COMMONWEALTH OF AUSTRALIA

Health Services Division
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Commonwealth Department of Health and Ageing

Mrs Helen Owens
Commissioner
Productivity Commission
Locked Bag 2, Collins Street East
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Dear Mrs Owens

Study on Compliance Costs in General Practice

The attached package provides responses from individual Department of Health and Ageing program areas to matters specifically identified in the Issues Paper (Circular 1), released by the Productivity Commission on 29 July 2002. I anticipate that the Department will provide some further more general comment in the near future. I apologise for the delay in forwarding this information.

For ease of accessibility, the information in this package is presented in a standardised format and with a covering schedule.

If you require further information please contact Claire Caesar on (02) 6289 3684 or Joan Kieboom on (02) 6269 7831.

Yours sincerely

Leonie Smith
Assistant Secretary
General Practice Branch

October 2002

PRODUCTIVITY COMMISSION STUDY ON COMPLIANCE COSTS IN GENERAL PRACTICE

Schedule of responses to issues raised in Productivity Commission Issues Paper 1

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Program: Practice Incentives Program (PIP)
Overview

The Practice Incentives Program (PIP) was developed in consultation with, and with support from the general practice profession. The Program was introduced following recommendations of the General Practice Strategy Review in 1998, General Practice: *Changing the Future Through Partnerships*.

Ongoing advice on the PIP, including the design and operation of components, has been provided by the profession first, through the General Practice Financing Group (GPFG), - comprised of membership from the Australian Divisions of General Practice (ADGP), Rural Doctors Association of Australia (RDAA), Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA) - and more recently through the GP Memorandum of Understanding Group (ADGP, RDAA, RACGP and AMA as participatory observers).

Question	**Response**
1. Are GPs made aware of the Program rationales?	Yes. The rationale for the PIP and its components is published in a program information booklet which is distributed to practices by the HIC. This information is also placed on the HIC website. All practices have access to this material when they apply to join the PIP. Recent additions to PIP and major changes have been the subject of announcements by Government, such as the introduction of incentives for asthma, diabetes, cervical screening, practice nurses and mental health which were included in the 2001 Federal Budget. Information on these incentives was mailed to participating practices and placed on the HIC website. Other sources of information about the Program's rationale include presentations at conferences, to Divisions of General Practice, and other groups by Department and HIC representatives, as well as articles in the medical media.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	The PIP is available to general practices that are accredited, or registered for accreditation, against the RACGP Standards for General Practices. Practices registered for accreditation need to be accredited within 12 months of joining the Program. The PIP offers incentives to eligible practices for a range of activities, as outlined in **Attachment A**. To be eligible for the particular incentives the practices must: - Enrol in the program - Complete biennial updates to ensure HIC records on which doctors work in the practice are correct - For diabetes, to apply for the "patient register and recall/reminder system" incentive, for asthma and cervical screening to apply for "sign on payments," complete a single form to cover all three incentives. - For the practice nurses incentive, which was introduced separately, complete a single form. - For the mental health incentive, obtain appropriate training. - For the medical student teaching incentive, a form completed by the university must be verified each quarter. Apart from informing the HIC when situations change, and quarterly completion of a form for the teaching incentive, there are no ongoing forms. All data is collected through the normal Medicare Benefits Schedule (MBS) claiming system.
3. What are the benefits of GPs undertaking these activities - to government,	The PIP aims to compensate for the limitations of fee-for-service medicine arrangements and payments focus on aspects of general practice that contribute to quality care. This has benefits to general practice and the community.

GPs, consumers and others?	*Accreditation* provides a mechanism for improving and acknowledging the quality of a general practice. General practice accreditation in Australia is voluntary, but it provides eligibility for payments through the PIP. Approximately 75 percent of general practice patients currently use accredited practices. It is recognised that *IM/IT* will be critical to ensuring that general practices maintain a high quality of care provided to patients. Use of clinical software offers benefits to both doctors and patients and the electronic interchange of data between general practices and other organisations (such as Divisions, pathology labs, hospitals and governments) will enhance practice and quality of care. Almost 90 percent of practices in the PIP are now computerised. *After hours care* is recognised as an integral, but often difficult, part of providing a comprehensive general practice service to patients. Payment through PIP is intended to help resource a quality after hours service. It is also intended to compensate practices that make themselves available for longer hours, in recognition of the additional pressures this entails. Almost all PIP practices provide access to 24 hour care including access to out of hours visits where necessary and appropriate. Of these, 70 percent provide at least 15 hours after hours care from within the practice. Twenty-nine percent of practices provide 24 hour care from within the practice. The *care planning* incentive was introduced to improve the take up of multidisciplinary care planning and case conferencing for patients with chronic conditions and multidisciplinary care needs. First payments were made under this incentive in February 2002. As the incentive has exceeded its targets, it will be discontinued after November 2002. Quality *teaching* is central to ensuring that the GPs of tomorrow are appropriately trained and have actual experience of quality practice. Around 10-15 percent of PIP practices participating in the medical student teaching incentive. The *quality prescribing* incentive is intended to assist practices in keeping up to date with information on the quality use of medicines. It aims to assist GPs achieve more effective, quality prescribing. Around 30 percent of PIP practices participate in this incentive. The PIP *rural* loading provides extra support general practice located outside metropolitan areas. Rural payment is higher for practices in more remote areas, in recognition of the difficulties of providing care, often with little professional support in small towns or isolated communities. The *diabetes* incentive aims to provide earlier diagnosis and improve management of people with diabetes through general practice. Diabetes is a debilitating disease, which contributes significantly to ill health, disability and premature death in Australia. An estimated 900,000 Australians aged 25 years and over have the disease, although around half of these are currently undiagnosed. There is also evidence that improvements are needed in the management of people with diagnosed diabetes. Eighty-two percent of practices in the PIP have registered to participate in the diabetes incentive. The *asthma* incentive aims to help GPs further improve the clinical care they provide to patients with moderate to severe asthma. More than two million Australians have asthma, including one in four primary school children, one in seven teenagers and one in 10 adults. Asthma is a potentially life threatening disease, which can be controlled by appropriate diagnosis and management. Eighty-two percent of practices in the PIP have signed on to participate in the asthma incentive. The *cervical screening* incentive aims to increase rates of participation in the National Cervical Screening Program. This will improve early detection of cervical abnormalities, thereby aiming to reduce death rates from cervical cancer. Eighty-four percent of practices in the PIP have registered to participate in the cervical screening incentive. The *practice nurses* incentive recognises the valuable role nurses play in primary health care. The incentive aims to enable GPs to focus more on diagnosis and clinical care, while allowing practice nurses to support the management of chronic diseases, such as diabetes and asthma, and undertake population health activities and provide clinical support. The *mental health* incentive recognises that most people use their GP as the first point of help with mental health issues and aims to assist GPs develop their skills in mental health diagnosis, care planning and treatment. Mental illness is one of the most serious health issues facing Australia with 2.4 million Australians – 18 percent of the population – experiencing a mental health problem each year.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	PIP incentive payments available are detailed in Attachment A. PIP payments, together with the General Practice Immunisation Incentives Scheme, will provide an average of around $20,000 per participating full time general practitioner in 2002-03.

5. How does the Department use the information provided by GPs?	- The HIC uses information provided to determine eligibility and to calculate PIP payments. - The Department uses PIP information to monitor program performance and inform policy development.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	No. Participation in PIP is voluntary. Practices can choose whether to enter the PIP, and in which of the PIP components they wish to participate.
7. Are there ways in which the information could be provided more efficiently?	Where possible existing information is used, for example HIC and MBS data, to calculate PIP payment.
8. Is there any existing information about compliance costs imposed on GPs?	The HIC routinely collects information about the time taken to complete application forms.
8.1 - 8.4 For particular programs, and in general, are you aware of any recent or proposed reforms to reduce the burden of GP's compliance costs? Have they been effective? What specific additional measures could be undertaken to reduce compliance costs? Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a les costly way? Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	PIP components were designed in consultation with the profession to minimise compliance burden and to avoid duplication of information collection. As much as possible, payments are generated automatically from information held by HIC in initial PIP application forms or from MBS data In particular, the diabetes, asthma, cervical screening and mental health service incentive payments have been designed to be triggered using MBS item numbers rather than any separate claim process.

