
General Practice Compliance Costs

*Feedback and Context for the
Assessment of Commonwealth Forms*



December, 2002
Job No: 83102579

Research Conducted by
Max Yann, Mark Zuker,
Kim Kreuzer & Kamela Bearlin
Millward Brown Australia
245 St Kilda Road, St Kilda 3182
Ph: (02) 9927 0000 Fax: (02) 9953 9035
e-mail: : kim.kreuzer@au.millwardbrown.com

ACN 000 029 630 ABN 86 000 029 630



Millward Brown

Page 1 of 100

TABLE OF CONTENTS

EXECUTIVE SUMMARY.....	3
1. BACKGROUND	9
2. RESEARCH OBJECTIVES.....	10
3. RESEARCH METHODOLOGY	11
4. INSIGHTS INTO THE BURDEN ON GENERAL PRACTITIONERS .	13
5. CENTRELINK	19
5.1 Treating Doctor's Report	22
5.2 Medical Review - Disability Support Pension	37
5.3 Medical Certificate.....	42
5.4 Carer Payment: Doctor's Medical Report for a Child – Under 16 years	50
5.5 Carer Allowance: Treating Doctor's Report for a Child – Under 16 years	52
5.6 Carer Payment and/or Carer Allowance: Health Professional Assessment for a Person – 16 Years or over.....	55
6. DEPARTMENT OF VETERANS' AFFAIRS	58
6.1 Claim for Disability Pension and/or Application for Increase in Disability Pension	60
6.2 Associated GARP Forms	65
7. DEPARTMENT OF HEALTH & AGEING	72
7.1 Australian Childhood Immunisation Register - Encounter Form.....	74
7.2 Pharmaceuticals Benefits Scheme RPBS Authority Prescription	82
7.3 Application for a Hearing Services Voucher for Adult Applicants	94
8. ADDITIONAL ISSUES	95

Appendix A: Moderator's Guide

EXECUTIVE SUMMARY

For some time Australian general practitioners (GPs) have expressed concerns about the increasing burden on them arising from paperwork and other government requirements. In response, the Commonwealth Government requested that the Productivity Commission provide an independent assessment of GPs' compliance costs associated with Commonwealth programs that impact on General Practice in particular.

Millward Brown, in turn, were requested to provide the Productivity Commission with independent feedback from GPs nationwide into the burden of one particular area of Commonwealth compliance tasks, Commonwealth forms.

The key objectives of Millward Brown's investigation were to:

- Obtain indicative data on the costs imposed on GPs and general practices by requirements to comply with a specific group of government programs and policies. These include a select group of high volume Department of Health and Ageing, Centrelink and Department of Veterans' Affairs forms.
- Gather qualitative information on complying with these specific Commonwealth Government requirements to complement and support the quantitative data attained.

The current study comprised both qualitative and quantitative elements, administered via a compliance workshop environment. The information will complement information obtained directly from Commonwealth government departments and agencies, GP organisations and other sources, including other research initiatives. This report represents the qualitative findings of the study. A separate data file has been provided to the Productivity Commission inclusive of the detailed quantitative findings.



The following forms, identified as having the highest volume, were nominated as priorities within this research study:

1. *Treating Doctor's Report (Centrelink jurisdiction)*
2. *Medical Review - Disability Support Pension (Centrelink jurisdiction)*
3. *Medical Certificate (Centrelink jurisdiction)*
4. *Claim For Disability Pension and/or Application For Increase In Disability Pension and Associated GARP Forms (DVA jurisdiction)*
5. *Pharmaceutical Benefits Scheme RPBS Authority Prescriptions (DHA jurisdiction)*
6. *Australian Childhood Immunisation Register - Encounter Form (DHA jurisdiction)*

Commonwealth forms, such as those issued by agencies such as Centrelink, Department of Veterans' Affairs and Department of Health & Ageing, were seen by GPs to be a minor part of their overall compliance burden. However, there were serious areas of frustration relating to various processes and forms and the ongoing proliferation of forms of every type from all agencies was seen to be the core issue for GPs.

Generally, GPs expressed their concern with their changing roles, with less time spent seeing patients and frustration and burn-out due to the extensive amount of compliance tasks. There is also a large amount of frustration about the lack of remuneration and thus the inability for GPs to produce quality input into many of these Commonwealth programs.

Centrelink

In general, Centrelink was a top of mind frustration amongst agencies that issued health-related forms. In particular, there was a sense of devaluation of the forms and a lack of communication between Centrelink and the GPs.

The three high volume Centrelink forms, including the Treating Doctor's Report, the Medical Review – Disability Support Pension, and the Medical Certificate were discussed across all 10 workshops.

- The Treating Doctor's Report took, on average, anywhere from 5 to more than 60 minutes to complete, depending on the number of conditions the patient has, the GP's familiarity with the patient, the quality of the information provided in the form and the value placed on the form.

The key issues GPs have with this form are a general lack of understanding of the processes and structure involved, a distinct lack of feedback from Centrelink, patient pressure and a conflict of interest, privacy, subjectivity and lack of reimbursement.

Perceptions of the new form were mixed with some GPs indicating it was an improvement over the previous version and others indicating it now required too much detail.

Suggestions for improvement included both means of improving the process as a whole, as well as practical means of improving the current reporting mechanism. Means of improving the overall process included the GP providing a medical report, for which they would need to be reimbursed, to an assessing medical officer at Centrelink. Suggestions for improvements to the current form included a computerised form or carbon versions of the current form to allow the GP to easily retain copies.

- GPs reported similar feedback on the Medical Review, as to the TDR. Where time in completing the form varied from the TDR, this was related to GPs assisting the patient in filling in their portion of the form, which lengthened the time spent completing the form. The time spent alternatively may have been shorter if the GP had a copy of the initial TDR or previous review forms.

The Medical Review also presented additional frustrations for the GP, primarily in relation to the patient's section of the form. GPs reported the inability of the patient's to fill in their portion of the form due to limited understanding of the questions or memory of their medical treatment (e.g. hospital stays and dates), literacy or language difficulties. A reduction in the frequency of these forms, especially in relation to patients with permanent disabilities was desired.

- The Medical Certificate could be completed anywhere from half a minute up to 15 minutes. Generally the amount of time spent completing this form varied primarily depending on the value the GP put on the form, it could either be filled in quickly or with great detail and accuracy.

Generally, this form was not considered a significant frustration and the time taken to fill it out was considered fairly reasonable. The areas of frustration in relation to the Medical Certificate were: pressure from the patient to indicate they were unable to work, privacy issues in providing the information to Centrelink, a lack of understanding of the purpose and processes related to the form, the level of detail required in the new form, a lack of feedback from Centrelink and the lack of intermediate option in terms of the patient's ability to work.

Suggestions in relation to improvements for the form included shortening the form, by simply requesting the GPs opinion as to how the medical condition may or may not affect the patient's ability to work, provision of the form electronically, further feedback from Centrelink and remuneration for completing the form.

Department of Veterans' Affairs

Compliance tasks imposed by the Department of Veterans' Affairs were discussed during half of the ten workshops. The Claim for Disability and/or Application for Increase in Disability Pension form, along with the Associated GARP forms were addressed in the framework of this study.

Interestingly, a significant number of GPs were aware of the Associated GARP forms over and above the initial Claim form. There was a perception raised that the initial form is being completed elsewhere outside the jurisdiction of the patient's treating doctor. This creates a frustrating situation for a GP where the Associated GARP forms "*just arrive*" at their surgeries without any prior involvement with the claim. It becomes difficult where the GP is unfamiliar with the patient and/or the condition/s for which a claim is being made.

Ethical concerns have been raised about others encouraging the patients to submit claims for medical conditions which are either not apparent or are unrelated to war service. This places a significant amount of pressure onto the GP who often feels obliged to complete the forms in the way expected from the patient. This is particularly in relation to familiar patients.

The time requirements of both the initial Claim for Disability and/or Application for Increase in Disability Pension form, and the Associated GARP forms appears to vary greatly across GPs and individual cases at hand. Major factors influencing the time spent on the forms include familiarity with the patient and/or conditions, number of conditions for which claim is made, and the value placed in the forms and the system overall. For the initial Claim form, a further determining factor of time required by the GP is the extent to which the form has been filled out by the patient as expected.

Major frustrations and difficulties associated with the Department of Veterans' Affairs forms were associated with the number of GARP forms arriving per claim, repetition of the GARP forms, GP pressure to sign invalid applications and unfamiliarity with patient and/or condition. A further difficulty is separating war related conditions and conditions arising from other sources when making a diagnosis and discussing its source.

While time requirements can be significant, as can frustrations and difficulties, the remuneration awarded to GPs for the completion of each GARP form alleviates this somewhat. In the main, the Department of Veterans' Affairs is seen in a favourable light.

