



FAR NORTH QUEENSLAND RURAL DIVISION OF GENERAL PRACTICE ASSN. INC.

ABN: 70 424 702 153
31 English Street
PO Box 191
MALANDA Q 4885
Ph: (07) 4096 5046
Fax: (07) 4096 6423
Email: admin@fnqrdgp.com.au
Website: www.fnqrdgp.com.au

30 August 2002

GP Coompliance Costs
Productivity Commission
Locked Bag 2
Collins Street East Post Office
Melbourne VIC 8003

Dear Commissioner

-
The Board of Far North Queensland Rural Division of General Practice believe there is a significant compliance cost in time and money in the application of various Commonwealth policies and programs. This is compounded by the significant time and money involved in complying with State and private company requirements also. This is an important issue that needs to be rectified as soon as possible for reasons of efficiency of general practice, therefore consumer outcomes and satisfaction with work environment, to name just a few.

This submission is based on direct GP comments from board members (all GPs) and other Divisional GP members.

-
Issues -

Inadequately insured consumers

- By far the largest cost to general practice is subsidising patients who can't afford to pay the appropriate fee. These include many disadvantaged groups including pensioners, HCC holders / low socio-economic areas, ATSI patients and rural patients. This issue could be addressed by having appropriate and indexed rebates for these groups of people.

Accreditation

- The cost of complying with accreditation is a significant amount (thousands of dollars) and would require a widespread survey of GPs to assess. Ideally the cost should be retrieved through it being a continuous quality improvement program. We need to work further towards this making it a program with voluntary areas to improve in resources to assist. RACGP, AGPAL and Divisions should be heavily involved in improving the process.

Practice incentive program

- Basic feedback from GPs seems to be that the PIP was ok but with the increasing complexity, some GPs are considering not bothering with it.

-

Service incentive program

- Immunisation SIP – an average immunisation takes 5 minutes, the paperwork takes 25 minutes, including recalls, checking databases and appropriately recording it.
- Diabetes SIP – this incentive is no great burden, in that the clinical work is what GPs do anyway. However, the clinical software needs to be improved to support the GP is correct and simplified storage and use of data and recalls. The diabetes summary can't even be printed in Medical Director.
- Cervical screening SIP – the difficulties include:
 - virtually impossible if not computerised
 - the initial input of date – once again the clinical software is not advanced enough to pick up when someone has had a smear or when the pathology result is returned. It has to be manually transferred to another data storage area which is ridiculous
- Asthma SIP – this supports GPs who structure their work as clinics of particular disease type (eg asthma clinics) but not those who have a more open and flexible work structure. There is also a perverse incentive to increase the number of visits per patient. Most patients who will comply with this are the ones who would comply with treatment guidelines anyway, ie 'preaching to the converted'.
- Mental health - the training required to access the new item numbers is not only not required and irrelevant but also offensive to those who have for many years looked after the mental health requirements of our communities. A number of practitioners who do a lot of mental health work in Far North Queensland, will be not using this, 1) because of the training requirements or 2) because of the extent of paperwork required.

New Medicare items -

- EPC items -

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

"I believe we could do a lot more by paying for a nurse in each practice to visit the aged, mentally ill or those requiring dressings etc than we do in planned health assessments. Why not combine the budgets for health assessments and state community health and place community health in general practice? Get around the problem of profiteering by ensuring only GPs can own a general practice."

"I've done one case conference ever and if I never do a health assessment, I'll be happy. I have more patients wishing to come and see me because they're sick than I can cope with and taking time out to do health assessments is nowhere near as important as helping people who are unwell".

These types of comments and the lack of evidence that these types of arrangements improve the health of patients make it questionable as to their value. Why not make the Medicare rebate for these less and the paperwork burden less.

- DMMR – the poor uptake speaks for itself. Once again, improved clinical software could assist this program, in referrals, prompts and incorporation of pharmacists' advice.

Vocational registration

- attaining VR status
- maintaining VR status -

1. CPD requirements - there is no doubt that most GPs attain many more points than required to maintain VR status. There is a genuine wish to keep up with current issues and improve skills. Some of the difficulties with the process are, the time and cost to the GP and to the practice. For example, most GPs would like to attend 2-3 conferences per year. The costs per conference would be \$ 500- \$800 registration, \$500-\$1500 for an airfare, \$800-\$1200 accommodation, \$200 -\$400 expenses - i.e.: \$3900 + family costs; then \$3000 for a locum & \$2000 lost income (or if no locum, then \$8000 lost income - half of which is practice costs).

2. GPs must pay a fee to RACGP to count their points - about \$150.

3. Costs of audits are about \$500 to purchase, then about 10-20 hours of time. Alternatively it is possible to get a pharmaceutical company to do one - free- but these are all around increasing drug prescribing - obviously a cost to consumers and the PBS, though perhaps saved cost in secondary care.

Centrelink requirements

- TDR's - these are frequently requested and often complicated documents. It is stated that a Medicare rebate can be claimed if it is done as part of a patient consultation. It is not often advised to the patient to book a long consultation and expect to pay the appropriate fee (about \$80) for which the Medicare rebate is \$46.45. As most of these patients are pensioners, most GPs feel obliged to charge less thus the cost comes out of their (the GPs) pocket.

Authority scripts

- Multiple scripts are required every day in most GP's practice. Although the process has been streamlined, is there significant savings? Once again, it is on the premise that GPs will not stick to guidelines. Why assume this? There must be significant costs in having the program run at all.