ATTACHMENT A

PIP – Incentive	PIP payment rates
IM/IT – Tier 1- the practice provides data to the Commonwealth through completion of the application form and undertakes to provide additional relevant information when requested. Payments commence after lodgement of initial application form and are calculated automatically each quarter.	$3.00 per standardised whole patient equivalent (SWPE)* per year
IM/IT - Tier 2- the practice uses bona fide electronic prescribing software that includes a patient medical record, gives automatic warnings for drug reactions and assists with dosage calculation. For practices participating in this tier, payments commence after lodgement of initial application form and are calculated automatically each quarter unless HIC is notified of a change in eligibility.	$2.00 per SWPE per year
IM/IT - Tier 3- the practice has on site and uses a computer/s connected to a modem to send and/or receive clinical information. For practices participating in this tier, payments commence after lodgement of initial application form and are calculated automatically each quarter unless HIC is notified of a change in eligibility Note – payment for the IM/IT tiers is cumulative, ie a practice can be paid up to $7.00 per SWPE per year for IM/IT activities.	$2.00 per SWPE per year
After Hours – Tier 1- the practice ensures that patients have access to 24-hour care including ensuring access to out of hours visits where appropriate. For practices participating in this tier, payments commence after lodgement of initial application form and are calculated automatically each quarter unless HIC is notified of a change in eligibility.	$2.00 per SWPE per year
After Hours – Tier 2- The practice qualifies for Tier 1 of the after hours incentive and, on average, provides at least 15 hours per week of its after hours care arrangements from within the practice. For practices participating in this tier, payments commence after lodgement of initial application form and are calculated automatically each quarter unless HIC is notified of a change in eligibility.	$2.00 per SWPE per year
After Hours – Tier 3- the practice provides 24 hour coverage seven days a week from within the practice. For practices participating in this tier, payments commence after lodgement	$2.00 per SWPE per year

of initial application form and are calculated automatically each quarter unless HIC is notified of a change in eligibility Note – payment for the after hours tiers is cumulative, ie, a practice eligible for tier 3 would also be paid tiers 1 and 2.	
Care Planning – the practice ensures a target percentage of its patients with chronic conditions and multidisciplinary care needs are covered by multidisciplinary care plans and case conferences. The target is measured as 10 percent of patients aged over 65 years. Payments are calculated automatically from existing HIC data. Note- this incentive will cease in November 2002.	$10.00 per whole patient equivalent aged over 65 years attending the practice per year
Teaching – practices host university medical student placements, providing appropriate training sessions. Medical students must be enrolled in an Australian Medical University and the session must be part of the curriculum for the student. Sessions must be a minimum of three hours duration. To generate a PIP payment, the practice verifies a claim form prepared by the relevant university and forwards the form to HIC.	$50.00 per session (maximum of 2 sessions per day)
Quality Prescribing Initiative – practices participate in activities recognised or provided by the National Prescribing Service (NPS). These include: clinical audit of prescribing for specific drug groups; case studies using problem-based distance learning; practice visit(s) by an independent pharmaceutical detailer. Practices participating in this PIP element are required to undertake an average of three activities per FTE GP per year, one of which must be a clinical audit. The NPS provides information to HIC to enable calculation of payment of this incentive.	$1.00 per SWPE per year
Rurality – the practice's main location is outside metropolitan areas. Payment is calculated automatically by HIC based on the practice's location.	15% to 50% loading on total practice payment – increases with the extent of remoteness
Diabetes – Patient Register and Recall/Reminder System – practices are eligible if they use a register of all known patients with diabetes in the practice and an active recall/reminder system of patients for their diabetic care. The information in the register must include the patient's name, identifier and contact details. Registers may be either electronic or paper based, and may be held at the practice or the local Division of General Practice. This component is a pre-requisite for participating in diabetes service	$1.00 per SWPE – this is a once-only payment

incentive payments and diabetes outcomes components. Diabetes patient register and recall/reminder system payment is calculated by HIC upon submission by the practice of a registration form. Note - A common registration form is used for the diabetes, asthma and cervical screening incentives.	
Diabetes – Service Incentive Payment (SIP) – GPs are required to complete an annual diabetes program of care for a patient of the practice. Minimum requirements of care are based on general practice guidelines and set out in the Medicare Benefits Schedule (MBS) book. Payment is generated automatically by the use of specific MBS diabetes incentive items.	$40.00 per annual cycle of care per patient. Payable once per year per patient.
Diabetes – Outcomes – practices will be required to reach target levels of care for their patients with diabetes. This component is under development and expected to be introduced in early 2003. It is expected that, for eligible practices, payment will be generated automatically from existing HIC data.	$20 per patient with diabetes per year
Asthma – Sign On – practices are required to agree to have their details forwarded to the National Asthma Council, Divisions of General Practice or State Based Organisations so they can receive information about the Asthma 3+ Visit Plan. Practices also agree to implement the Asthma 3+ Visit Plan for patients with moderate to severe asthma in their practice. This component is a pre-requisite for participating in asthma service incentive payments. Asthma sign-on payment is calculated by HIC upon submission by the practice of a registration form. Note - A common registration form is used for the diabetes, asthma and cervical screening incentives.	$0.25 per SWPE – this is a once-only payment
Asthma – SIP – GPs are required to complete an Asthma 3+ Visit Plan for their patients with moderate to severe asthma. Payment is generated automatically by the use of specific MBS asthma incentive items.	$100.00 per year per patient with a Asthma 3+Visit Plan completed. Payable once per year per patient.

Cervical Screening – Sign On – practices are required to agree to participate in the cervical screening incentive; to have practice details provided to the state/territory cervical screening registers; to receive information from the registers and consider strategies they propose to improve the level and quality of participation in the National Cervical Screening Program; and, that the state cervical screening register can provide information about the aggregate number of women screened in the practice to HIC for the calculation of the outcomes incentive payment. This component is a pre-requisite for participating in cervical screening service incentive payments. Cervical screening sign-on payment is calculated by HIC upon submission by the practice of a registration form. Note - A common registration form is used for the diabetes, asthma and cervical screening incentives.	$0.25 per SWPE – this is a once-only payment
Cervical Screening – SIP – GPs are eligible if they screen women between 20 and 69 years who have not had a cervical smear within the last four years. Payment is generated automatically by the use of specific MBS cervical screening incentive items.	$35.00 per patient screened
Cervical Screening – Outcomes - practices will be required to reach target level of cervical screening for their female patients aged 20 to 69. This component is under development and expected to be introduced in early 2003. It is expected that, for eligible practices, payment will be generated automatically from existing HIC and state/territory cervical screening register data.	$2.00 per female whole patient equivalent (aged 20 to 69 years) per year.
Practice Nurses and/or Aboriginal Health Workers – practices in areas of high workforce shortage receive an incentive to employ or retain the services of a practice nurse and/or aboriginal health worker. The nurse or aboriginal health worker must undertake functions from a list of agreed functions. Payment is automatically calculated by the HIC on an ongoing basis following submission by the practice of a single registration form.	$8.00 per SWPE per year for practices in RRMA classifications 1-2 $7.00 per SWPE per year plus rural loading for practices in RRMA classifications 3-7. Payment is capped at a maximum of 5,000 SWPEs per practice and 10 sessions per week.

Mental Health – Sign On - GPs must have accredited mental health skills. GPs must be working in an accredited general practice. Payment is automatically calculated by the HIC on submission by the GP of a registration form.	$150 per eligible GP
Mental Health – SIP – GPs need to complete the required 3 step mental health process for their patients. Payment is generated automatically by the use of specific MBS mental health incentive items.	$150 per patient per 3 step process completed. Payment is capped at $10,050 per GP per year.

*SWPE = Standardised Whole Patient Equivalent. This measure is used to calculate practice size based on patient load. The SWPE value for a practice is the sum of the fractions of care the practice provides to each of its patients, weighted for the age and sex of each patient. The average FTE GP sees 1,000 SWPEs per year. PIP payments are made quarterly.