Department of Health and Ageing

The Department of Health & Ageing impose a significant number of compliance tasks upon GPs. Three high volume tasks were included in this study's terms of reference, including the Immunisation Childhood Register – Encounter Form, Pharmaceuticals Benefits Scheme RPBS Authority Prescriptions, and the Application for a Hearing Services Voucher for Adult Applicants form.

None of these three tasks pose significant time pressures upon GPs.

- The Australian Childhood Immunisation Register – Encounter Form is a very familiar form to GPs, and is perceived as a minimal burden only. It is particularly viewed favourably as it can be completed by other staff in the practice. When combined with the further paperwork associated with each child's immunisation, the level of paperwork can become frustrating. Issues were raised in relation to the faint ink used on the hard copy form, along with frustrations associated with missing batches of forms, and unfamiliar patients where immunisation history is unavailable.
- The Pharmaceuticals Benefits Scheme RPBS Authority Prescription is typically conducted over the telephone with the completion of the script electronically. While the time associated with each authority prescription is not great, there were some frustrations raised in relation the concept of calling a non-medical person to seek approval for the prescription of medication. While the majority claimed to understand the overall objectives of the system, there was some doubt associated with its value. Some GPs felt that the system undermined their authority as medical professionals. Where the phone call is concerned, GPs raised concerns about the breach of patients' privacy where their specific condition must be read over the telephone to a 'clerk' for authorisation of the required medication. This can create an uncomfortable situation for both the GP and patient alike. Some of the call centre staff members were more flexible than others in getting around this situation.

1. BACKGROUND

For some time Australian general practitioners (GPs) have expressed concerns about the increasing burden on them arising from paperwork and other government requirements. In response, the Commonwealth Government requested that the Productivity Commission provide an independent assessment of GPs' compliance costs associated with Commonwealth programs that impact on General Practice in particular. The terms of reference stated that in undertaking the study, the Productivity Commission is to analyse the magnitude of the administrative and compliance costs, and to report on worthwhile avenues to ameliorate these costs.

The Productivity Commission decided to undertake a survey of GPs, as part of its research program, and commissioned Millward Brown to execute it. Following an initial set of focus group discussions and a pilot survey, the current study evolved.

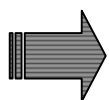
While the number of compliance tasks imposed on GPs is wide ranging, the specific terms of reference of the current study included a conglomerate of the higher volume Centrelink, Department of Veterans' Affairs (DVA) and Department of Health and Ageing (DHA) forms, predominantly including:

1. *Treating Doctor's Report (Centrelink jurisdiction)*
2. *Medical Review - Disability Support Pension (Centrelink jurisdiction)*
3. *Medical Certificate (Centrelink jurisdiction)*
4. *Claim For Disability Pension and/or Application For Increase In Disability Pension and Associated GARP Forms (DVA jurisdiction)*
5. *Pharmaceutical Benefits Scheme RPBS Authority Prescriptions (DHA jurisdiction)*
6. *Australian Childhood Immunisation Register - Encounter Form (DHA jurisdiction)*

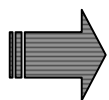
The current study comprised both qualitative and quantitative elements, administered via a Compliance Workshop environment. The information will complement information obtained directly from Commonwealth Government departments and agencies, GP organisations and other sources, including other research initiatives. This report represents the qualitative findings of the study. A separate data file has been provided to the Productivity Commission inclusive of the detailed quantitative findings.

2. RESEARCH OBJECTIVES

The key objectives of this research study were to:



Obtain indicative data on the costs imposed on GPs and general practices by requirements to comply with a specific group of government programs and policies. These included a select group of high volume Centrelink, Department of Veterans' Affairs and Department of Health & Ageing forms.



Gather qualitative information on complying with these specific Commonwealth Government requirements to complement and support the quantitative data attained.

Specifically, the research objectives were to:

- ⌘ Explore GP perceptions of Commonwealth compliance tasks overall, and to gain an understanding of the extent to which their burden has increased over recent years.
- ⌘ Understand the length of time taken to prepare for and complete the compliance tasks i.e. forms, highlighted within the study's specific terms of reference.
- ⌘ Understand the frequency with which these compliance tasks are completed.
- ⌘ Assess the level of difficulty and frustration associated with these tasks.
- ⌘ Understand specific areas of difficulty, frustration and the consequent sources of burden.
- ⌘ Assess GPs' level of understanding with the purpose and reasoning behind each form, along with GPs' perceptions of the appropriateness of them providing the information requested.
- ⌘ Investigate possible options for change to the requirements currently imposed.
- ⌘ Provide GPs with an opportunity to express any further concerns they may have in relation to the burden imposed on them by Government paperwork requirements.

Ultimately, the purpose of the Compliance Workshops was to provide input into the Productivity Commission's research study - *General Practice Compliance Costs*.



3. RESEARCH METHODOLOGY

To understand the burden associated with the nominated high volume Commonwealth compliance tasks, a series of workshops were administered. These Compliance Workshops comprised both qualitative and quantitative elements.

This methodology allowed for the detailed exploration of a range of issues of interest via a group discussion forum, while also enabling the administration of a series of self-completion questionnaires covering these same issues, allowing for the development of a quantitative database. The qualitative aspect enabled a range of opinions to be understood, along with a detailed understanding of perceptions and motivations. The administration of self-completion questionnaires alone would not have provided this same level of insight.

The research comprised a series of **10 Compliance Workshops** amongst vocationally registered GPs with at least 3 years experience in the medical profession. The workshops were conducted amongst those practising in Inner Capital City, Outer Capital City and Remote/ Rural Locations across Australia, as defined by the 'Post code to RRMA (DoHA) 230902' database provided by the Productivity Commission. Such a number and composition allowed for the representation of GPs in Australia, in line with the budget available.

The workshops were held in the following locations:

	<i>Inner Capital City</i>	<i>Outer Capital City</i>	<i>Remote/ Rural</i>
Victoria	St Kilda	Deer Park	Shepparton
New South Wales	Mosman	Liverpool	Tamworth Bathurst
Queensland	Kelvin Grove		Toowoomba
Tasmania	Hobart		

The workshops were held across the **6th to the 21st of November 2002**, and lasted for an approximate duration of 1½ hours. GPs were offered an incentive of \$150 for their participation.

For each of the Inner and Outer Capital City workshops, 8 GPs were recruited with the anticipation that 7 would attend. In the Remote/ Rural locations, there were alternatively 6 GPs recruited with the expectation that 5 would attend. **In total, 62 GPs participated in the study.**

Across Victoria, New South Wales and Queensland, the GPs were randomly recruited by Millward Brown based on the region in which they practiced. In Tasmania however, the Southern Division of Tasmania were responsible for the recruitment of the GPs.

The order on which the forms were presented within each group differed to avoid any biases occurring. This also ensured that there was as much feedback as possible on each of the priority forms.

It is important to note that the information and feedback reported herein represents the 'perceptions' of the GPs. It may not necessarily be a true reflection of actual processes and procedures involved in the completion of the forms included in the study. It must be understood however, that perceptions are a person's reality, and are important for the Commonwealth Government to understand.

It is important to note that whilst a cross section of GPs have been included in this study, the findings are not necessarily representative of the entire GP population. Moreover it should be noted that as this research is qualitative in nature, that the findings are indicative only and should not be viewed as conclusive.

This caution should also be applied to the quantitative data file, where small sample sizes of less than n=50 exist.

A copy of the moderator's guide is appended to this report.

The Productivity Commission have been provided with audio tapes of each of the 10 Compliance Workshops, with approval from respondents. The tapes have been de-identified to protect the confidentiality of the participants.

4. INSIGHTS INTO THE BURDEN ON GENERAL PRACTITIONERS

Across the total of 10 workshops, including across states and between inner and outer Capital City and Remote/Rural locations, the feedback and concerns of GPs in relation to the burden of Commonwealth forms was very consistent overall. Due to the limited numbers of GPs and thus increased patient numbers in rural areas, there were some unique and important differences in some areas of overall frustration with the processes involved in Commonwealth compliance tasks amongst these GPs. This will be discussed in detail throughout this document.

Amongst GPs there were mixed perceptions of the burden placed on their profession by Commonwealth forms. Certainly, there were individuals who felt the forms were an enormous frustration while for others they were inconsequential and simply part of their responsibility. However, there was consensus in the feeling that Commonwealth forms were just one area of the various range of compliance tasks enforced upon GPs. The greatest frustration was the sheer number of forms for every type of government program. The insight GPs most wanted to communicate was that this was just one small area and simply another addition to the various other types of programs, legal requirements and compliance matters the GP must undertake to meet regulations and ensure they are providing a valuable service to their patients.

There is seen to be a proliferation of forms of every type by all agencies that has led to an increasing frustration with forms in general. Additionally, there is seen to be inconsistencies between these various forms, how the forms are evaluated and remuneration for the forms. This also leads to comparison and devaluation of some forms.

