Centrelink accounted for much smaller shares of total administrative costs, largely due to the small average number of forms completed per GP.

Comment:

ADGP believes the report should clarify the proportion of administration costs of programs such as VR, PIP and EPC relative to the *total* activity undertaken by a general practitioner. For example, standard GP consultations (under the Commonwealth Medicare program) represent the vast majority of GP activity,

but the administrative cost associated with this activity has not been considered. This would be helpful in gaining a proper understanding of what GPs perceive to be their main administrative burdens. Such perceptions will also be influenced by the level of remuneration against incremental administrative costs, and the nature of the task undertaken.

ADGP requests that the Commission provide more qualitative data (under its "third source of incremental costs") that distinguishes GP attitudes/feelings about categories of cost. For example, is the administrative cost of EPC a positive cost with less "stress and frustration" than say a Centrelink form because the former provides a direct health service to the patient and attracts adequate remuneration? PIP and EPC are direct medical services with a payment that the Commission has estimated on page 15 to gain payments four times greater than the administrative cost.

ADGP also requests that the Commission provide an indication of the increase in volume of administrative requirements over time associated with such programs as PIP and EPC. This would provide some insight into why GPs are feeling overwhelmed by administrative requirements and would strengthen the impact of Recommendations 1 to 3 of the Commission's Progress Report.

DRAFT FINDING 3

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

DRAFT FINDING 4

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

Comment:

Findings 3 and 4 indicate that practices in low socio-economic rural/remote and outer urban areas carry a disproportionate level of administrative cost. ADGP believes that a further recommendation should be included that promotes investment in building the capacity of general practices in low socio-economic rural/remote and outer urban areas, where there are greater proportions of solo, un-accredited, un-computerised and bulk billing practices. Providing resources to enhance the practical support provided to GPs working in such areas would contribute to reducing the relative burden of administrative costs. ADGP also believes that greater levels of support for these practices would reduce disincentives for GPs to practice in these areas.

DRAFT FINDING 5

Many programs within the scope of this study are voluntary and GPs (or general practices) are remunerated for participation. Therefore, departments have not been required to prepare a Regulation Impact Statement as part of the implementation process for these programs.

Comment:
While these items are 'voluntary', the Commission should also be cognizant that GPs may perceive them as "essential" in that they provide much needed additional income, particularly for bulk billing practices in low socio-economic rural/remote and outer urban areas, and also support high quality care for the targeted patient group.

Programs such as EPC and PIP are designed to support GPs to deliver evidence-based management and preventative care to patients. Where GPs perceive the items to be both good medicine but 'bad business' (in the sense of over regulated and too much paperwork), increased stress and frustration is generated. Qualitative data that explores this issue would be useful in progressing an understanding of how to reduce administrative costs to GPs.

ADGP also believes that GPs and their patients may incur costs by NOT accessing and using some of the available items, and that further resources should be made available to promote to GPs ways to reduce the administrative burden of using such items (such as integrated, active electronic templates – see comments on Recommendation 6) and the "business case" for doing so.

DRAFT RECOMMENDATION 1

When conducting program evaluations (for programs within the scope of this study), departments should include GP administrative costs associated with participation in the program (whether or not GPs are explicitly remunerated or their participation is voluntary) unless departments can show that these costs are insignificant.

DRAFT RECOMMENDATION 2

Departments should take GP administrative costs into account when setting the structure and level of program payments. The level of such payments does not necessarily have to equal GP administrative costs.

DRAFT RECOMMENDATION 3

As part of the program evaluation process, departments should consult with relevant GPs (or their organisations) regarding the potential magnitude and impact of GP administrative costs associated with the program.

Comment:
ADGP requests that Draft recommendations 1-3 include direction to Departments that the differential administrative costs of particular socio-economic and geographical locations should also be taken into account when setting payment structures and levels and evaluating programs.

DRAFT FINDING 6

There is variation across departments in their approach to remunerating GPs for similar tasks, particularly in relation to the preparation of medical reports.