Program: General Practice Immunisation Incentives (GPII) Scheme

Question	Response
1. Are GPs made aware of the Program rationales?	The General Practice Immunisation Incentives (GPII) scheme was introduced in 1998 as part of a package of measures - *Immunise Australia: A Seven Point Plan* - designed to lift immunisation rates in Australia. The GPII provides financial incentives to general practitioners who monitor, promote and provide age appropriate immunisation services to children under the age of seven years in their practices. The scheme was developed through consultation with the medical profession and a stakeholder Advisory Group provides ongoing input and advice to the Department of Health and Ageing on the scheme's implementation and management. Representation on the GPII Advisory Group includes the Australian Medical Association, Australian Divisions of General Practice (ADGP) Limited, Royal Australian College of General Practitioners (RACGP), State Based Organisations, National Immunisation Committee (through its constituent State Public Health Authority), consumers, the Department of Health and Ageing and the Health Insurance Commission (HIC). The overall aim of the scheme is to encourage at least 90 per cent of practices to achieve 90 per cent proportions of full immunisation of children under seven years of age. The scheme has high up take rates with 5,527 practices currently registered to participate. Information about the operation of the scheme and its rationale is published in an information booklet which is distributed by the HIC. The booklet is also published on the HIC website along with other information about performance of the GPII. Practices have this material as part of their kit when they apply to join the scheme. Other sources of information about the program include Divisions of General Practice which receive funding under the scheme to assist them in improving the proportion of children who are immunised.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	Under the GPII scheme, GPs and practices are required to ensure that children under seven years of age attending the practice are fully immunised for age in accordance with the schedules of the *Australian Standard Vaccination Schedule (ASVS).* Practices apply to the HIC to participate in the GPII outcomes component. The scheme uses information from the Australian Childhood Immunisation Register (ACIR) and Medicare benefits data held by the HIC to calculate payments and generate feedback reports to participants. This information is collected separately from the GPII scheme.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	The GPII has offered substantial benefits to the Australian community. Since its introduction in 1998, childhood immunisation rates have risen substantially. Average practice immunisation coverage of children under seven years of age is now 89 percent and there has been a reduction in the incidence of vaccine-preventable diseases in this age group. GPs are a key group able to improve national childhood immunisation levels. GPs have significant levels of contact with children under seven years of age which provides opportunity to monitor a child's immunisation status and to provide immunisation services if required. The payment components are – **Service Incentive Payments (SIPs)** GPs who complete one of the six age appropriate ASVS vaccination schedules for a child under seven are eligible for a service incentive payment (SIP) of $18.50 per child per schedule. GPs do not have to register to receive SIPs. GPs who have Medicare provider numbers are automatically considered as eligible to participate in the SIP component of GPII.

	Payment of SIPs is calculated automatically by HIC using data on the Australian Childhood Immunisation Register (ACIR). **Outcomes** To be eligible for outcomes payments practices need to achieve a minimum of 85 percent full immunisation coverage of children under seven years of age that attend the practice. Note - practices need not provide immunisation services to be eligible for this incentive. The outcomes component calculates the proportion of age appropriate immunisation of the children seen by a practice, regardless of who performs the immunisation service. In this way, practices that have developed links with other immunisation providers are rewarded for their efforts. Practices achieving 85-90 percent immunisation coverage receive a payment of $3 per quarter per whole patient equivalent child under seven years of age attending the practice. Practices achieving coverage of 90 percent or more receive a payment of $3.50 per quarter per whole patient equivalent child under seven years attending the practice. These payment tiers are not cumulative. From 1 January 2003, practices will need to achieve a minimum of 90 percent immunisation coverage to be eligible for outcomes payments. Practices wishing to participate in the GPII outcomes component need to apply to HIC. There is a common application form for both GPII and PIP. Practices applying for PIP are automatically included for GPII outcomes, or practices can elect to participate in GPII only. Once an application form is lodged, ongoing payments for eligible practices are calculated automatically by HIC using Medicare Benefits Schedule and ACIR data. Further notification to the HIC may be required if practice arrangements change (eg adding a new provider) to ensure that practices receive their correct payment.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this?	GPII incentive payments are detailed above.
5. How does the Department use the information provided by GPs?	HIC uses information to determine eligibility and to make payments. The Department uses GPII information to monitor the scheme's performance and to inform policy development.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	Participation in GPII is not compulsory.
7. Are there ways in which the information could be provided more efficiently?	Except for the initial application form for the GPII outcomes component (a common application form with the PIP), HIC use existing information from MBS and ACIR data to calculate GPII payments.
8. Is there any existing information about compliance costs imposed on GPs?	The HIC routinely collects information about the time taken to complete application forms.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they	The GPII scheme uses the ACIR infrastructure to avoid duplication of information reported to Government in relation to the implementation of the GPII scheme. The GPII's Service Incentive Payment is calculated directly from the ACIR and requires no additional effort for GPs to access this payment. The quarterly GPII Outcomes Payment also sources data from the ACIR and existing Medicare systems, to also avoid duplication of processes involved in determining and making this payment.

been effective?	The HIC is working with the Department and other stakeholders to enhance the flow of information between immunisation providers and the ACIR. This includes working with software developers to improve the ability of practice desktop software to upload immunisation data to the ACIR, and improving feedback to practices and Divisions through better reporting in electronic format
8.2 What specific additional measures could be taken to reduce compliance costs?	See above.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	See above.
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	Nil response

Program: Australian Childhood Immunisation Register (ACIR)

Question	Response
1. Are GPs made aware of the Program rationales?	Information about the program rationales of the ACIR is widely published both through government and professional bodies. The Health Insurance Commission (HIC) website provides information about the ACIR and its performance.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	Registered medical practitioners listed on the ACIR as recommended immunisation providers are required to send immunisation data to the ACIR either by: - recording an immunisation encounter through the secure area of the ACIR Internet site; - utilising Electronic Data Interchange to record immunisation encounters electronically; - recording an immunisation encounter manually. Medical Contraindication forms and Conscientious Objection forms can also be completed to update a child's history on the ACIR.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	**Government:** - Protection of children under 7 years of age from vaccine preventable diseases eg measles, mumps, rubella, with a target of herd immunity; - Monitoring of the effectiveness of the ACIR; - Identification of areas with lower immunisation coverage; - Provision of feedback on provider (including GPs and other recognised immunisation providers) activity; - A measure of the number and work volume associated with immunisation in general practices; - Promotion of more efficient care of patients through encouragement of quality settings. **General Practitioners:** - Recognition of their central role in childhood immunisation.; - Provision of incentives to manage and/or monitor children under 7 years of age; - Provision of feedback to GPs and practices on immunisation coverage of children under their care. **Consumers:** - Encouragement for GPs to provide opportunistic vaccinations. - More children will be protected against vaccine preventable diseases. - Provision of a quality setting from which care can be provided.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	- Immunisation providers receive an Information Payment for sending immunisation information to the ACIR, which completes one of the six individual childhood immunisation Schedules (ie. 2, 4, 6, 12, 18 months and 4 years). The amount is agreed between each State or Territory and the Commonwealth and is up to $6 for each completed individual schedule. Payment is also made where the catch-up provisions for vaccinations have been completed. - GPs and practices also receive payments under the General Practice Immunisation Incentives (GPII) Scheme to encourage them to achieve high levels of immunisation coverage. - ACIR information payments are made to offset the administrative costs to providers in notifying the ACIR about immunisations given. These payments (Information and GPII Payments), can be made in addition to the fee-for-service arrangements under the Medical Benefits Schedule.
5. How does the Department use the information provided by GPs?	- To monitor the effectiveness of the ACIR in raising childhood immunisation coverage. - To monitor expenditure of the ACIR to ensure that the overall expenditure is within the appropriation. - To identify areas with lower immunisation coverage so that targeted action might be undertaken to improve immunisation coverage. - To inform the ACIR Management Committee whose role is to advise the Department on the operation of the ACIR.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	Participation in the ACIR is not compulsory.
7. Are there ways in which the information could be provided more efficiently?	Where possible existing information is used, for example HIC or Medical Benefits Schedule data. Comparisons are also made with Australian Bureau of Statistics data where applicable. Transmission of data electronically directly from practice management systems (outlined below) will be a more efficient process.
8. Is there any existing information about the compliance costs imposed on	In respect of the ACIR, no.