Another insight provided through discussions with the GPs was their frustration with the changing scope and purpose of their job. GPs are mainly in the profession in order to help people and to practice medicine. More and more compliance tasks are taking their time away from seeing patients and prescribing treatments and more towards paperwork – to run their businesses, to meet legal requirements and to complete compliance tasks and forms. This

does lead to increasing frustration with their jobs and the things that are taking them away from what they got into medicine to do. This may increase tendencies for burn-out.

“I am overburdened with paperwork as well as patients to the point that I don’t enjoy my work half as much as I used to. I feel that some paperwork is necessary and I have to do that. We are taken for granted by a lot of people that our paperwork is just box ticking and signature and there is no responsibility associated to it so therefore just get the doctor to do it. That is wrong particularly in the days of medical litigation and personal responsibility. I find it very stressful.”

In addition to the changes in what they are doing many GPs indicated that time was an increasing issue. This either meant they saw less patients and were therefore forced to charge more for each consultation or meant that they were trying to balance a significantly increased workload against their personal lives.

The frequency and proportion of time spent on Commonwealth forms could also vary greatly based on the GP’s patients, practice and attitude towards filling these forms out. This is discussed in further detail below.

The GPs’ patients have an impact on how frequently they see Commonwealth forms. Practices that were made up substantially of elderly patients or younger patients were more likely to see a significant quantity of forms due to their patients’ needs. The elderly patients are more likely to be on some form of disability pension while the younger patients may require more immunisation forms or for the tertiary age medical certificates. Also, in some areas the demographics of the patient base affect the quantity of forms and the time spent on these forms. For example in low income areas there generally is a large quantity of forms for disability pension, carer pension and medical certificates. These areas may also inherently have literacy and language issues, which require further support and time from the doctor in filling out their portion, as well as the patient’s part of the applications.

Finally, the GP’s philosophy on the forms had a great impact on how many they saw in their practice. Some GPs indicated they would be unwilling to complete such forms and would often send the patients elsewhere to have them filled out.

“I don’t fill these in any more .. I send them to someone down the road.”

“I have said that no (my overall compliance burden from paper work associated with government policies and programs has not increased in the last 2 years). It has increased I have just chosen not to do it.”

Others felt that their involvement in these processes is part of ensuring the care and quality of living of their patients and considered this a part of their role as the patient’s treating doctor. Thus, depending on the acceptance of their role in this matter the quantity of forms they filled out varied greatly.

Another more attitudinal area that led to differences in the proportion of time GPs spent on such forms was the value they placed on the form. Some GPs took the responsibility very seriously of completing the forms fully and in detail and spent a great deal of time in ensuring they were accurate and complete representations of the client’s condition. However, many GPs discussed the idea that some forms held little value and thus were completed in as little time and with as little information as possible.

GPs also talked about the devaluation of their role and their professional opinion. They are not given the responsibility to consult on the matters involved, but are expected to fill in a form full of boxes for little, if any remuneration.

“Centrelink should be giving GPs money. The GP is the lowest rung of the ladder.”

A key insight from the research is that the time taken to complete the form is not the key frustration, though an important part of the overall burden of the forms as this affects other areas of their practice.

In particular more lengthy forms tended to include greater amounts of detail that were not necessarily perceived as relevant. Longer forms took up more consultation time and thus they could see fewer patients. The forms were often given to them at the end of a consultation and thus they did not have the full time needed to complete the form. GPs often had to ask the

patient to come back for a longer consultation next time, inefficiently taking up additional consultation time.

In addition to time and potentially more important was frustration related to:

- **Perceived value of the form** – understanding the process and purpose of the form and receiving feedback from the relevant department.
- **Inherent ethical dilemmas** – there is a clear conflict of interest and substantial pressure for the GP to determine whether or not the patient is eligible for the program.

“There is pressure put on us to fill it in the way the patient expects us to fill it out. It says you can post it yourself ... there would be some merit in getting the government to pay us for our time to do it outside our consultation.”

- **Privacy** – was a great concern amongst GPs who were unclear about the ethics and legal implications of providing the required information.

“When we release 2nd party reports I don’t know if they have enough knowledge to handle the information appropriately or knowledge to understand the medical reports.”

- **Subjectivity** – GPs considered the majority of these forms to be quite subjective in nature, as opposed to a more objective statement of the patient’s diagnosis and prognosis.
- **Role of GP** – The role of the GP is changing to encapsulate a range of tasks, this is taking the focus off the patient.

“Takes more focus off the patient.”

- **Displacement** – for GPs in rural areas, these forms were displacing consults with individuals who actually need medical attention.

“Time spent filling in these forms is sacrificed time spent with patients. We are here to help people.”

“In a GPs life – every minute is filled. ‘Can you do it in your spare time’. Pressures on time are enormous a request to spend an extra 5 minutes on a form just can’t happen.”

“My paperwork burden is enormous – I’m seeing far fewer patients. Most of my patients are over 65 so I see a lot of DVA and Centrelink forms.”

It is also clear that many GPs see compliance tasks in general as having a huge impact on not only themselves and their practices but also on the entire health care system of Australia.

“I don’t think that anything will change, for the simple reason that at the end of the day we’re cheap – we’re very cheap - we accept to be cheap. Nothing will ever change. If we’re too expensive then there will be some other second rate tier of general practitioners brought in to do it – we’ve got ourselves into a real hole here. And we give crap information often which we haven’t got resources to track down and get appropriate information –we’re doing the system a dis-service. It’s everybody.”

CENTRELINK COMPLIANCE TASKS



5. CENTRELINK

In general, Centrelink was a top of mind frustration amongst agencies that issued health-related forms. In particular, there was a sense of devaluation of the forms and a lack of communication between Centrelink and the GPs.

Centrelink forms were also a key driver of the overall issue of the doctor/patient conflict. Generally, GPs were open in admitting they had little understanding of the processes involved and in particular who was responsible for reviewing the forms they completed for their patients. However, there was a perceived burden on the GP to decide whether their patients should get 'the payment' or not. On the whole, they did not believe this was a decision that they should be responsible for making and added to the overall burden of completing such forms.

In particular, Centrelink was seen as 'bureaucratic' by the GPs and many were sceptical about the reasons and motivations behind the forms. In particular, across a range of groups GPs mentioned that when unemployment numbers were high in their area they received an influx of Disability Support Pension forms. The perception is that this is to shift the numbers from unemployment to disability for political motives.

Also, there was significant confusion and uncertainty amongst GPs about the new forms and whether Centrelink would still accept older versions. While some had received a letter, there were many who were not even aware the new forms existed. There seemed to be too many changes to the forms and the GPs felt they were never informed about why the changes were made or what was expected from the GP in the new version. GPs were also seeking clarity on whether they were expected to use the new version and if there is a cut-off time for accepting older versions of the forms.

"It changes monthly – the Treating Doctor's Report. There are obviously different drawers at Centrelink that have different piles of old versions because it is always a different version."

The specific Centrelink forms included in the terms of reference of this study were:

- Treating Doctor's Report (SA012.0209 AWT and SA012.0202) with a volume of approximately 130,000 completed per year.
- Medical Review – Disability Support Pension (SA012R.0209) with a volume of approximately 87,000 completed per year.
- Medical Certificate (SU415.0209 (AWT) and SU415.0003 SSAA) with a volume of approximately 685,000 completed per year.
- Carer Payment: Doctor's Medical Report for a Child – Under 16 Years (A333(r).0110).
- Carer Allowance: Treating Doctor's Report for a Child – Under 16 Years (SA333(tdr).0202).
- Carer Payment and/or Carer Allowance: Health Professional Assessment for a Person –16 years and over (SA332(a).0110).

Each of these will now be discussed in more detail.

Treating Doctor's Report

Patient's details


Name

Address

Postcode

Date of birth / / CRN

TDR



Centrelink
Linking Australian Government services

Treating doctor's report

Authority to release information

I authorise Centrelink to obtain any relevant medical information necessary to decide my qualification for pension, allowance, eligibility for employment assistance or access to the Supported Wage System from my doctor(s), or other registered medical practitioner(s) whom I have consulted, or to whom I may be referred by Centrelink upon the recommendation of a Centrelink psychologist, a work capacity assessor and/or a medical assessor; and

I give permission for any relevant medical details and clinical notes about me to be supplied to a work capacity assessor and/or a medical assessor; and

I give permission for my doctor(s) to exchange relevant information with Centrelink, and/or a work capacity assessor and/or a medical assessor about my medical conditions and any other relevant barriers impacting on my ability to participate in assistance programs in order for Centrelink to decide correct payments and suitable services and programs for myself and where relevant third parties; and

I consent to any decision of Centrelink to refer me for any further assessment necessary, upon the recommendation of a Centrelink psychologist, a work capacity assessor or a medical assessor.

Instructions for the patient

- 1 When you make your appointment, please let the receptionist know that you will need this form completed. The time taken to complete the medical report may be claimed by your doctor under a Medicare item when included as part of a consultation. If your doctor does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the form.
- 2 Before you give the doctor this form:
 - please see the back page for information about privacy
 - then read and sign the Authority to release information below.

