AMA RESPONSE TO THE PRODUCTIVITY COMMISSION PROGRESS REPORT 10 FEBRUARY 2003.

GENERAL PRACTICE ADMINISTRATIVE AND COMPLIANCE COSTS STUDY.

1. Progress Report Recommendations

The AMA supports in principle the recommendations of the Productivity Commission's Review of General Practice Administrative and Compliance Costs on the basis that further detailed consultation will be required to ensure that findings are adequately addressed and that recommendations are implemented.

In relation to **draft recommendation 2** of The Productivity Commission's Review of GP Administrative and Compliance Costs the level of program payments to GPs must be established in consultation with GP representative groups. This should occur in the context of consultations on the potential magnitude and impact of GP administrative costs associated with the program proposed in **draft recommendation 3.**

The Coordination Group proposed in **draft recommendation 5** of the Productivity Commission's Progress Report on the Review of GP Administrative and Compliance Costs must include appropriate mechanisms for consultation with GP representative groups.

In relation to **draft recommendation 5** the Productivity Commission notes that in assessing the cumulative administrative costs and activities there are also State and Territory, and local government policies and programs that should be recognised.

The AMA agrees and, in the context of the Coordination Group proposed under **draft recommendation 5** these non- Commonwealth policies and programs must be incorporated into the assessment. AMA acknowledges the limitations of the Productivity Commission's terms of reference for this current study. However, the recommendations of the Productivity Commission must be implemented in a manner that recognises and takes account of the non-Commonwealth programs and policies that contribute to overall compliance and administrative costs.

Further AMA is of the view that national collaboration is necessary to ensure a general reduction in administrative and compliance costs. For example, the National Health Information Management Advisory Council should play a significant role in ensuring national collaboration measures aimed at reducing GP administrative and compliance costs through a coordinated strategy related to the efficient and effective use of information technology.

2. Methodology

2.1 Costing of GP's time

It is a central tenet of economic theory that the relevant costs to assess are marginal costs, not average costs. Furthermore, proper economic analysis would take account of economic opportunity costs and not be limited to the financial costs that can be measured or estimated.

There is an issue of perspective as well. AMA members naturally enough approach this issue from the perspective of practitioners in private practice. The Commission's task, of course, is to assess the overall impact of compliance costs on the whole economy, not just the medical practice industry. We recognise that those working within a particular industry may not find it easy to gain that wider perspective, but in offering these comments, the AMA has certainly tried to see the issue in that wider context.

As we noted in our comments of December 2002, marginal impact on revenue when a GP is, say, filling in forms without specific remuneration (as is most often the case) is of the order of $200 per hour. That is the gross revenue foregone at current "fair" prices for the services provided. The $200 figure is, of course, the gross business income. To the extent that filling in forms resulted in lower practice costs than seeing patients, then it might be argued that the net revenue foregone could be less than $200 per hour. There are two issues that follow from this point:

- First, if the GP's own time is valued at his/her rate of ***net*** practice income before tax (in other words, his/her own remuneration), that is effectively the same thing as saying that red tape activities involve no on-costs (practice costs) whatsoever. Further, all practice costs are infinitely variable in the short term—in other words, while filling in forms, the GP does not have to pay wages to the staff, rent to the landlord, electricity for lighting and power, and so forth. ***Such a proposition is simply absurd***. Many practice costs are not variable in the short term.

- The Commission would be expected to argue that the figure of $200 per hour represents an ambit claim by the AMA, and does not reflect the actual market value of GP services given that some 70% of GP consultations are bulk-billed. The likelihood of a meeting of minds is, we think, slim. The Councils of the AMA remain convinced that $200 per hour is an appropriate figure to use while seeing why the Commission would prefer to use a figure based on strong empirical evidence. That said, there is a counterfactual issue here. In the relative value study (RVS) process, there was never any real meeting of minds between the Government board members and the representatives of the profession in regard to the total clinical time involved in GP consultations (including non face-to-face time). The AMA presented empirical evidence that the ratio of face-to-face time to non face–to-face time was 75:25, while the Department's ambit claim was 85:15 (a position not supported by any

evidence). The counterfactual point is that the empirical earning rates of GPs (both gross and net) are already reduced by the burden of red tape, so the use of the empirical figure necessarily underestimates the true cost of red tape to the medical services industry.

Do things change dramatically when we take the economy wide perspective as opposed to the medical services industry perspective? We think not. Australia has an overall shortage of GPs with particularly acute problems in remote, rural and outer urban areas. If the burden of red tape were reduced, the GPs would not be sitting around doing nothing. Far from it. The burden of red tape is detracting from their ability to meet the needs of the population for primary care and preventative services. People are turning to A&E departments in the hospitals as an alternative, but these services are under much pressure and are necessarily rationed. The upshot of underspending on primary care and inefficient use of the primary care workforce is overspending in tertiary care. We conclude that the opportunity cost to the medical services industry is not too bad a proxy measure for the opportunity cost to the economy as a whole.

In summary, it is the AMA's view that the Commission's methodology is unsound and that as a result, it has underestimated the cost of red tape to the wider economy.

2.2 Cost per GP

The AMA also has a concern about the way the Commission has expressed the cost of red tape per GP (put at $9,500). This is, of course, a derivative of the overall estimate and the number of GPs. We are informed that the Commission has used a figure of 24,307 obtained from the Department/HIC Medicare data sets. That estimate is starkly different from the latest estimate published by the Australian Institute of Health and Welfare (AIHW)[1], of 20,996 primary care practitioners. The reason is clear. The HIC data set headcounts GPs on the basis of services in respect of which a benefit is claimed. If, say, a medical practitioner who is employed in a hospital goes out into the community and delivers a single GP service in any quarter (eg, as a locum), then we understand that he or she comes within the headcount. In our view, the AIHW's way of measuring the medical labour force is far more useful than that adopted by the HIC.

We believe that it would be far more informative if the derivative cost per GP were expressed as the cost per Full Time Equivalent (FTE) GP. As discussed at length in the AIHW publication, there are various ways of calculating FTE estimates. One is to adopt a standard hours approach (AIHW illustrates outcomes for 35, 40 and 45 hours a week). That is a very mechanical way of going about it, of course. The AMA's own survey of the GP workforce (conducted in 2001) indicated that GPs were working 52 hours a week on average. Therefore, the arbitrary rules of thumb can result in an FTE headcount that exceeds the total headcount (some of the tables in the AIHW report have precisely that outcome). If one starts with the proposition that a "full-time" GP is one working the typical 55 or so hours a week, then the FTE count is lower than the total headcount, as there are quite a few GPs who work part time.

[1] See "Medical Labour Force 1999", AIHW, February 2003, catalogue number HWL24

In summary, it is the AMA's view that the average cost figure of $9,500 is misleading, and the Commission should have used a sound figure for the number of FTE GPs to illustrate the cost of red tape for the typical full-time GP. We are quite certain that this would have resulted in a more realistic estimate of $11,000 to $12,000 per typical full-time GP. Furthermore, were the total cost or red tape re-estimated having proper regard to marginal costs (as we suggest in the previous section), then the cost would be higher again.