GPs?	
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GP's compliance costs? Have they been effective?	- The current methods of reporting child immunisation data include the Internet, Electronic Data Interchange (EDI) and paper claiming. The HIC is currently working with software developers to improve the ability of practice desktop software to upload immunisation data directly from their practice management system. The system is being developed as part of HIC online, which is the first in a series of projects designed to provide online access to HIC services. - There is no legislative requirement for the general practitioner to retain a paper copy of the immunisation information they have notified to the ACIR. - Reports have been designed to maximise available information for practices and to reduce the administrative burden to manage/monitor the immunisation status of children attending the practice. - The HIC has also developed reports in electronic format to facilitate easy manipulation of information by Divisions and practices. - The HIC is currently working with Divisions of General Practice and other immunisation provider coordinators to produce an immunisation Toolkit. The Toolkit will include program information about the ACIR and the GPII and advise on how to best use immunisation information to maximise practice coverage rates and payments to providers. - The HIC has also drafted a brochure designed to simplify the use of one particular GPII practice report (ACIR020A). The HIC has taken feedback from GP representatives and Divisions on this draft brochure prior to its (imminent) release. - ACIR Field Officers are deployed in each State and Territory to assist GPs and Divisions in complying with the provision of immunisation data on the ACIR. A key focus for the Field Officers is to lend assistance to Divisions to enable them to aid practices in improving their GPII outcomes payment amount and immunisation coverage of children who have attended their practice.
8.2 What specific additional measures could be undertaken to reduce compliance costs?	The HIC is continually seeking ways of making the process of participation in the ACIR more efficient.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	- The HIC is working with stakeholders to enhance the flow of information between immunisation providers and the ACIR. - The ACIR infrastructure has been designed to avoid duplication of information reported to Government in relation to the implementation of the GPII scheme. The GPII's Service Incentive Payment is calculated directly from the ACIR and requires no additional effort for GPs to access this payment. The quarterly GPII Outcomes Payment also sources data from the ACIR and existing Medicare systems, to also avoid duplication of processes involved in determining and making this payment.
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	N/A

Program: Medicare Benefits Schedule – Enhanced Primary Care (EPC) Items

Question	Response
1. Are GPs made aware of the Program rationales?	The EPC Medicare items were introduced in consultation and with the agreement of representatives of the medical profession. With the introduction of the items, the Royal Australian College of General Practitioners (RACGP) was commissioned to develop a comprehensive publication on the general practice standards and guidelines associated with their use. This publication, *Enhanced Primary Care: Standards and Guidelines for the Enhanced Primary Care Medicare Benefits Schedule Items*, covered the rationale for the items, advice on best practice implementation of the items, and detailed information on implementing health assessments, care planning and case conferencing services. Copies of this publication were distributed to all GPs from September 2000. The RACGP is in the process of updating this publication. The Commonwealth also funded an extensive two-year program to support the implementation of the EPC Medicare items in general practice. The GP Education, Support and Community Linkages Program, which was implemented through Divisions of General Practice, raised awareness of the EPC items and their rationale as well as providing other specific training and support services for GPs. Comprehensive information about the EPC Medicare items is available through the Department of Health and Ageing website at www.health.gov.au/epc.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	• 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. • GPs' use of the EPC items is voluntary. • These items do not impose a specific business or administrative requirement on general practice or practitioners, other than indirectly in terms of the practice or individual GP maintaining the capacity to provide non-referred medical attendance items. • GPs are not required to undertake training or purchase equipment to deliver EPC Medicare services. • The EPC Medicare 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 and for case conferences this means a record or summary of the case conference. • The Medicare EPC items were designed to support doctors in undertaking 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 documentation needed for the EPC items reflects: - the 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. • Another purpose of documentation supporting clinical care is for GPs to be able to demonstrate, if required to do so, that they have not inappropriately or fraudulently billed an item for a service which has not been delivered. The requirements in this regard are no different from those for any other attendance item. • The EPC items do not require practitioners to complete a specific form. Use of a tool or proforma to assist with capture and retention of the information required as part of the clinical service is recommended. For example, the MBS explanatory notes for care planning state that while a standard format for the care plan is not mandated, practitioners should consider a recognised care planning tool such as those developed by the RACGP or Divisions of General Practice. • Payment of the Medicare rebate for an EPC service is not conditional on a form being completed. Any forms used by GPs are not transmitted to the Department of Health and Ageing, the Health Insurance Commission (except for normal auditing purposes when required) or to other agencies. • The RACGP *Guidelines and Standards* for the EPC Medicare Items include suggested proformas which GPs may use to assist in the delivery of EPC services. Individual GPs, practices and Divisions of General Practice have adapted these proforma or developed their own to suit their specific needs and

	preferences. • Appropriate forms to support use of the EPC items are also incorporated into commonly used medical software products. • 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.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	**Government** - For Government the principal benefit of the EPC Medicare items is improved access to health and care services matched to the needs of the individual, contributing to improved health outcomes. EPC Medicare items also facilitate better service coordination, reducing overlaps, duplication and gaps for people in need. **General Practitioners** - For GPs, the EPC items recognise and reward the more complex work involved in assessment and preventive work for older people, and in coordinated, team-based management of people with chronic conditions and complex needs. These items reimburse GPs for work they perform in organising improved care for patients without requiring the patient to be present. - The Medicare rebates for the EPC items are significantly higher than standard consultation items, in recognition of the nature of the work involved. They provide an opportunity for practices to incorporate EPC services into practice arrangements as a complement to standard, short consultation work. **Consumers** - The EPC Medicare items are designed to facilitate more preventive care for older Australians and better coordinated care for people of any age with a chronic condition and complex needs requiring care from a multidisciplinary team of health and care providers. The intended benefits for consumers are better health care leading to better health outcomes. - For older people health assessments enable a systematic check of the person's health and physical, psychological and social function, and an assessment of whether preventive health care and education should be offered to the person, to improve their health and physical, social and psychological function. An annual, voluntary health assessment can improve a person's health status and contribute to their capacity to continue living in their own home. - For people with chronic conditions and complex needs, multidisciplinary care planning and case conferencing enables better identification and coordination of the health and care services they require through team based management of their needs. - 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.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	- GPs are compensated for undertaking EPC activities through the applicable Medicare rebate and any additional patient fee that the GP may charge, as per any other consultation item. The cost of the EPC service may be invoiced to the patient, for reimbursement through Medicare, or direct billed to Medicare. The amount payable by Medicare is set out in the Medicare Benefits Schedule. - 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 amount of the relevant Medicare rebate varies depending on nature of the item and the work involved, including the amount of time likely to be involved. The EPC Medicare items were developed in consultation with the relevant medical groups, including consideration of proposed rebates for the items. - A high proportion of EPC items are direct-billed to Medicare, for example, almost 97% of all EPC health assessment items claimed in 2001-02 were direct-billed to Medicare with no cost to the patient.
5. How does the Department use the information provided by GPs?	The Department does not require or receive information from GPs on their use of the EPC Medicare items. The GP (or practice) retains any information collected by the GP related to the specific clinical service provided. Copies or extracts are provided to participants in the service. This information is in the form of a report of the health assessment, a written care plan or a summary of a case conference. These are provided as

	appropriate to the patient and their carer (where appropriate) and to other health and care providers involved in the provision of that service.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	GPs' use of the EPC Medicare items is voluntary. There are no specific legislative or regulatory requirements on the use of the EPC items, beyond 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).
7. Are there ways in which the information could be provided more efficiently?	The Medicare requirements for the EPC items specify what should be undertaken when providing an EPC health assessment, care plan or case conference, and what information should be documented and provided as a report, plan or summary of the service to the patient etc. This information is not provided to the Department of Health and Ageing or other agencies (except for normal auditing purposes when required) and there is no mandatory format in which such information must be recorded. There may be scope for efficiencies in documenting and recording the information involved in an EPC Medicare item, provided this enables the Medicare requirements for that service to be addressed. Individual GPs, practices and Divisions have developed approaches to documenting and reporting information as part of EPC services that have presumably delivered efficiencies in their particular circumstances. The main GP software products have incorporated basic pro forma that can significantly assist the GP through the process of using the EPC items. There may be scope through further application and integration of IT for more efficiencies.
8. Is there any existing information about compliance costs imposed on GPs?	There is no information on specific, separately identifiable compliance costs involved in providing an EPC item under Medicare.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	The EPC Medicare items, and the associated GP Education, Support and Community linkages program are being independently evaluated with a report due in late 2002. The evaluation will address areas relevant to issues of compliance costs, including impacts of the items on practice by GPs, satisfaction levels, changes in health care delivery systems etc. Its recommendations may identify changes relevant to this area. The RACGP is also developing a new practical guide to quality implementation of the EPC items, which may have some relevance for this area of compliance.
8.2 What specific additional measures could be taken to reduce compliance costs?	The use of appropriate software systems for EPC could offer significant improvements in clinical information collection and management. This would also have applicability to other areas of General Practice.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	Information on use of the EPC items is not reported to the Government (except through the standard Medicare claiming process).
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	Not applicable.