Patient's signature →

Date

Instructions for the doctor

This report may be used to:

- decide which payment your patient may be medically eligible for
- decide if your patient could benefit from vocational rehabilitation or training
- decide if your patient is able to enter the Supported Wage System.

Payment for your report

We have asked your patient to let you know at the time of making their appointment that they require you to complete this form. This is to ensure you have sufficient time for the examination. The time taken to complete the medical report may be claimed under a Medicare item when included as part of a consultation.

Completing this report

In this report you will be asked to provide clinical details of the patient's medical conditions. Please complete all the required parts of the form.

Returning the report to us

Please return this report and any attachments as soon as possible directly to us, or if you prefer, you can give the report and any attachments to your patient to return to us.

For information about confidentiality and disclosure of information

Please see the back page.

SA012.0209 AWT

page 1

5.1 TREATING DOCTOR'S REPORT

The Treating Doctor's Report was reviewed in both the most recent version (SA012.0209 AWT) and the previous version (SA012.0202) in all 10 of the workshops.

The new and old versions of the form were included in the workshops in the anticipation that some GPs were still filling out the older versions of this form and thus would be unable to comment on their experience with the most recent version. In addition, this review of both versions provided feedback on what types of things were seen as improvements or deteriorations in the forms, thus providing practical feedback as to areas and issues to consider going forward.

There were mixed impressions about the new compared to the old version of this form. Generally, GPs felt that the forms changed frequently and each time this happened they required extra time to become familiar with the new form.

“When you get used to a form, it gets changed. They are professional form changers.”

Generally the new form was perceived to take longer to complete and required a substantial amount of detail. However, in relation to perceptions about the length of the forms overall, GPs ability within the workshop environment to accurately indicate the amount of time each form takes to complete on average is fairly erratic (potentially due to the value placed on the form) and should be considered cautiously in any predictions or assessment of the time spent by GPs on these forms.

How long does the form take to complete?

The Treating Doctor's Report was seen to be a lengthy form to complete (if it was completed correctly). The time reported by GPs to complete this form ranged from 5 minutes to 60 minutes. The majority of GPs reported times in the vicinity of 10 to 30 minutes.

The **time** it takes to complete this form varies greatly and is dependent on a range of things including:

- The number of conditions the patient has.
- The GP's familiarity with the patient and their medical history.

"20-30 minutes. Obviously if its your patient. If it's a new patient it takes longer."

"15 minutes unless you are filling out the form for the 2nd or 3rd time and you'd photocopied previous copies."

- The quality of the information provided.
- The value placed on the form.

What is the burden?

This was considered to be a very frustrating form and importantly was considered to have little value, thus increasing the frustration with having to fill it out. Key areas of frustration with the TDR for Disability Support Pension included:

- **Lack of understanding of the overall process and structure of the Centrelink program.** GPs felt that their lack of understanding of the processes related to these forms, how decisions were made about the patient's conditions and receipt of payment and who made these decisions were key areas of frustration and stress for the GP. GPs firstly did not believe they understood why and when the patient needed to have a TDR filled out, in particular they questioned the frequency of these forms. GPs spoke about their lack of knowledge in terms of what determined whether someone received a disability pension and thus their frustration and uncertainty about what information was important to include in the TDR. Finally, there was considerable stress and frustration about who was actually deciding whether the patient was to receive money; was it the GP, a medical officer at Centrelink or a clerk?

“Why do we have to complete both the Medical Certificate and TDR? The Medical Certificate has the same information as the TDR.”

“General information - understood. Very minute details such as symptoms and signs, precipitating factors etc. Why, what is it used for?”

“Bureaucratic nature, where does form go?”

- **Lack of feedback.** There is seen to be a distinct lack of feedback from Centrelink to the GP. This sense is driven by several key factors:

The GP does not find out about the outcome of the form (e.g. whether the patient gets a payment or not). They feel that if they are part of the process they should also have knowledge of the outcome.

“Does all this work make any difference? We never hear the outcome.”

“I find it very difficult if no one contacts me back. Seems like a lot of wasted time and effort and no feedback.”

There is not seen to be any feedback from Centrelink in terms of individual cases, for example confirming the doctor's opinion of whether the case is valid or conferring with the doctor about the best outcome for this patient. Even when the GPs indicated on the form they wished to be contacted in regard to the case, they never heard from Centrelink.

“It would take you 3 minutes over the phone to get to the core of the problem – this guy is working really hard but needs support – this guy isn't for real.”

Finally, GPs have received no feedback in terms of what Centrelink expects from them, nor whether they are filling in the forms correctly. Thus, for those GPs that took the risk of providing minimal information and received no feedback, they have continued to do this, as it seemed apparent that no further information is necessary. However, if this is the case then GPs question why the form requests so much detail.

This is frustrating in itself for GPs who generally take pride in the quality of the reports they provide to others. There is a sense that they are expected to do a half hearted job and they do not like being put under pressure to do so.

“The fact is that we do all this for \$10, \$20, whatever and when it comes to writing a report - proper unbiased medical documentation, it ain’t going to happen, because we’d have to charge \$100 to \$200 and yet we are talking about making decisions about people.”

“It is about time we thought outside the cottage industry and write proper reports for a proper descent amount of money and put ourselves back in a professional way we seem to have lost.”

- ✧ **The general lack of communication to the GPs from Centrelink about their processes, expectations and feedback in relation to patients has created a devaluation of the TDR. Thus, the key frustration has become having to fill the form in at all. This, in turn, has lead to a decreasing amount of information and quality of reporting through the form. Thus, in GPs eyes creating a useless and invalid process.**

“There is no value placed on this, often there’s not enough information. We don’t know what happens to these – are they approved – does a medical person see it.”

“Inaccurate answers.”

- **Patient pressure and conflict of interest.** The pressure felt by GPs from their patients to fill out the form so that they will get payment is significant and a key area of burden on the GP.

GPs feel they have been left in a position in which they are determining whether their patients get Disability Pensions or not, and this integrates obvious pressure and ethical dilemmas into the process of filling in the TDR. There were mixed opinions about ultimately how much say the GPs wanted in the process. Many felt that this conflict of interest and being put in a position to essentially be screeners for Centrelink was unacceptable.

While some GPs indicated they were happy to make the decision, but in respect for their professionalism, there was then no need to follow this with substantiating medical information and ongoing forms.

“I don’t want to be responsible for peoples incomes.”

“It gives us a role we shouldn’t have.”

“We’re happy to provide the information – just take the decision away from us.”

“It is not appropriate for us to do them.”

“Repetition. Having to be a gate keeper, instead of just providing medical information.”

GPs are also under significant pressure from their patients to complete the form in a specific way. Thus, it is difficult for the GP to provide an honest and accurate report.

“Patient expectations and pressure on doctor.”

Centrelink is also creating situations in which it is difficult for the GP to be honest and accurate in the information they provide.

“I’ve had people coming back where Centrelink have said ‘you shouldn’t have filled it in like this – have the GP check this box’. I just write what I see.”

GPs also saw a clear conflict of interest arising in filling out these forms. Essentially, this again is about the GP making the decision about whether the patient should be awarded a payment or not.

“To try to be ethical when making decisions.”

“Sometimes when you know a patient for a long time there might be a slight bias towards a patient. I wonder whether it’s a good idea for another doctor to do the form or assess the patient.”

- **Difficulty of completing the form in front of patient** (terminal in 3 months/ pressure to indicate unable to work). In some cases the GP might not want to disclose their full treatment regime or the prognosis to the patient. Generally, GPs were not aware of the ability to send the form directly to Centrelink, but there was distrust that this information would not be passed on to the patient anyway.

“Too much detail on treatment program. It might be overwhelming for patient to see all treatments, the contingency plans you might have.”

“No address to any Centrelink office - whoever issues. Pressure can't do it in confines of consultation therefore call up IPTA's later. Not beneficial to patients care, but we are here to facilitate change of money.”

- **Privacy.** GPs expressed concern about the issue of compliance with privacy laws in relation to Centrelink forms. In particular, GPs considered some of the information requested in the forms (e.g. specialist reports) to be outside their legal ability to provide.

“I think their questions should reflect the Privacy Act. Centrelink should have to go to specialists directly – I don't understand how we can release it.”

- **Subjectivity.** There was a consistent complaint from GPs about the subjective rather than objective nature of many of the questions in the TDR. Primarily this related to Part C – Work ability in the old version of the form.

“WorkCover forms – the question asks if the patient ‘states’ – whereas this is all about me saying these things.”

- **Time is a limited resource** for all GPs, but especially those in rural areas. Thus, having to extend consults, block out four consults and have patients come back for additional consults are key issues the TDR creates for GPs. This often occurs because the form is presented at the end of a consultation or is simply dropped by the office for the GP to fill out in their own time. It is believed that patients are not informed of the need to book a longer consult and are sometimes even misinformed about process, in particular that they will not be charged for having the form filled out.