Taxi subsidy applications

- As one GP commented "I filled out the practitioner's part of the form; it was sent back to the patient asking for it to be filled out correctly as she hadn't done the patient's part, so I filled that part out also; then I got a further phone call asking for "objective evidence" of the patient's arthritis - not only had I already outlined the appropriate clinical evidence on the form, I had commented that her X-ray had been destroyed in an accident some years previous. It is not only offensive that I'm asked for "objective evidence", it is a waste of my time, and ensures some bureaucrat is employed in a job of questionable importance. If we are required to maintain our skills as general practitioners, why is it assumed that we might lie on patient application forms."

Daycare sick certificates

- It is now a requirement for parents to show daycare centres evidence of the child's illness. Further time wasted writing certificates for 1-5 yr olds!

Note there have been many similar concerns voiced regarding state based organizations, especially ambulance and workcover forms.

Divisions of General Practice

Whilst there are a variety of opinions amongst GPs about the value of Divisions of General Practice, there are certainly a number of areas that commonwealth policies and programs take up unnecessary GP time of questionable outcome. For example, reporting 6 and 12 monthly on our business plans and 12 monthly for the NIS seems an extraordinary waste of time. Much of this time could have been saved over the years by having more senior / experienced commonwealth staff in assisting with plans and financials and putting reasonable systems in place to assess outcomes. Once again the sense of mistrust of GPs & the over concern with minutiae pervades the attitude of those we deal with.

IMIT

- The level of clinical software seems unacceptably low considering the vast majority of GPs use medical director. It seems that this tool should be developed to a much higher level than currently eg.
 - 1) the date searching tool is limited – making clinical audits and GP research more difficult than expected
 - 2) the ability to automatically record results of PAP smears, diabetics pathology etc. should be well advanced but is not even an issue
 - 3) Workcover, sickness benefits and driver's licence forms could all be simple templates taking clinical information from progress notes
 - 4) Templates for DMMR, care plans, case conferences etc. could be much improved/developed with appropriate information retrieved from various areas – again a better tool searching for information may be required.

Are the owners of the company so busy with the new forms each government program requires that development of the basic tool be hindered?

The ongoing development of IMIT systems and services has a significant potential to reduce work done by GP's and practice staff, especially if it occurs automatically as a result of normal patient management through the practice software, for example HIC initiatives such as HIC Online.

As the number and sophistication of these online services and tools increase, there is little doubt that GP's will eventually need a permanent internet connection and access to some mode of broadband service. Some 60% of our practices do not have access to ADSL and the alternative of two way satellite is costly and in most part much slower than the service level purchased and patchy even on a good day. We must also consider that in the Tropics, where rainfall can be very heavy over a long duration, we would also expect satellite service interruption or degradation due to signal attenuation.

It is important to point out that even if Government does introduce measures to reduce GP paperwork overheads, this will probably only be effective in rural areas if the infrastructure services and technology are available at an acceptable cost.

Answers to some of the questions raised in the document

1) The definition of a GP should include VR, non VR and registrars - the same issues apply to all and all provide equivalent services. Similar issues will apply to AMSs, especially those who are accredited. It may be that they have other issues to be addressed, these are probably best done in a separate review - so as not to make this one too extensive and so as not to dilute the important issues for AMSs.

2) Issues are as per Attachment C and as above

3) GPs are made aware of the rationale of programs.

However it is often unnecessary to ask for: -

- extra training to be done (eg the mental health training). As various GPs have commented "will it be a requirement that each GP has upskilling in reading ECGs, treating patients with pneumonia, plastering for fractured forearms etc etc to be able to access to individual item numbers. This is what I do every day and have been for 20 years. I have had more training over that time than any 6 hour course in mental health training could provide me."
- Extra forms to be done "Filling out forms means less time spent looking after sick patients."
- "The benefits have to be questioned. Granted that this is the basic way that GPs do look after particular conditions (diabetes, asthma, Cx screening, and mental health), why make the red tape so complicated that we have to question whether it is worthwhile registering and claiming for PIPs. If this has been to address the inadequate remuneration for looking after patients with chronic illness, then what about all the other chronic illnesses? Why not just make the usual Medicare rebates for patients with a chronic illness higher and provide better practice assessment tools for doing practice audits?"

4) There is no doubt that the cost is not only monetary and in time, but also the psychological impact. One of the great frustrations of general practice is the paper work. "It is a thankless task that is often poorly paid and it is often insinuated that we (the GP) cannot be trusted to make reasonable decisions about our patient's health"

5) Influences on compliance costs.

Rural practice costs more to run, is generally busier (fewer GPs per population) and more complicated (less referral to specialist and often caring for hospitalised patients as well as outpatients), and faces a lack of allied health professionals to assist in the care of patients. All of these influence the costs in terms of monetary, staff time and the stress of implementation. SES of the area serviced by the GP affects all costs, as any time used in compliance means fewer consults in a practice, that may not be able to charge reasonable fees in the first place. Better medicare rebates for these patients is the solution.

"The cost of a reasonable IM/IT system is about \$40000/3 years in hardware and about \$5000 per year in maintenance". These costs and the infrastructure costs of having a team based general practice system have not been reasonably addressed. Some practices have not been able to implement offered programs due to a lack of space eg: practice nurses in rural areas, MAHS allied health personnel in the practice.

Ownership of practices is a complex issue and this makes it more complex as to who gets what proportion of the PIP payments, especially with variable workloads. If the PIP is meant to be part of our income, then the lag time of 1 year in counting SWPEs is unacceptable.

-
Dr Nikki Williams
Medical Director, FNQRDGP
PO Box 191
Malanda Qld 4885
Telephone: (07) 4096 5046