Program: Home Medicines Review (HMR) MBS Item (also known as Domiciliary Medication Management Review)

Question	Response
1. Are GPs made aware of the Program rationales?	The HMR Medicare item was introduced on 1 October 2001 in consultation and with the agreement of representatives of the medical profession. The Medication Management Review Implementation Steering Group (ISG) was formed to assist with the development and implementation of HMR. The AMA, RACGP, and ADGP were all represented on the ISG. A comprehensive GP HMR information kit was developed and widely distributed from October 2001. The Minister for Health and Ageing. Senator the Hon Kay Patterson, wrote to GP practices in April 2002 drawing attention to the availability of the new item and providing information on its purpose, rationale and use. In addition, the Commonwealth has provided funding for Divisions of General Practice to engage medication management review facilitators to assist with the implementation of HMR. The facilitators' role is to raise awareness of the HMR item and its rationale as well as providing training and support for GPs and pharmacists. Comprehensive information about the HMR Medicare item is available through the Department of Health and Ageing website at www.health.gov.au/epc/dmmr.htm.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	• The HMR item provides 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. • GPs' use of the HMR item is voluntary. • This item does not impose a specific business or administrative requirement on general practice or practitioners, other then indirectly in terms of the practice or individual GP maintaining the capacity to provide non-referred medical attendance items. • GPs are not required to undertake training or purchase equipment to deliver HMR Medicare services. • The HMR Medicare item is designed to support GPs in the provision of clinical services involved in collaborative medication management reviews. 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 documentation needed for the HMR item reflects: - the 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. • Another purpose of documentation supporting clinical care is for GPs to be able to demonstrate, if required to do so, that they have not inappropriately or fraudulently billed an item for a service which has not been delivered. The requirements in this regard are no different from those for any other item. • The HMR Medicare item identifies 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. This information is identified in general terms, for example, when referring a patient to their preferred community pharmacy, a GP should provide relevant clinical information for the purposes of the review, 'covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.' • The HMR Medicare item does not require practitioners to complete a specific form. However, the use of a proforma to assist with referral to a pharmacist and development of a medication plan is recommended. Appropriate pro formas have been developed and are readily available and can be adapted or developed to suit specific needs and preferences. • Payment of the Medicare rebate for a HMR service is not conditional on a form being completed. Any forms used by GPs are not transmitted, or required to be transmitted, to the Department of Health and Ageing, the Health Insurance Commission (except for normal auditing purposes when required) or other agencies.

	• Appropriate forms to support use of the HMR item are also incorporated into commonly used medical software products.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	The objectives of HMR are to: • achieve safe, effective, and appropriate use of medications by detecting and addressing medication-related problem/s that interfere with desired patient outcomes; • improve the patient's quality of life and health outcomes using a best practice approach, that involves a collaborative effort between the GP, pharmacist, other relevant health professionals and the patient (and where appropriate, their carer); • improve the patient's, and health professionals', knowledge and understanding about medications; and • facilitate cooperative working relationships between members of the health care team, in the interests of patient health and well being. One of the benefits of HMR is the requirement for a medication management plan to be developed and discussed with the patient and/or their carer. A copy of the agreed medication management plan is provided to the patient and pharmacist. **For GPs**, the HMR item recognises and rewards the more complex work involved in undertaking the assessment, the referral, discussion with the pharmacist and preparation of the medication management plan. The Medicare rebate is significantly higher then standard consultation items, in recognition of the nature of the work involved. **For the Government** the principal benefit of the HMR Medicare item is improved access to health and care services matched to the needs of the individual, contributing to improved health outcomes.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	GPs are compensated for undertaking HMR activities through the applicable Medicare rebate and any additional patient fee that the GP may charge, as per any other consultation item. The cost of the HMR service may be invoiced to the patient, for reimbursement through Medicare, or direct billed to Medicare. The amount payable by Medicare is set out in the Medicare Benefits Schedule. The rebate for the HMR Medicare item was 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 medication management plans. The HMR Medicare item was developed in consultation with the relevant medical groups, including consideration of proposed rebates for the items.
5. How does the Department use the information provided by GPs?	The Department does not require or receive information from GPs on their use of the HMR Medicare item.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	GPs' use of the HMR Medicare item is voluntary. There are no specific legislative or regulatory requirements on the use of the HMR item, beyond the regulations that govern the provision of non-referred GP attendance items in general and the definition of the HMR item in the Health Insurance (General Medical Services Table) Regulations (which enables its inclusion in the MBS).
7. Are there ways in which the information could be provided more efficiently?	The Medicare requirements for the HMR item specify what should be undertaken when providing the service and what general types of information should be documented, including the need for a medication management plan to be prepared for the patient. This information is not provided to the Department of Health and Ageing or other agencies (except for normal auditing purposes when required) and there is no mandatory format in which such information must be recorded. There may be scope for efficiencies in documenting and recording the information involved in a HMR Medicare item, provided this enables the Medicare requirements for that service to be addressed. Individual GPs, practices and Divisions have developed approaches to documenting and reporting information as part of HMR services that have presumably delivered efficiencies in their particular circumstances. GP software products have incorporated basic pro forma that can significantly assist the GP through the

	process of using the HMR item. There may be scope through further application and integration of IT for further efficiencies.
8. Is there any existing information about compliance costs imposed on GPs?	There is no information on specific, separately identifiable compliance costs involved in providing a HMR item under Medicare.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	No.
8.2 What specific additional measures could be taken to reduce compliance costs?	The use of appropriate software systems for HMR could offer improvements in clinical information collection and management. This would also have applicability to other areas of General Practice.
Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	Information on use of the HMR item is not reported to the Government (except through the standard Medicare claiming process).
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	Not applicable.

Program: Pharmaceutical Benefits Scheme (PBS)

Question	Response
1. Are GPs made aware of the Program rationales?	The purpose of the PBS is to provide timely, reliable and affordable access for the Australian community to necessary and cost-effective prescription medicines. All GPs would be aware of the benefits to their patients of the subsidies available under this Program.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	For patients to access pharmaceutical benefits under the PBS, doctors must provide certain information on the prescription and abide by the PBS rules. For certain "authority required" medicines, doctors must seek approval from the Health Insurance Commission by posting an Authority Prescription Form, or by using the HIC's Authority Freecall service (1800 888 333). For increased maximum quantities or repeat prescriptions of PBS listed medicines required for patients in excess of standard therapy, doctors must also complete an Authority Prescription Form and seek the necessary approval from the HIC. These rules are explained in the Schedule of Pharmaceutical Benefits which can be accessed at http://www1.health.gov.au/pbs/index.htm
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	**Government** - The benefit to Government is improved health outcomes for the Australian population while maintaining necessary controls over costs in an uncapped Scheme. **General Practitioners** - The benefit to GPs is improved access for their patients to affordable and necessary medicines as prescribed. **Consumers** - The benefit to consumers is affordable access to necessary medicines.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	No.
5. How does the Department use the information provided by GPs?	The Department, through its agent, the Health Insurance Commission, uses the information to substantiate the patient's eligibility to subsidised medicines under the Scheme.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	Under section 88 of the *National Health Act 1953*, a medical practitioner is authorised to write prescriptions for pharmaceutical benefits. A "medical practitioner" is not defined in the *National Health Act 1953*, so the definition in the *Health Insurance Act 1973* applies for the purposes of the PBS. It means a person registered as a medical practitioner in a State or Territory. The writing of prescriptions is further governed by the *National Health (Pharmaceutical Benefits) Regulations 1960*.
7. Are there ways in which the information could be provided more efficiently?	The proposed adoption of online authority transactions will be more convenient for doctors and will improve efficiency.
8. Is there any existing information about compliance costs imposed on GPs?	No.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	Yes. Development of online authority processing of PBS prescriptions has the potential to increase efficiency with the corollary being reduced time and costs for doctors.
8.2 What specific additional measures could be taken to reduce compliance costs?	The Department has no additional measures in train.
8.3 Is there duplication in the	No and not to the Department's knowledge.

information reported to Government? Are there other ways of collecting the existing information in a less costly way?	
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	Any reduction in prudential controls and restrictions on supply of pharmaceutical benefits prescribed by doctors would inevitably result in increased costs to government.