“Patients don’t understand that you can’t bulk bill.”

“Patients are being told they won’t have to pay.”

- **Reimbursement for time.** GPs were greatly confused and frustrated about how they could handle billing for the form, if at all. Generally, there was frustration that there was inadequate remuneration and this was inconsistent with other government departments such as Department of Veterans’ Affairs.

Some GPs perceived the only means of being reimbursed for the time spent on the form was to bill the patient. This was seen as neither acceptable by law nor practicable given these patients situation.

“The patients who need these are always very poor. Can’t afford very much, so it’s hard to charge them for filling in the form.”

“In theory we are not allowed to charge and many patients are not in the position to pay.”

“People feel funny about charging these people since they’re disadvantaged already.”

However, some GPs were of the opinion that they should be charging their patients for the service.

“It takes a lot of time to do it properly – you need to charge your patient.”

“If we don’t fill out the form he can’t get paid, and then can’t afford medication so I charge a medical consultation.”

“The top of the form should say ‘patient is responsible for expenses’.”

Most, however, felt that the reimbursement should come from Centrelink directly or through a billable Medicare number. There was no clear understanding of what was allowable in terms of charging for the form. Most GPs were not aware that the form indicates it can be

charged as part of a consultation. Some GPs suggested that this was in conflict with Medicare rules and thus there is still debate about how GPs can seek reimbursement.

“They are really down on the socio-economic ladder and Centrelink should pay, therefore there should be an item number with it.”

“Time. Lack of financial reimbursement.”

“I am not happy with it because you can’t claim Medicare – have to make sure you check blood pressure, so that you can charge for the consultation.”

- **Repetition of completing the forms**, particularly for individuals with permanent disabilities. GPs felt there was undue repetition of completing these forms for their patients. This again is potentially related to a better understanding needed by GPs as to the processes involved in the Centrelink system. However, GPs felt there were inefficiencies in filling out a TDR every 6 months for someone who had a permanent disability such as down syndrome.

“I don’t understand why Centrelink can’t have that (history, symptoms, diagnosis, etc.) on file. It’s repetitive to fill it in every time. Just follow up for review – one question – has the condition improved, remained stable or deteriorated?”

“The frequency of needing to complete the form.”

“Confidentiality issues. Repetitive details. Questionable relevance to patients current problems or ability to work. Often about problem should already have known about (e.g. long standing health problem.”

- **New patients.** Filling out the TDR for new patients was particularly difficult and raised scepticism about the validity of the patient’s condition. Generally, filling out a TDR for a new patient took a substantial amount of time and involved chasing down medical records and waiting for feedback from the patient’s treating doctor. GPs also felt they needed to take the time to investigate whether the patient’s condition was valid, or whether they were going from doctor to doctor until they received the answer they wanted. This issue is primarily focused in inner and outer metropolitan practices.

"I hate it. It's confusing before you start. I have a lot of patients who come who I have never seen before."

"Many details asked are ridiculous, I may not know the consumer. I may not have the specialist's report. No hospital reports in file"

"Problem is new patients – cant' trust them – probably just came from another GP who knocked them back."

"They are consumers they will shop around until they get what they want."

What are the positive aspects of this form?

Some GPs provided positive feedback in relation to changes made in the new version of the TDR. Perceived improvements to the form related to two key aspects of the form's structure and content.

- Some GPs recognised the new TDR to be a better medical report and to provide them with the opportunity to provide their feedback, as opposed to just ticking boxes that may not accurately describe the patient's condition.

"This is probably better. It gives us more scope, as long as they believe us. You could spend half an hour to an hour – you could spend up to 1 and ½ hours. You can't get too medical, because it is going to a bureaucrat, therefore it all has to be re-phrased."

"Definitely an improvement on the old one."

"I think the new version is what VA should have, rather than ridiculous boxes. Here at least we have some input."

- The exclusion of Part C – Work ability in the new version was seen to be a significant improvement, as this section caused the most frustration. This section was seen to be very subjective and to be the role of someone who could work with the patient in their home/school/academic life. This was seen to be the role of a case manager and outside the GP's ability within the confines of a 12 minute consultation.

- One GP also commented that it appeared as though Part B had also been improved in terms of the type of feedback required.

“In depth information required. However – Part B on affect or functions is much improved on old form.”

What are the opportunities for improvement?

Given that the perceived issues with this form were two-fold, both relating to the overall process as well as the GP’s input itself, there are a variety of suggestions in terms of both improving the overall process as well as feedback in terms of improving the current reporting mechanism.

GPs felt they could improve the quality of the information provided to Centrelink by providing a medical report or a referral letter to be sent to the medical officer assessing the case (as discussed below). However, this could not be done without appropriate reimbursement. Generally, it was felt that Centrelink should reimburse the GP in the same way a GP would be paid for producing a medical report, thus up to an hour or more of the GPs time may need to be compensated.

“If we were allowed to give a report, the person at the other end would have something to work on. People check that the boxes are filled in, but in terms of management who knows.”

“I would prefer to write a report. You can get your point across ... look at person’s condition – the form doesn’t describe limitations and Centrelink are challenging it, which is crazy. It can be a very short letter.”

“You send a letter – you type it up – it’s more legible. The form ends up being useless – its all scribble except box J. You do that (type it up and ensure it is legible and comprehensible) when you are being paid.”

“A specific allocated payment for completion of forms; allowing adequate time to be allocated.”

“A fair payment for the time and effort put in to submit an accurate and comprehensive report.”

To limit the conflict of interest with the doctor and to take the ethical burden and decision of whether the patient should be receiving a pension away from the GP, it was suggested a system similar to WorkCover (and closer to the old system) would be a benefit. This would include the treating doctor providing the medical background to a case manager or Centrelink medical officer who would then assess the patient and determine their eligibility for a pension.

“We are the treating doctor so the medical summary is in our records, therefore we should provide the diagnosis and a statement of the prognosis/disability (level roughly) and then send up to a Centrelink doctor to make an assessment and determine what is appropriate in terms of study/work. Then the Centrelink doctor can contact us for any additional information. This may be a more objective way of looking at it.”

“They should have case managers like WorkCover to take on medical decisions.”

“Medical report as per WorkCover then case manager decides or board decides.”

“1. Letter writing templates, 2. Cutting out unnecessary information, 3. Employing government medical officers or Commonwealth medical officers and not playing the cost on the HIC.”

“ Doctor interview by appropriate, trained staff member in company of patient.”

GPs felt a **better communication** channel with Centrelink was needed. This communication related to managing the patient:

“We should have a secure communication with Centrelink to indicate whether the case is genuine or not.”

As well as Centrelink communicating their processes and expectations more clearly and more frequently to the GPs.

“We just need on sheet of paper telling us what the forms are about.”

GPs also suggested that Centrelink should further consult with them in determining the most appropriate way to meet both parties needs and limitations.

“Cooperate in a meaningful way with GP organisation to 1. determine what information is required and why. 2. then design a form in conjunction with GPs. 3. come to a fair agreement of remuneration.”

There were also many suggestions about ways to improve the system in its current state.

- Simply ensuring that the patient has been informed about the time it takes to complete the form will significantly reduce the GPs frustration and mediate the patients’ expectations. In particular, ensuring that the patient books a longer consultation and is aware that they have to have the form filled out during a consultation will lessen the conflict between doctor and patient. It is also important that the patient is made aware that they must present the form to the doctor at the beginning of the consultation and ensure that the patient is aware of any financial obligations they may have in relation to the consultation.

“Patients to be informed to advise doctor ahead of time if longer consultancy time required.”

- The provision or ability for the GP to retain copies of the TDRs to expedite reviews.

“They should make the form in carbon copy. I need to keep a copy for my records; it would make things a lot easier. There should be an item number for Medicare.”

- Generally, decreasing the frequency of the reports and the number of questions on the form was suggested as a means of decreasing the overall burden of these forms.

“Decrease the frequency of reports, decrease the number of questions.”

“No repetition. First time –fill out form in full. Second time-shouldn’t have to regurgitate the same information, should just have a simple form for thereafter as discussed.”

- There were a variety of suggestions about the types and qualities of the questions that should be included on this sort of form. Improvements were believed to relate to more objective questions, limiting questions to relevant areas and a means of streamlining the process by indicating that all diagnosis and prognosis are the same as at the last review.

“Making less subjective questions, asking for just the main health problem that keeps them off work. Not all patients need to get these forms so frequently, e.g. patients with chronic health problems should get these forms less frequently.”

“If the condition hasn’t changed then there should be a facility for stating that the patient is the same as the last form.”

“Simple targeted questions with specific answers required as to client’s ability to work.”

“Limit questions to relevant issues only”

- The government’s provision of a means of remuneration was also a common suggestion as a means of alleviating the current drain on their personal time. However, this would not alleviate the time and resource issues within rural areas.