DRAFT FINDING 7

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

DRAFT RECOMMENDATION 4

Consistent principles for remunerating GPs for providing medical information should be adopted across departments. This does not require identical payment schedules.

Comment:

ADGP agrees with this Recommendation. Payments should, however, recognise both the discrete and cumulative costs associated with providing the information.

DRAFT FINDING 8

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

DRAFT FINDING 9

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

DRAFT RECOMMENDATION 5

A coordination group should be established, consisting of relevant Commonwealth departments with programs affecting GPs, to assess cumulative GP administrative costs associated with Commonwealth programs.

Comment:

The problem of uncoordinated implementation of programs is one not only between Departments, but within Departments. Since 1999 GPs have experienced the introduction at least 40 new item number services (that is EPC, PIP, SIP, DMMR, Mental Health, Discharge Planning etc). The Commission should be cognizant of the cumulative change management effect on GPs of the quantity and manner of the implementation of new services. All of the above items were introduced with complex paper guidelines, without electronic templates/software to reduce administration and increase compliance/effectiveness and without education/facilitation to GPs regarding

the interface of these new items and how they can be integrated together and into the general practice.

ADGP recommends that the Commission consider adding a recommendation that, where relevant, each Department establish an internal coordination group that addresses reduction of administration costs, increase of GP efficiency and, relates to the inter-departmental coordination group. Further, the involvement of practicing GPs in the coordination groups would be essential.

ADGP also recommends that the Commission's report include a recommendation for resources to support the implementation of mechanisms that build practices' capacity to undertake quality care. ADGP is able to provide the Commission with further information/presentation on a holistic, integrated approach for patient management using the PIP, SIP and EPC items that achieves increased efficiencies and improved patient outcomes and which could provide the basis of a support program for GPs to reduce their administrative costs.

DRAFT FINDING 10

The extent to which information technology is used for GP administrative activities differs between Commonwealth departments. The reliance on paper-based systems is still significant.

DRAFT RECOMMENDATION 6

Departments should examine options to accelerate the use of information technology by GPs, including integrating forms into the computer based software systems used by GPs (such as Medical Director), and allowing more forms to be submitted electronically where there is a net benefit.

Comment:

Anecdote and some statistics suggest that between 7% and 20% of general practices maintain quality electronic patient records and practice management systems. The Commission should recognise that GP frustration with administration will be increased if Departments increase requirements for electronic management without the resources and facilitation to increase overall practice IM/IT use and efficiency.

The Commission should also explore the need for Departments to provide not only electronic information systems for the interface between the practice and the Department, but also for the internal administration within the practice of the particular task/service being conducted for the Department. For example, the DoHA has only supplied GPs with triplicate *paper* forms for the two major steps of the DMMR service. A practice that has since developed its own active electronic templates estimated after testing with nine GPs that the paper referral form for DMMR takes a minimum of 23 minutes to complete, whereas the electronic template takes six minutes.

Provision of paper only resources and forms to practice simply serves to increase levels of frustration in general practices toward such Commonwealth initiatives, the recent Asthma 3+ Plan Resource Kit is another example.

ADGP recommends that the Commission consider adding a recommendation that Departments:

- consult with GP organisations regarding the development of effective electronic software supporting new items and programs;
- require and fund software support in the regular updates provided by all medical software companies supplying general practice;
- provide coordinated intra- and inter-departmental facilitation to GPs that promotes integrated, whole of practice efficiency in administration; and
- assess the administration cost to Divisions of General Practice in supporting inadequately resourced and uncoordinated implementation of GP programs.

DRAFT FINDING 11

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

DRAFT RECOMMENDATION 7

A set of guidelines should be developed to ensure the standardisation of information collection and form design across departments, where appropriate. The proposed coordination group could assume responsibility for developing these guidelines.

Comment:

See previous comment.

DRAFT FINDING 12

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

DRAFT RECOMMENDATION 8

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

Comment:

ADGP believes that requirements should focus on information that is necessary to ensure quality practice.
