COMMONWEALTH OF AUSTRALIA

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Commonwealth Department of Health and Ageing

Mrs Helen Owens
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Productivity Commission
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Dear Mrs Owens

Productivity Commission - General Practice Administrative and Compliance Costs Study – Progress Report

Thank you for the opportunity to comment on the Study Progress Report released on 10 February 2003. I acknowledge the considerable task required of the Commission, and the breadth of ground covered in this Progress Report.

I think it is important to recognise, at the outset, that any investigation of general practice administrative and compliance costs should be viewed in the context of broader health policy goals in this area, in which the involvement of skilled general practitioners is essential to the community's access to high quality primary health care. There is a balance to be struck between the design and delivery of programs that support the provision of high quality general practice services to the community and the accountability requirements which largely generate administrative and compliance costs. I note that the Progress Report's Key Points acknowledge that 'form filling' by GPs (the traditional concept of administrative costs) accounts for only a small share of the estimated costs and that by implication 'paperwork' required of GPs is minimal.

Main Concerns

The study has identified three areas, Vocational Registration, Practice Accreditation and Enhanced Primary Care, which together account for over 75 percent of the Commission's estimated total cost of administrative and compliance activities by GPs. This Department manages programs in each of these areas or with links to these areas and I offer a brief description of how each program operates, at Attachments A, B and C respectively. Including such descriptions in the report would, I think, improve the understanding of these programs.

While the Study mentions that this Department's programs provide a net benefit to GPs, I think it is important to acknowledge clearly in the final report that participation in these programs is voluntary, that they are developed in consultation with the general practice profession and the rebates or incentives offered to participate are well above the estimated administrative and compliance costs identified in the Study.

In addition, Vocational Recognition (including continuing professional development) and Practice Accreditation are two industry led developments that provide the infrastructure for maintaining and improving the quality of General Practice. The Department's programs provide support for these developments through higher MBS rebates and access to PIP incentives respectively.

Vocational Registration

In relation to Vocational Registration, linking the entire cost of participating in the general practice professional development program as a compliance cost to access higher Medicare rebates is not valid. I suggest that continuing professional development is a normal cost of any professional group and therefore should be excluded from the study. I note the RACGP's response on this issue. In a recent communication to their membership, the RACGP referred to the Commission's approach to Vocational Registration in this Study as 'misunderstanding the desire of GPs to pursue their professional development.'

Practice Accreditation

In relation to Practice Accreditation, it is important to note that while the Practice Incentives Program (PIP) uses the profession's accreditation system as an indicator of practices that meet minimum quality standards, it of itself is not a system developed for the PIP. Practice Accreditation is a profession led program and is based on standards developed by the RACGP. In addition, while Practice Accreditation standards mainly cover general practice specific issues they also cover a number of standards that are imposed through other agencies, for example in matters relating to the handling of poisons, infection control and physical access requirements.

Enhanced Primary Care

In relation to EPC, these items are similar to other Medicare items. Any paperwork generated through provision of these items is clinical in nature and for the patient, other participating care providers or the initiating GP rather than administrative or compliance activities. Also the estimated compliance costs of EPC are based on a very small sample size and are well above those of other studies.

That said, I do acknowledge that there have been some concerns raised about the complexity of these items, and I believe it is important for this Department to work closely with professional groups to resolve this issue.

Study Findings and Recommendations

I recognise that the Progress Report contains some valuable perspectives and information. I am generally supportive of the Study findings and recommendations and am interested in using the information provided to better administer our programs.

I would also like to take this opportunity to thank you for your willingness to consult with the Department on these important issues.

Yours sincerely

(SIGNED)
Jane Halton
Secretary

14 March 2003

Attachment A

Vocational Registration

Vocationally recognised general practitioners (Fellows of the Royal Australian College of General Practitioners or general practitioners who were eligible to be "grandfathered" under the pre 1995 regulations) are those Medical Practitioners that meet the minimum requirements of the Royal Australian College of General Practitioners (RACGP) Quality Assurance and Continuing Professional Development (QA&CPD) Program.

The primary role of the QA&CPD Program is to assist general practitioners to maintain the quality of their professional skills and meet the ongoing medical needs of the Australian population. RACGP QA & CPD program requires GPs to complete over a period of three years, a range of professional development activities covering clinical audits, supervised clinical attachments, participate in small group meetings and attend educational activities such as seminars, workshops and presentations.