“Government to pay GP for the form as VA does for same.”

“Better remuneration”

“Item number for completion of form i.e.; pay the doctor for doing this paperwork, no-one likes to work for free.”

“Fund this activity (filling in the TDR) appropriately, then I would be able to fill in the form adequately.”

- While, electronic versions of some Centrelink forms had been made available by one GP division most GPs were unaware that Centrelink would accept forms in this format. Some GPs felt that the process would be improved if they could fill the forms out electronically, this would solve issues of legibility and saving copies.

“Tick boxes on computer program (e.g. Medical Director).”

“Electronic template compatible with medical director – our practice does not use paper files. So Commonwealth paper is a pain – we have difficulty filing. Electronic forms would improve legibility.”


- Address the issue of new patients, potentially by sending patients to a government or special allocated doctor if they did not have a consistent family practitioner.

“Preferred to complete forms for patients well known to the practice rather than a ‘new’ patient requiring forms to be completed.”

- Some GPs even felt they could be taken out of the process all together because they did not feel the current process would be able to filter out cases of fraud.

“Listen to the clients and believe them. If they are so desperate not to work that they will lie and fill in forms they are obviously sick. If unemployment forms/ benefits were easier to get we wouldn’t have to fill in so many of these forms.”

Medical Review – Disability Support Pension



Date of issue

Date of birth

SA012R.02/09 (Page 1 of 16)

Centrelink office Telephone Number
13 27 17

Your Customer Reference Number

Return Address
Please use the envelope supplied.



Medical Review - Disability Support Pension

It is important that you take the time to read all of this letter.

Dear Sir/Madam

Payment of your Disability Support Pension is now due for a medical review. This letter asks you to provide details about yourself in Section A and to provide a report from your Doctor in Section B. Two reply paid envelopes are enclosed - one is for you to return Section A and the other is for the return of Section B. This notice is given under section 84 of the *Social Security (Administration) Act 1999*. Section A and Section B must be returned to Centrelink within the time specified at the top of this form. If both sections are not returned within this time your pension may be suspended or cancelled under section 80 of the *Social Security (Administration) Act 1999*.

Section A

Section A is for you to tell us about your disabilities, illnesses or injuries. Please fill in Section A and return it to Centrelink as soon as possible even if you cannot give Section B to your doctor straight away. If there is not enough space to answer the questions, please attach a separate note. If you have difficulty in filling in any part of this form, contact Centrelink on 13 2717. For people who are deaf or have a hearing or speech impairment with access to TTY, call our free TTY service on 1800 810 586. For access to the multilingual service, see languages listed on the second page.

If you have any other medical reports that are relevant to your disabilities, illnesses or injuries, please bring them in or post them to us with Section A.

Section B

Please give one of the return envelopes to your doctor for the return of this Section. This Section (Section B, the Treating Doctor's Report) must be filled in by your general practitioner or your specialist. Please sign the authority to release the report before giving it to your doctor. Your doctor will probably prefer to complete the form after examining you to make sure the information he or she provides is up-to-date. Please let the receptionist know that you need a form completed when you make your appointment. The time taken to complete the medical report may be claimed by your doctor under a Medicare item when included as part of a consultation. If your doctor does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the form.

It is important that the report is returned to us quickly. If your doctor gives the report back to you, please bring or post it to us straight away.

If you have an intellectual disability, you can give us details of this using a letter from any government agency that provides you with services such as accommodation support, community access, disability services, ATSS or post school options. The letter should confirm that you are using these services because of your disability, the level of service you receive and the service's eligibility criteria. If you have any reports that show your IQ level, these can be provided instead of, or as well as, Section B.

If you have any problems getting a report from your doctor, contact Centrelink on 13 2717.



Millward Brown

5.2 MEDICAL REVIEW - DISABILITY SUPPORT PENSION

Only the new version of the Medical Review for Disability Support Pension (SA012R.0209) was included for comment in the workshops, however the comments regarding this form were consistent with the new and previous versions of the initial Treating Doctor's Report. This form was discussed in all 10 groups.

It is apparent from the feedback and suggestions about the initial TDR, that most GPs do not differentiate between the two types of forms. Though we did seek additional feedback about the patient's portion of the Medical Review and more generally about this form.

Generally, the feedback in relation to the Medical Review reflected that of the initial TDR. However, where there were differences in the process or the burden overall this has been noted in this section.

How long does the form take to complete?

Similar to the initial TDR, the time to complete the Medical Review varied greatly. The Medical Review was reported to take between 7 and 60 minutes on average to complete. Most GPs reported times in the vicinity of 15 to 30 minutes.

The time it took to complete this form depended on similar issues to those raised for the TDR, with value again being a significant driver of the time spent on the form.

*"Time required with no recompense makes it difficult to fill out forms as requested
– I tend to spend minimal time on these forms."*

However, the amount of time spent on the Medical Review also varied depending on:

- If the GP has to assist the patient to fill in their portion, or feels they need to review the patients portion of the Medical Review, the time it takes to complete the form is significantly lengthened.

“When I have to fill in Part A, it doubles the time.”

- If the GP has a copy of a previous review form in the patients file, the time is significantly lessened as they do not have to search through medical records again, but rather can copy across the detail written previously.

What is the burden of this form?

Frustration and feedback surrounding the Medical Review reflected the feedback for the initial TDR. However, the patient’s section adds an additional frustration (as well as the time mentioned above):

GPs found that in some cases the patients’ section is too difficult for many patients to fill out on their own. It is felt to be too difficult because the patient either does not understand what is needed or more often feels they need to consult their GP about their abilities and medical details (for example: hospital visits). Also, GPs in some areas discussed that the area in which they practice has a diverse multi-cultural demographic and often language or in some cases literacy is a barrier to the patient filling out the form on their own. Those GPs who saw this section more regularly were very frustrated that Centrelink did not assist the patient with the information, but felt that instead it was pushed onto them.

“I’m not being paid to check Part A – so I don’t look at it.”

“It should be emphasised that the patient should have the front section filled in before you go to the doctor.”

“The state should be responsible – don’t push it on me.”

Similar to the TDR, GPs did not understand the processes involved with the Medical Review.

“I don’t understand the process of what we are doing – people just come in with them.”

“What is the bottom-line of the process? No one has explained to me what it is all about. There is a sense that if I don’t fill the form in properly – the patient wont get rewarded.”

However, one GP also mentioned that their patients don't understand the process and that this caused undue stress on the patient and created a burden on the GP to schedule in an urgent consultation and explain that Centrelink has review processes periodically.

"This usually follows a letter sent to the patient to say they are coming up for review – it instils fear and terror and they ring us up for an urgent appointment."

The Medical Review was also seen to be particularly frustrating and unnecessary for individuals who have a permanent disability. The logic as to why they needed a full medical review was lost on many GPs.

"Waste of time for people with permanent and irreversible conditions. I object to the time required to fill out different varieties of treatment plans."

What are the opportunities for improvement?

The suggestions for means of improving the Medical Review may also be applied to the TDR.

Generally, it was felt the form, or the means of providing information to Centrelink, could be more flexible in its structure and depending on the type of condition the patient has. Thus, the form should be more flexible or the GP should be allowed to provide a brief summary and opinion of the patient's condition and abilities.

"Require less detail, pay for the report, the detail required should vary according to the medical condition(s) of the patient – thus there should be more flexibility in the questionnaire."

GPs also believed it would be simple enough to review the process to ensure unnecessary forms were not being filled in repetitively for individuals whose condition was not expected to change. GPs also made a similar suggestion for the TDR, however this was potentially related to the Medical Review, and is an example that the GPs did not necessarily distinguish the TDR and Medical Review as separate forms, or as separate processes.

“Asking the doctor for a broad opinion on whether the patient is permanently and irreversibly injured or has temporary/irreversible status at the outset could help in streaming applicants more efficiently and avoiding some unnecessary recalls.”


“Why can’t we give them a little letter and send it to a government doctor. Include a brief summary of the patients notes and a diagnosis.”

“Why not just give us space to indicate what our professional opinion is.”

One option presented for lessening the quantity of these types of forms seen by GPs is to require the patient to pay for the form. Alternatively, a similar suggestion was made for requiring Centrelink to pay for every form they have filled out.

“The reason for having adequate financial payment is not because it makes us happier, but they won’t ask unnecessarily for the forms if it is coming out of their pocket.”

Medical Certificate


Medical Certificate

Office use only
Customer CRN

Patient's details

Surname _____

Given names _____

Date of birth _____

Home address _____

Postcode _____

Signature and date _____

Your personal information is protected by law. The authority to collect this information is contained in the Social Security (Administration) Act 1999. The information provided on this form will be used to decide correct payments and services for you and where relevant, third parties. For the purposes of referral for appropriate assistance, Centrelink may give your information to: Centrelink contracted assessors; the Department of Employment and Workplace Relations (DEWR) and Job Network members or service providers working on their behalf; to the Department of Family and Community Services (FACS) and their funded services; to the Department of Health and Ageing (DoHA) and their funded services; and to the Department of Education, Science and Training (DEST) and their funded services.