Program: Sharing Health Care Initiative (SHCI)

The Sharing Health Care Initiative is part of the Enhanced Primary Care package introduced in the 1999/2000 Federal Budget. The main component of the Initiative is the implementation of 12 demonstration projects (including four community focused Indigenous projects) that are testing a range of chronic condition self-management models in each State/Territory. A suite of education and training materials (including tools to assist in the development of care plans) have been developed by the RACGP and Flinders University for testing within the demonstration projects by a range of health providers including GPs.

Participation is voluntary and limited to GPs within the catchment areas of the demonstration projects. CPD/CME points will encourage GPs to participate in education and training arranged by the relevant demonstration project. Funding has been provided within the project budgets to assist GPs who attend education and training sessions with payments to GPs to be arranged at the local level.

Question	Response
1. Are GPs made aware of the Program rationales?	Yes – When GPs are recruited to be involved in the Sharing Health Care (SHC) Projects, they are fully briefed on the SHCI and what it means to be involved.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	Although the GP's role varies from project to project, generally the activities that GPs are required to do are divided into two areas: 1) Activities that are about doing core business differently, for example: - Jointly undertake holistic health assessments of clients, - Jointly develop and review self management plans with clients (which involves using specially developed tools), - Facilitate behaviour change in clients using a range of techniques including motivational interviewing, and - Referring clients to other health providers, local courses and groups that support care management. 2) Activities that arise from SHCI , for example: - Identify and recruit clients into the project, - Undertaking education and training sessions, - Being actively involved in health professional self management networks, and - Contributing to the evaluation of the SHCI (eg: through focus groups).
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	Improved results for clients Increased understanding for GPs of the principles of self-management
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	GP involvement is remunerated through use of the EPC Care Plan and Care Plan Review, Health Assessments and Case Conferences item numbers. Some projects provide funding to GPs for time spent at chronic disease self management training.
How does the Department use the information provided by GPs?	The information provided by GPs feeds into the National Evaluation of the Sharing Health Care Program.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	Participation in these activities is entirely voluntary.
7. Are there ways in which the information could be provided more efficiently?	The Sharing Health Care Projects are demonstration projects testing a range of chronic condition self-management models. As the information is collated by the National Evaluators, consideration will be given to how this information can be provided more efficiently for possible future programs.
8. Is there any existing information about	No.

compliance costs imposed on GPs?	
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	N/A
8.2 What specific additional measures could be taken to reduce compliance costs?	N/A
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	N/A
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	N/A

Program: Quality Innovation Funding for Medical Deputising Services (MDSs)

Question	Response
1. Are GPs made aware of the Program rationales?	The rationale is clearly articulated on the application form available on the Department's website or by request. MDSs are aware of this Program through marketing undertaken by the Department directly to this sector.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	MDSs employ GPs and some Services are owned and run by GPs. The applicant is required to submit proposal meeting the objectives of the Quality Innovation Funding (QIF) Program. Each application is assessed against criteria developed by the Evaluation and Policy Advisory Group (EPAG). All successful applicants are required to conform to the reporting requirements of a Commonwealth Funding Agreement and participate in the evaluation process for this Program. Evaluation measures outcomes associated with QIF and is conducted on an annual basis.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	The Program will assist MDSs to provide better care for patients - more timely care, better continuity through enhanced communication back to patients' own GPs and higher quality service.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	All successful applicants receive a flagfall payment of $80 000 per annum. MDSs offering clinic-based care may apply for an additional payment of $20 000 per annum per clinic. The Program will run until June 2005.
5. How does the Department use the information provided by GPs?	The Department will utilise deidentified data on the quality improvement activities undertaken by MDSs in the evaluation reports for the Program to inform future policy direction to build capacity in this sector. The Department uses individual identified data from each applicant to ensure continued compliance with the aims and objectives of the Program to enable applicants to receive ongoing funding for the life of the Program.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	No, the Program is entirely voluntary.
7. Are there ways in which the information could be provided more efficiently?	The Program is voluntary and the only Program of its type. MDSs are financially rewarded for participating.
8. Is there any existing information about compliance costs imposed on GPs?	Not in relation to this Program which has only just commenced. The Department is undertaking a concurrent evaluation process, however, which may provide this information.
Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	None in relation to this Program.
8.2 What specific additional measures could be taken to reduce compliance costs?	None in relation to this Program. The Department is undertaking a concurrent evaluation process which may provide this information.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	No. This is a voluntary grants program.

8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	Nil in relation to this program.

Program: General Practice Registrars Rural Incentive Payments Scheme (RRIPS)

Question	Response
1. Are GPs made aware of the Program rationales?	General Practice (GP) Registrars are made aware of the Program rationales through the guidelines. General Practice (GP) Registrars in the Rural Training Pathway of the Australian General Practice Training Program administered by the General Practice Education and Training (GPET) Limited are eligible for the Program. The GP registrars are provided with information about RRIPS by their training provider. The training provider formally advises the Health Insurance Commission (HIC) of GP registrars participating in the Rural Training Pathway. The HIC provides application forms and guidelines to eligible GP registrars. The General Practice Helpline also provides information and advice to applicants.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	In order to receive incentive payments, GP registrars are required to be registered in the Rural Training Pathway of the Australian General Practice Training Program and undertake the majority of their training in a Rural, Remote and Metropolitan Area (RRMA) 4-7 location. GP registrars are required to complete and return an application form to the HIC. Eligible GP registrars receive incentive payments every six months. The HIC provides payment forms to eligible GP registrars every 6 months. GP registrars are required to have this form signed by their supervisor and return the form to the HIC before payment is made.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	GP registrars benefit by receiving significant financial incentives (up to $60,000 over three years) to encourage them to take up the Rural Training Pathway and undertake the majority of their general practice training in rural and remote areas (RRMA 4-7) of Australia. This program also assists consumers in rural and remote areas by increasing the number of GP registrars and services available in rural and remote areas.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	GP registrars are provided with significant financial incentives to participate in the Rural Training Pathway and undertake the majority of their training in a RRMA 4-7 location. GP registrars receive financial incentives of up to $60,000 over a three-year period. Payments are made every six months. Eligible GP registrars receive up to $10,000 in the first year, $20,000 in the second year and $30,000 in the third year.
5. How does the Department use the information provided by GPs?	The Department of Health and Ageing monitors the distribution of GP registrars in the Scheme by State/Territory and by RRMA 4-7 location.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	There is no legislative requirement for GP registrars to undertake the Rural Training Pathway or participate in the Scheme. GP registrars elect to take up the Rural Training Pathway (RTP) as part of the Australian General Practice Training Program. In order to be eligible for the program, GP registrars registered in the RTP are required to undertake the majority of their training in a RRMA 4-7 location.
7. Are there ways in which the information could be provided more efficiently?	The inclusion of the Program guidelines on the Department's and GPET's Website would assist in providing information to GP registrars.
8. Is there any existing information about compliance costs imposed on GPs?	There are minimal compliance costs for GP registrars to participate in the Program. GP registrars are required to complete an application form to register for the Scheme and payment forms every six months. GP Registrars are required to be registered on the Rural Training Pathway and undertake the majority of their general practice training in a RRMA 4-7 location, which may have associated costs.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	N/A
8.2 What specific additional measures could be taken to reduce compliance costs?	N/A
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the	GP Registrars provide information through their application form to the HIC. The HIC provides reporting information to the Department.

existing information in a less costly way?	
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	N/A