The RACGP determines whether a GP meets the Vocational Registration requirements and advises the HIC for the purposes of paying a higher Medicare rebate. HIC holds and maintains a register of vocationally recognised general practitioners for this purpose. Vocationally recognised general practitioners removed from the register may apply to be reinstated on the vocational register once they meet the minimum requirements.

Comment

The Study notes that vocational recognition of general practitioners accounts for over 30 per cent of the compliance costs for general practitioners and general practice. The assumption being that Medical practitioners who meet vocational registration requirements are able to access the higher A1 Medicare rebate and therefore only undertake this activity for this purpose. The full estimated cost ($74.2m pa) of undertaking this activity has been included as a compliance cost.

Whilst vocationally recognised general practitioners are provided with access to the higher Medicare rebate, the RACGP sets the QA&CPD requirements for vocational recognition. The RACGP, like most specialist medical colleges, sets the standards for maintaining and improving the quality of services provided by their profession. Whilst the time taken to provide information to the RACGP about professional development activities that have been undertaken might be considered a compliance cost, the time taken for the professional development activity should not be considered a compliance cost against access to the higher Medicare rebate.

Irrespective of the requirements set by the RACGP, general practitioners including 'other medical practitioners', do undertake professional development activities to enhance the quality of care they provide. The inclusion of the full costs denies the professions desire to maintain their vocational development. I understand that the profession has indicated that they are concerned to find this included in the Study progress report.

Attachment B

General Practice Accreditation

Background

The establishment of a general practice accreditation system in Australia was first flagged in 1991, with the Commonwealth Government, the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) resolving to develop a set of national standards for general practice. The overall intent at that point was to engage the profession in a comprehensive process of continuous quality improvement.

Support for accreditation gained momentum following the release in 1992 of a national report into challenges and proposed reforms in general practice, *The Future of General Practice: A Strategy for the Nineties and Beyond*. This report supported the development of an independent, voluntary system of general practice accreditation, placing particular emphasis on continuous education for general practitioners, and establishing standards for the new system which would function as a recognisable measure of improved quality in general practice.

The Current Accreditation System

The overall purpose of the current system is to support the high quality and safe delivery of general practice services.

Under the current system of general practice accreditation, practices are accredited against the Standards for General Practice 2nd Edition developed by the RACGP in consultation with the profession and other stakeholders. The accreditation process is undertaken in a three-year cycle by representatives from one of two organisations endorsed to carry out this work. These organisations are Australian General Practice Accreditation Ltd (AGPAL) and, a more recent entrant in the system, a partnership involving General Practice Accreditation (GPA) and Quality Assurance Services (QAS). The partnership's accreditation program is known as General Practice Accreditation-*Plus* (GPA-*Plus*). The accreditation bodies in turn involve general practitioners in governance and as the peer reviewers. They are remunerated for this activity.

Currently, over 4,500 practices are accredited nationally, with this figure representing around 75% of practices.

Practice Incentives Program (PIP)

The PIP is a package of incentives targeted at improving the quality of general practice in the areas of clinical practice and patient services. The package includes a range of incentives including information technology; after hours care; practice nurses; targeted service incentive payments for chronic disease management; rurality and to reward teaching practices.

Entrance to the PIP is restricted to those practices that already meet minimum quality standards, for which the current industry benchmark is Practice Accreditation.

Participation in PIP is voluntary and practices are able to choose the incentives that are best suited to their clinical practice from the PIP package of incentives and outcome payments. Joining the PIP and each incentive require an initial application to the Health Insurance Commission and then further notification only if practice arrangements change, for example practices moving location. PIP has a biennial process to confirm practice details.

Comment

The AMA and the RACGP identified the need for practice accreditation as early as 1991; the profession has essentially developed the current accreditation arrangements with minimal funding support by this Department.

Government and consumers can use accreditation as a quality marker in that if a practice receives accreditation, enough systems and arrangements should be in place for doctors to provide a quality, comprehensive level of service. These include assurance of adequate and secure record keeping, safety of equipment and supplies such as vaccines, provision for after hours care and appropriate use of information management and information technology.