Authority to release medical information

- I authorise Centrelink to release any relevant medical information necessary to decide my qualification for allowance, pension and eligibility for assistance from my doctor(s), or other registered medical practitioners and/or health professionals whom I have consulted, or to whom I may be referred by Centrelink.
- I consent to Centrelink exchanging relevant information about my medical conditions and any other relevant barriers impacting on my ability to participate in assistance programs with my treating doctor(s) and any other health professionals I may have consulted, or to whom I may be referred by Centrelink in order for Centrelink to decide correct payments and suitable services and programs for myself and where relevant, third parties.

Diagnosis - Please list all medical conditions (illness, injury or disability) which impact on your patient's capacity for work or study.

1 _____ **2** _____ **3** _____

Is this condition (Tick one for each condition)

Temporary	Permanent	Exacerbation of existing condition	Temporary	Permanent	Exacerbation of existing condition	Temporary	Permanent	Exacerbation of existing condition
-----------	-----------	------------------------------------	-----------	-----------	------------------------------------	-----------	-----------	------------------------------------

Date of onset (if known) _____

Symptoms (Please list all functional symptoms of the condition)

Prognosis - Symptoms are:

Likely to persist	Likely to show considerable improvement within 2 years	Likely to persist	Likely to show considerable improvement within 2 years	Likely to persist	Likely to show considerable improvement within 2 years
Stabilised	Likely to deteriorate within the next 2 years	Stabilised	Likely to deteriorate within the next 2 years	Stabilised	Likely to deteriorate within the next 2 years
Uncertain		Uncertain		Uncertain	

Fitness for work/study

In my opinion this person is/has been unfit for work/study from _____ to _____ inclusive.

Can the patient currently do their usual work/study, or any other work for 8 hours or more per week? Yes ☐ No ☐

In order to prepare your patient for return to work/study, certain assistance may be offered. Please identify any factors which may impact on participation.

Treatment - Please describe the patient's treatment regime. Include past, current and planned treatment.

Certification by Medical Practitioner

This person has been: My patient since _____

A patient of this practice since _____

Doctor's printed name _____

Qualifications _____

Surgery/Medical Centre/Hospital name _____

Street address _____

Postcode _____

Telephone (Area code _____) _____

Doctor's signature _____

If this form was completed by a business with fewer than 20 employees, please provide an estimate of the time taken to complete this form.

Hours _____ Minutes _____

SU-415.0209(AWT)

5.3 MEDICAL CERTIFICATE

The new (SU415.0209 (AWT)) and previous (SU415.0003 SSAA) versions of the Medical Certificate were included in all of the 10 workshops. Not all GPs had seen the new forms and there was a large amount of confusion about why they hadn't seen them and whether or not Centrelink would still accept the old version.

The Medical Certificate was seen to be much less of a burden than other Centrelink forms and on the whole was not a substantial burden on the GP. However, due to particular questions the form was sometimes difficult to fill out and GPs had other areas of frustration with this form.

Again, there were mixed opinions about whether the new form was an improvement on the previous version.

"I think the new form will be better. It asks you to list functional symptoms. I think I read that the new form has been brought out to reduce the bigger forms (like TDR)."

How long does the form take to complete?

Generally, this form was not considered a significant frustration and took a reasonable amount of time to fill out. However, the new version of the form did take significantly longer and required much more detail.

The time reported to complete a Medical Certificate on average ranged from .5 of a minute to 15 minutes. With the majority of GPs reporting a time of around 3 to 10 minutes. While not a significant amount of time, one GP did point out that this was a significant portion of their 12-minute consultation time, particularly as the patient will have come in as a result of their condition.

“Two to three minutes for the old version – five minutes for the new. It means less time for the consultation. They want to tell you all these other things. Depending on how many conditions they have it can take a long time.”

The perceived value of the form, similar to the TDR and MR, is a significant driver of the time it takes to fill in the form.

“There are two ways to fill out this form. There’s the five-minute way – which is tick, tick, tick, scratch, scratch. Then there is looking up records, ensuring the information is legible and considering the privacy regulations – do we have the authority to release.”

“If you don’t care you can fill it in BOOM, BOOM, BOOM but if you do care ... you just don’t know. Sometimes it is simple and so sensible – if it’s an injury and they don’t have insurance. But not for chronic conditions.”

“I believe Centrelink should get value for money – they pay nothing, they get nothing.”

What are the areas of frustration with this form?

GPs feedback on their frustration with the Medical Certificate generally reflected some of the key issues in general with Centrelink forms, specifically major areas of frustration included:

- **Pressure from the patient to indicate unable to work.** In some cases, GPs experienced extreme pressure from their patients (and to some extent Centrelink) to indicate that they were unable to do work. GPs also felt the pressure to determine whether or not their patient was able to do work (8 hours per week). This was not always seen to be a clear-cut answer and something that a case manager may be more equipped to answer.

“You worry that if you put down the wrong thing you may get them into trouble.”

“It’s the fact that we are left with the stress of making the bureaucratic decision that really frustrates me.”

“Guilt - if tick the box that patient is unable to work for 8 hours, when the patient may be able to work >8hours, but I feel pressured to give them what they want.”

“I constantly hear from patients that they are directed by Centrelink officers to pursue further sickness benefit ‘just get another medical certificate’ when this is often not medically justified”

Some GPs even discussed situations in which they had been physically threatened because they did not fill out the form the way the patient wanted.

“Last time it took me 30 minutes because I questioned the validity – it involved physical threats of violence. You can send the TDR to Centrelink, but not the Medical Certificate. The ability to send the form in is a good thing, otherwise they can go somewhere else if they don’t like your answer.”

- It was also felt that Centrelink was often sending people to the GP without first assessing their eligibility for different types of financial aid.

“The Centrelink officer should not be pushing people to pursue Medical Certificate/TDR for sickness pensions. They are pushing the problem directly onto doctors rather than addressing the issue and educating individuals regarding valid entitlements at the Centrelink office.”

“Sending forms back directly. Retraining staff or Centrelink –that it’s not that easy to get payments just from getting doctor to fill it in”

- **Privacy is considered a significant issue with this form.** Whereas, with the TDR, privacy was not an issue in terms of the patient’s medical condition, for this form this was the primary concern. As the form is only meant for temporary conditions, GPs questioned whether it was appropriate to share the patient’s conditions with anyone, including Centrelink. The parallel was draw with whether you would need to tell your workplace why you needed time off.

“I find it is not necessary to include the patients diagnoses on the form. This is a violation of his/her privacy.”

“This is a temporary medical certificate – certifying short term illness – this new form requires personal information that would not normally be divulged on a temporary work certificate.”

- **Lack of understanding** of this form’s relationship to the TDR and the processes involved. Following on from the feedback received on other Centrelink forms, there is a sense of confusion and frustration about the processes and people involved. Specifically, GPs were confused about why the Medical Certificate often prompted the need to fill out a TDR.

“Even if it is for a small two week thing, they then send you a Treating Doctor’s Report.”

“I still object to filling in the diagnosis. I think if we say they are not fit to work, then it means they are not fit to work.”

There was also confusion about the frequency of the patient needing a Medical Certificate filled out.

“If we circle 6-12 months – we shouldn’t get people coming in again in that period.”

“However, sometimes if we put that long, it doesn’t help their rehabilitation – so you put down three months.”

- The **level of detail required** in the new version of the form was seen to be unnecessary for their understanding of the purpose of the form. They felt that this could be used instead of the TDR and in fact one GP believed that this was in fact the purpose of the new version.

“The request is more akin to that of a report rather than a certificate.”

- Again, there seemed to be a **lack of feedback** and thus disinterest from Centrelink that was consistent across the different types of forms.

“Do they really care what you write – no one has ever rung me and said...”

“The people behind the Centrelink forms don’t really care ... as long as you tick every box it doesn’t really matter. It just gets filed away.”

“No remuneration. Contempt shown by Centrelink staff for the medical input.”

- GPs also found it frustrating both ethically and in relation to their patient’s treatment progression that the system offers **no intermediate option for the patient’s ability to work**. Quite often the GP felt that the patient would be able to do something part time, this may even help them improve faster, but forcing them to go back to work full time may over-stress them and the patient will be back needing another form which says they cannot work at all.

“If you tick yes they can work 8 hours per week, Centrelink say they are back to work full time.”

“I seem to get the feedback – that you do nothing or you go full-time because Centrelink can’t administer 12 hours, 20 hours or whatever they are able to work.”

“The biggest frustration is that they don’t allow for the patient to return at a diminished capacity, less hours and return to work gradually.”

“Doesn’t indicate type of work (patient is able to do). The hours per week question.”