Program: Rural Other Medical Practitioners (OMPs) Program

Question	Response
1. Are GPs made aware of the Program rationales?	GPs are made aware of the Program rationales through the guidelines. The Rural OMPs Program provides access to the higher A1 Medicare rebate for OMPs providing general practice services in a RRMA 4-7 location. The Department of Health and Ageing provides program application forms and guidelines to Rural Other Medical Practitioners (OMPs) enquiring about the Program. Rural Workforce Agencies (RWAs) also promote and provide guidelines to Rural OMPs.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	OMPs require a Medicare provider number from the Health Insurance Commission (HIC) in order to participate in the Program. OMPs contact the Department of Health and Ageing or RWAs to request a program application form. The Department and RWAs provide the two-page program application form and nine-page program guidelines to interested OMPs. OMPs forward the completed application form to the South Australian Office of the HIC to formally register for the Program. As part of the eligibility requirements, OMPs are required to express an interest in undertaking an alternate pathway to Fellowship of the Royal Australian College of General Practitioners. OMPs not already located in a Rural, Remote and Metropolitan Area 4-7 (RRMA 4-7) would be required to move to one of these areas in order to be eligible for the Program. OMPs are required to lodge a new application if they move from one practice location to another.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	**General Practitioners** The Rural OMPs Program provides access to the higher A1 Medicare rebates to non-vocationally recognised doctors in rural and remote areas (RRMA 4-7). **Consumers and Government** Consumers in rural and remote areas (RRMA 4-7) are able to access the higher A1 Medicare rebate. The Rural OMPs Program may assist in increasing the number of doctors in rural and remote areas of Australia.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	OMPs registered in the Rural OMPs Program are provided with access to the higher A1 Medicare rebate as an incentive to provided general practice services in rural and remote areas. The A1 Medicare rebate is $24.45 which is an increase of $6.60 over the non-vocational rate.
5. How does the Department use the information provided by GPs?	The Department monitors the number of OMPs participating in the Program.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	General Practitioners are not required to participate in the Program. Participants in the Program are required to comply with the Program requirements ie provide general practice services in RRMA 4-7 and express an interest in undertaking a pathway to Fellowship of the Royal Australian College of General Practitioners.
7. Are there ways in which the information could be provided more efficiently?	The inclusion of the Program guidelines and registration form on the Department's Website would assist in providing information to Rural OMPs.
8. Is there any existing information about compliance costs imposed on GPs?	There are minimal compliance costs to GPs. General Practitioners are required to complete and forward the application form to the HIC. As part of the Rural OMPs Program, doctors are required to express an interest in undertaking a pathway to Fellowship of the Royal Australian College of General Practitioners (FRACGP), which may involve costs to general practitioners. FRACGP provides unrestricted access to the higher A1 Medicare rebate of $24.45, which is an increase of $6.60 over the non-vocational rate.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	GPs are required to complete a 2-page application form on entry to the program and if they change practice locations. Compliance costs are minimal.
8.2 What specific additional measures could be taken to reduce compliance costs?	N/A
8.3 Is there duplication in the information reported to	Information on participation rates of GPs in the Rural OMPs Program is provided by HIC.

Government? Are there other ways of collecting the existing information in a less costly way?	
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	N/A

Program: 3GA PROGRAMS

In 1996 the Government introduced restrictions under Section 19AA of the Health Insurance Act 1973 (the Act) to restrict access to Medicare benefits for medical practitioners who do not hold postgraduate qualifications. Doctors subject to the restrictions are able to gain temporary access to Medicare when working in approved placements under Section 3GA of the Act through such programs as the Approved Medical Deputising Service Program, Rural Locum Relief Program and Temporary Resident Other Medical Practitioners Program.

Question	Response
1. Are GPs made aware of the Program rationales?	Information about 3GA programs is available on the Department of Health and Ageing website. Guidelines have been put in place to provide the Rural Workforce Agencies responsible for administering the Rural Locum Relief Program with the background, principles, eligibility criteria and operational procedures of the Program. These guidelines are issued to general practitioners upon request. An information sheet and guidelines for the Approved Medical Deputising Service Program is available by calling the Workforce Regulation Section's information line. Information has been sent to all affected parties with the background, principles, eligibility criteria and operational procedures of the Temporary Resident Other Medical Practitioners Program.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	A GP seeking a locum placement under the Rural Locum Relief Program is responsible for sending the Health Insurance Commission form *Application for a Medicare Provider Number for a Medical Practitioner*, the Rural Locum Relief Program – 3GA Supplementary Application form (both locum and practice sections) and all supporting documentation (eg medical board registration, curriculum vitae, residency status), to the Health Insurance Commission at least 14 days prior to the commencement of the placement. The Health Insurance Commission then forwards this information to the Rural Workforce Agency for assessment. The doctor seeking a locum must also send a letter to the Health Insurance Commission preferably five working days prior to the locum filling the placement to allow the Health Insurance Commission time to process the application. Approved Medical Deputising Service Program medical practitioners provide after hours services during evenings, weekends and public holidays. They are required to complete reports on all attendances for the information of the patients' usual general practitioners. Medical practitioners participating in the Temporary Resident Other Medical Practitioners Program have a period of five years to complete their Fellowship with the Royal Australian College of General Practitioners to be classified in terms of the Act as unrestricted.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	*Benefits to GPs* Participation on these 3GA programs provides doctors restricted under the Act with a means to access Medicare benefits. Temporary Resident Other Medical Practitioners also ensures that doctors previously exempt from restrictions are given the opportunity to obtain postgraduate qualifications. *Benefits to Government and the community* **Rural Locum Relief Program** • Access to locums in rural and remote areas is maintained or enhanced. • Rural Workforce Agencies are accountable to the Department for review and evaluation purposes. • Government addresses workforce shortages. **Approved Medical Deputising Service Program** • The community is given increased access to after hours care. **Temporary Resident Other Medical Practitioners Program** • The Temporary Resident Other Medical Practitioners Program encourages medical practitioners to gain higher qualifications and to participate in either a relevant training program or a workforce distribution program which increases the number of available doctors in remote and rural districts of workforce shortage.
4. Are GPs compensated for	Specialist trainees and medical researchers will receive the Medicare A2 level rebate upon commencement of practice in an outer metropolitan district of

undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	workforce shortage.
5. How does the Department use the information provided by GPs?	The Department uses the information provided to assess the success of Section 3GA programs in directing doctors to work in areas where workforce shortage occurs.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	Most overseas trained doctors and Australian trained doctors who have graduated since 1996 are subject to restrictions under Section 19AA of the Act for access to Medicare unless they hold a Fellowship qualification or are on an approved placement under Section 3GA.
7. Are there ways in which the information could be provided more efficiently?	No.
8. Is there any existing information about compliance costs imposed on GPs?	There is no existing information about the compliance costs imposed on GPs.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	There is no awareness of any recent or proposed reforms.
8.2 What specific additional measures could be taken to reduce compliance costs?	No specific additional measures to reduce compliance costs have been identified.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	No information is duplicated in reporting information to Government.
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	This is not able to be assessed – see 8. above.

Program: Section 19AB Programs

Overseas-trained doctors who were first recognised as medical practitioners under the ***Health Insurance Act 1973*** on or after 1 January 1997 are ineligible under Section 19AB to provide services that attract Medicare benefits for a period of ten years unless they choose to work in designated districts of workforce shortage.

Question	Response
1. Are GPs made aware of the Program rationales?	Information on Section 19AB restrictions is available from the Department's website www.health.gov.au/workforce. This website gives background to 19AB legislation and explains restrictions in detail. Guidelines are also in place to provide information to medical practitioners who are subject to Section 19AB of the Act. These guidelines provide policy direction for the grant of exemptions under Section 19AB of the Act. These guidelines are issued to general practitioners upon request. Guidelines have been put in place by all States and the Northern Territory to provide general practitioners with the background, principles, eligibility criteria and operational procedures of the 5-Year Schemes. These guidelines are issued to general practitioners upon request.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	Medical practitioners who are subject to Section 19AB of the Act are required to apply for an exemption to the restrictions imposed under the Act using the same Health Insurance Commission form they complete to apply for a provider number. A decision to grant or refuse an exemption under Section 19AB of the Act is based on an assessment of whether an area is a district of workforce shortage.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	**Section 19AB** *Benefits to GPs* • Overseas trained medical practitioners working in rural and remote districts of workforce shortage can gain exemption to restrictions on access to Medicare provider numbers. *Benefits to Government and the Community* • Australians living in remote and rural areas of workforce shortage receive better access to medical services provided by general practitioners. **State 5 Year Schemes** *Benefits to GPs* • Overseas-trained doctors who are permanent residents or citizens are normally not eligible to obtain an unrestricted Medicare provider number under Section 19AB of the Act for 10 years from the date they are first recognised as medical practitioners under the Act. They are also ineligible to access Medicare under Section 19AA until they obtain Fellowship qualification. The Commonwealth has undertaken to waive the remainder of this 10-year moratorium for all doctors who complete the 5 years service on the State schemes, obtain Fellowship of the Royal Australian College of General Practitioners and acquire permanent residency or citizenship status. *Benefits to Government and the community* • Overseas trained doctors are encouraged to improve their medical qualifications by obtaining a Fellowship. They also provide medical services in areas that have found it difficult to recruit doctors. Government policy objectives are better served as doctor shortages in rural and remote areas are addressed.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	**Section 19AB** Overseas trained doctors working in RRMA 4-7 (and some areas classified as RRMA 3) districts of workforce shortage are eligible to claim Medicare benefits for services rendered. **State 5 Year Schemes** Doctors are compensated for working in difficult areas. Reduction of 10-year moratorium on provider numbers under Section 19AB of the *Health Insurance Act 1973* if they fulfil all conditions imposed under the Scheme.
5. How does the Department use the information provided by GPs?	The Department uses information provided to monitor success of programs in addressing doctor shortages in rural and remote areas.
6. Are these activities compulsory for GPs? (For example, are there any	It is compulsory for overseas-trained doctors restricted under Section 19AB to work in rural and remote areas of Australia if they wish to access Medicare benefits.