While general practitioners have a strong desire to constantly improve the quality of their practice, the Government also supports quality improvement through the PIP. The PIP uses the profession's accreditation system as an indicator of practices that meet minimum quality standards; it is not a system developed for the PIP.

Practice Accreditation standards mainly cover general practice specific issues, however they also cover a number of standards that are imposed through other Commonwealth or State agencies, for example in matters relating to the handling of poisons, infection control and physical access requirements.

General practice accreditation is voluntary and is industry led and driven.

Attachment C

Enhanced Primary Care Medicare Items

In November 1999 the Government introduced new Medicare items for Enhanced Primary Care. These items are focused on providing more preventive health care for older Australians and better-coordinated care for people of any age with a chronic or terminal condition and complex needs requiring care from a multidisciplinary team. The items include voluntary annual health assessments for people aged 75 years and over (55 years and over for Aboriginal and Torres Strait Islander people), and care plans and case conferences for people of any age with a chronic or terminal condition and complex needs.

The EPC Medicare items were introduced in consultation and with the agreement of representatives of the medical profession.

The EPC items provide a Medicare rebate for services provided to patients in accordance with the Medicare service description and explanatory notes, that are clinically relevant to that patient's needs.

The items define the minimum information that should be obtained and recorded as part of the clinical service for that patient, and as part of the clinical records for that patient.

For health assessments this means a record of the health assessment, for care plans this means a written care plan, for case conferences this means a record or summary of the case conference.

The EPC items do not impose a business or administrative requirement on general practice or practitioners, other than indirectly in terms of the practice or GP maintaining the capacity to provide non-referred medical attendance items.

They do not require practitioners to complete a specific form (though use of a form to capture and retain clinical information is recommended), and payment of the Medicare rebate is not conditional on a form being completed. The Royal Australian College of General Practitioners has published Guidelines and Standards for the EPC Medicare Items, including suggested proformas for use by GPs. Appropriate forms to support use of the EPC items are also incorporated into commonly used medical software products.

Any forms used, whether hard copy or electronic, are for the benefit of the patient, the general practitioner (and the patient's usual general practitioner, where different) and other health professionals involved in the provision of the EPC service. There is no requirement to transmit forms to the Department of Health and Ageing, the Health Insurance Commission or other agencies.

One of the benefits of the EPC Medicare items is that relevant clinical information in the form of a report or summary of the EPC service, is provided to the patient and their carer (where appropriate), as well as to other members of the patient's health care team. For example, in relation to care planning, the patient has an up-to-date assessment of their health and care needs, a statement of agreed goals for managing their needs, and a listing of the team members involved in their care and the services to be provided.

The Medicare EPC items were designed to support doctors in undertaking more complex clinical care. All clinical care includes a component of accurate and complete documentation of what has been done. Clear documentation is important for the continuing provision of safe care to the patient and is promoted by medical indemnity organisations as important in risk management. The clinical documentation needed for the EPC items reflects:

- the more complex nature of the clinical care that is being provided when these items are used;
- the need to keep all parties engaged in that care, including the patient and/or carer, adequately informed; and
- the need to ensure informed consent.

Individual GPs have commented that use of a proforma for EPC care planning saves them work. Medical specialists have found the information conveyed on care plans about patient conditions to be very helpful.

Comment

Payment of the relevant Medicare rebate for the EPC items is governed by the same arrangements and requirements as apply to Medicare rebates for GP non-referred attendance items generally. There are no additional requirements for claiming a Medicare rebate in respect of an EPC service.

The rebates for the EPC Medicare items were developed taking into account the nature of the work involved and the time requirements for GPs. This includes the time required to undertake both direct clinical and non-direct clinical care (ie no patient contact), such as liaising with other health professionals and preparing written plans. The rebates incorporate a significant premium over standard attendance items in recognition of this complexity.

There are no specific legislative or regulatory requirements on the use of the EPC items, other than the regulations that govern the provision of non-referred GP attendance items in general and the definition of the EPC items in the Health Insurance (General Medical Services Table) Regulations (which enables their inclusion in the MBS).

GPs' use of the EPC Medicare items is voluntary. Other than normal medical qualifications there are no additional qualifications required to use the items. GPs are not required to undertake training or purchase equipment to deliver EPC Medicare services. These items are available for use by medical practitioners, including general practitioners, but not including specialists or consultant physicians. There are separate case conferencing items available for use by consultant physicians.