specific legislative or regulatory requirements?)	
7. Are there ways in which the information could be provided more efficiently?	No.
8. Is there any existing information about compliance costs imposed on GPs?	There is no existing information about the compliance costs imposed on GPs.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	No awareness of any recent or proposed reforms.
8.2 What specific additional measures could be taken to reduce compliance costs?	No specific additional measures to reduce compliance costs have been identified.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	No information is duplicated in reporting information to Government.
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	This is not able to be assessed – see 8. above.

Program: Rural and Remote General Practice Program (RRGPP)

Question	Response
1. Are GPs made aware of the Program rationales?	The RRGPP aims to provide a flexible, coordinated, cost-effective and consumer-focussed framework for the delivery of incentives and support for the recruitment and retention of general practitioners in rural and remote areas. The Program is administered by State and Northern Territory based Rural Workforce Agencies (RWAs), funded for the period 2001 to 2004 and managed through the Department's State Offices. RWAs in turn, provide assistance to GPs through various incentive schemes. GPs are made aware of the program rationale through RWA individual websites, which are linked, to the Department of Health and Aging website www.health.gov.au. Information is also available through formal and informal Rural Doctors' Association of Australia (RDAA) and Divisions of General Practice networks.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	Collection and collation of a Minimum Data Set (MDS) is a core component of each RWA contract with the Commonwealth Government. Data collection methods vary. Some RWAs conduct voluntary surveys of GPs and others employ telephone surveys. Doctors are also required to complete forms to receive financial incentives and benefits from Rural Workforce Agencies.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	**Government** The collated MDS assists in building an accurate picture of the numbers and skills of GPs in each State and Territory. It is anticipated over time that the data will provide an accurate base for measuring GP workforce stocks and flows and assist the Department and Rural Workforce Agencies in anticipating and planning for future community needs for GP services. **General Practitioners** The benefits to doctors of filling in forms to receive program incentives are that they then receive the financial incentives and benefits in the most administratively effective and efficient way available. **Consumers** The RRGPP aims to provide a flexible, coordinated cost-effective and consumer focused framework for the delivery of incentives and support for the recruitment and retention of general practitioners in rural and remote communities.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	The Department is not aware of GPs being compensated for completing MDS surveys.
5. How does the Department use the information provided by GPs?	The MDS will provide a base for measurement of workforce stocks and flows in rural and remote Australia. It is anticipated over time that the MDS reports will provide an accurate base for measuring the workforce stocks and flows and assist the Department and Rural Workforce Agencies in anticipating and planning future community needs for GP services. Information provided on application forms enables the Department to track the utilisation of specific initiatives. This in turn builds up a picture of the types of incentives that encourage the recruitment and retention of GPs and of the costs involved.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	No. MDS surveys (either hard copy or telephone interviews) are voluntary.
7. Are there ways in which the information could be provided more efficiently?	Currently the only process for obtaining accurate data on doctors practicing in rural and remote areas is to contact them direct, either by survey or over the phone. There is no other State/Territory or national census that records the movements, skills, hours worked etc. of GPs in rural and remote Australia.
8. Is there any existing information about compliance costs imposed on GPs?	No. Rural Workforce Agencies may, however, be able to provide more detail if required.
8.1 Are you aware of any recent or proposed reforms to	No. Rural Workforce Agencies may be able to provide more detail if required.

reduce the burden of GPs' compliance costs? Have they been effective?	
8.2 What specific additional measures could be taken to reduce compliance costs?	None that are apparent or of which the Department is aware.
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	No. The Health Insurance Commission is able to provide information on the GP workforce based on Medicare data. As doctors also provide a range of services not covered by Medicare, however, the MDS data fills and provides more accurate information about doctors working "on the ground".
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	The data collected by RWAs is not obtainable from any source other than the rural GPs from whom it is collected.

Program: Rural Women's GP Service

Overview

The aim of this Program is to improve access to primary and secondary health services for women in rural Australia who currently have little or no access to a female general practitioner. It provides women in rural and large remote communities the opportunity to seek health care of their choice. Female GP's attend these identified rural communities as the need requires and deliver a range of services.

The general practitioner services include, though not limited to, during the course of consultations, cervical cancer screening, breast and skin examinations and other preventive health care. In addition the Service is required to identify and provide the necessary intervention for other conditions such as cardiovascular disease, diabetes, menopause, psychosocial problems and conditions related to the reproductive system an sexual health.

Question	Response
1. Are GPs made aware of the Program rationales?	Information about the Program is available through the Royal Flying Doctor Service (RFDS) and through Divisions. The RFDS conducts an orientation for doctors commencing working with the Program. This orientation is conducted by the Project Officer within each RFDS Section with the input of the Director of medical services, and includes the aims and philosophy of the Program.
2. What activities are GPs required to do (such as undertaking training, filling in forms, purchasing equipment)?	The GPs are required to travel to designated locations to conduct clinical sessions and are also asked to provide a statistical report. The RFDS conducts in-service sessions which GPs are encouraged and paid to attend. These sessions involve discussions about the Program and educational lectures on relevant topics.
3. What are the benefits of GPs undertaking these activities - to government, GPs, consumers and others?	The statistics are required by the RFDS and the Commonwealth Government to monitor and evaluate the Program. All follow up duties are conducted for the welfare of the patients. Attendance at the in-service sessions is for the benefit of the GPs and the Program.
4. Are GPs compensated for undertaking these activities? If so, in what way, and how much. What is the basis for this compensation?	GPs are paid for all their time involved with the Program including the activities as stated above. Each RFDS Section has their own payment arrangements for the GPs.
5. How does the Department use the information provided by GPs?	The statistics are required by the RFDS and the Commonwealth Government to monitor and evaluate the Program. As relevant, the statistics could be used in the development of policies to address specific health issues.
6. Are these activities compulsory for GPs? (For example, are there any specific legislative or regulatory requirements?)	The only compulsory requirements associated with the program are: - the agreement/document signed with the RFDS in regard to confidentiality and continuity of gp services. - the preparation of the statistical report on clinic activities.
7. Are there ways in which the information could be provided more efficiently?	Maybe, if all the GPs were computer literate the inputting of the statistics directly into a medical software system via a laptop may be more efficient. This would require the purchase of suitable IT equipment and associated training.
8. Is there any existing information about compliance costs imposed on GPs?	There are no compliance costs. GP fully remunerated for their participation in the program.
8.1 Are you aware of any recent or proposed reforms to reduce the burden of GPs' compliance costs? Have they been effective?	There are no compliance costs specific to this program. A broader initiative, the advent of the Statistical Clearing House could rationalise the number of survey etc GP's may potentially be asked to complete as input to a range of government programs.
8.2 What specific additional measures could be taken to	There are no compliance costs specific to this program.

reduce compliance costs?	
8.3 Is there duplication in the information reported to Government? Are there other ways of collecting the existing information in a less costly way?	This information recorded in this program is not reported to the Government in any other way.
8.4 Would measures to reduce compliance costs faced by GPs shift costs to departments, patients or other organisations?	There are no compliance costs specific to this program.