“Not sufficient options to explain capacity of individual to work-ie number of hours or type of work (such as on WorkCover forms) and insufficient options regarding prognosis time period.”

- Case managers were also mentioned as a means of lessening the burden on GPs and providing a system for assessing intermediary ability to work.

“GP to provide basic list of health problems then get occupational therapist to assess each handicap and then apply to job options.”

- Patients also **did not necessarily fit into the prognosis boxes given**, thus GPs thought a simple paragraph in relation to the patient’s abilities and prognosis would be more reflective of the patient’s situation.

“There is no box ‘show considerable improvement in less than 3 months’. The patient may be able to go back to work in 6 weeks.”

- Some GPs also discussed the issue of **uncertainty of their patient’s prognosis**. The new form does allow for this. This was seen to be particularly difficult for the GP to predict, particularly because it is highly dependent on the patient’s attitude and motivation to get back to work.

“They always ask us to make a prognosis – sometimes you are uncertain.”

What are the opportunities for improvement?

Generally, it was felt that given the understood purpose of this form (for temporary illnesses), it could be significantly shortened to simply ask 'are they fit for work'.

"A simple medical certificate stating fitness for work and time off work needed would be more acceptable."

"List diagnosis and indicated whether they are unfit or fit for work. Then ask for more information if they need it."

"Reduced the information requested."

It was also suggested that providing the ability to complete the form electronically could shorten the time taken to complete the form.

"The way you can speed these up is with a template on the computer."

"Make the form up in a letter template – suitable for insertion into medical letter written word processor so not one that is not integrated into a prescribing program as this requires double entry of patient data."

GPs also felt they could give a more accurate explanation if they were provided flexibility, without having to put the patient into a box.

"Not making the answers so rigid that they have to be put into boxes, e.g. 8 hours per week or 3-6 months. Allow greater flexibility in answering these questions."

GPs also suggested further feedback between Centrelink and themselves.

"Feedback from Centrelink on patient outcome."

Remuneration for completing the form was also a suggestion for lessening the GPs burden.

"Pay us for completing form viz AMA rate. I'm sure most GP's Australia wide would agree AMA is a reputable body to provide such rates."

Carer Payment: Doctor's Medical Report for a Child – Under 16 years

If you are claiming Carer Payment, fill in the steps below, then give this report to your child's treating doctor to complete.

MR

Centrelink <small>Helping Australia's people and communities</small>		Carer Payment Doctor's Medical Report for a child—under 16 years	
<small>Please use blue or black pen only.</small>			
STEP 1 Child's details	Child's full name	<input type="text"/>	
	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Customer Reference Number (if known) <input type="text"/>
STEP 2 Carer's details—person providing care	Carer's full name	<input type="text"/>	
	Address	<input type="text"/>	
		Postcode <input type="text"/>	
		Customer Reference Number (if known) <input type="text"/>	
STEP 3 Is this child in your care?	Yes <input type="checkbox"/>	No <input type="checkbox"/> Who has the care of the child?	
		Name <input type="text"/>	
		Address <input type="text"/>	
		Postcode <input type="text"/>	
		Customer Reference Number (if known) <input type="text"/>	
STEP 4 Authorisation for release of medical details by the person having care of the child.	<ul style="list-style-type: none"> I give permission for medical details and clinical notes about the child to be supplied to Centrelink. I understand that the reports will be used to assist in assessing a claim for Carer Payment for current and future carer(s) and may need to be released to that person(s) by Centrelink. 		
Parent/guardian's signature	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
STEP 5 Report completion	Answer no more questions. Give this report to your child's treating doctor to complete. When you make your appointment please let your doctor know that you require him/her to complete this Medical Report.		
PART A		Treating doctor's diagnosis	
Information for the child's treating doctor		Please complete this medical report and give it to the parent or carer to return to Centrelink.	
1. What is your diagnosis of this child's condition?	Primary condition	<input type="text"/>	
	Other conditions	<input type="text"/>	
2. Which of the following best describes this child's condition?	permanent <input type="checkbox"/> terminal <input type="checkbox"/> temporary <input type="checkbox"/>	For how long do you expect this child's condition to continue? <input type="checkbox"/> less than 3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 12 months	
A333(9/01)10		Questions for treating doctor continue ➡	



5.4 CARER PAYMENT: DOCTOR'S MEDICAL REPORT FOR A CHILD – UNDER 16 YEARS

The Medical Report for Carer Payment (where person being cared for is under 16 years) for a child under 16 years was only included in one workshop. The GPs in this workshop were not familiar with this form, therefore there is no feedback to report on this Centrelink form.

Carer Allowance: Treating Doctor's Report for a Child – Under 16 years

If you are claiming Carer Allowance, fill in this page only, then give this report to your child's treating doctor to complete.

TDR

Centrelink **Carer Allowance** Treating Doctor's Report for a child—under 16 years

STEP 1 Child's details

You will need a separate report for each child—contact Centrelink if you require additional reports.

Child's family name

Child's given name(s)

Child's date of birth

Child's Customer Reference Number (if known)

STEP 2 Parent/guardian's details

Parent/guardian's family name

Given name(s)

Address

Postcode

Daytime telephone number we can contact you on

Customer Reference Number (if known)

STEP 3 I would like to be assessed for:

Refer to **page 4–5** of the notes booklet for information.
If you are undecided, you should tick the box for claiming Health Care Card and fortnightly payment.

Health Care Card only

Health Care Card and fortnightly payment

STEP 4 Authorisation for release of medical details by the child's legal guardian

- I give permission for medical details and clinical notes about the child to be supplied to Centrelink.
- I understand that the assessment will be used to assist in assessing a claim for Carer Allowance for current and future carer(s) and may need to be released to that person(s) by Centrelink.

Parent/guardian's signature



Date

STEP 5 Report completion

Answer no more questions.

Give this report to your child's treating doctor to complete.

Your child's doctor will probably prefer to complete this Treating Doctor's Report after examining your child to make sure the information he/she provides is up-to-date. It is best if you let the doctor or receptionist know that you need a form completed when you make the appointment.

If you need an interpreter, please phone **13 1202** before you make your appointment with the health professional. Centrelink will arrange for an interpreter. You will not be charged for this service.

SA333(tdr).0202



5.5 CARER ALLOWANCE: TREATING DOCTOR'S REPORT FOR A CHILD – UNDER 16 YEARS

The Treating Doctor's Report for Carer Allowance (where person being cared for is under 16 years) was assessed in two groups, however the form was not familiar to everyone in these groups, therefore the feedback reported here is somewhat limited. Importantly, however this form was highlighted as a top of mind frustration by at least three other GPs from other workshops.

The Treating Doctor's Report for Carer Allowance took on average between 10 and 30 minutes to complete.

There were three major areas of frustration related to this specific form. These were the validity of the claim, reimbursement for their time and the types of questions asked. These are described in more detail below.

One GP pointed out that the validity of the claims were often questionable. He also expressed frustration at having to fill out a lengthy form, for what seemed like an inconsequential and invalid allowance. This also relates to a lack of understanding about the processes involved and how the various payments are structured.

"This is where we get lots of requests. Sometimes it's inappropriate. The child has mild episodic asthma and the mother knows if she gets this filled in she'll get an extra I don't know, \$12 a week or something. But they come in for what seems like a trivial amount of money and get us to fill this in and they don't really qualify."

"I suppose that's what makes it difficult – we don't know what we are doing it for."

It was felt that the form was quite subjective in the type of questions it asked of the GP. These questions were difficult to fill out and where more relevant to be asked of the carer. For example questions about the child's ability to do various activities and their care were outside of

the GPs knowledge and ability to answer. They must simply go through the form, asking the carer what their answers are.

“It’s difficult, you are relying on the mum – you are not there at bath time.”

“Some of these questions here – it is very hard to assess them. Gross motor skills – can the child hit a ball with a bat – I mean I’ve never observed that – how would I know – the parents would know. I’m not there to assess.”

“Question 5 I find very difficult – ‘does the child have a condition that requires extra care and attention for 14 hours or more per week’ – now how long does it take someone to bath them over and above a normal child.”

It was generally felt if they were being used as a gatekeeper to assess the validity of the claim, this was outside of the burden they felt was reasonable and believed the carer would be just as likely to be dishonest with them as they would if they filled in the form themselves.

“Parent should fill in the form and not have to bother the doctor, but the doctor needs to fill in the diagnosis.”

“If they are going to lie on the form, they are going to lie to you anyway.”

Finally, this form held particular issues in terms of remuneration. The GP could not charge for a consultation if the child was not present, however frequently the mother came in on her own while the child (or children) was at school. Thus, this time was essentially ‘volunteer’ time as there was no ability for any sort of reimbursement for their time and it displaced other patient consults for which they would be paid.

“Can’t charge for it (if child is not brought in).”

GPs felt that this form could be filled in by the carer themselves and thus remove this burden from the many things the GP is responsible for.

Carer Payment and/or Carer Allowance: Health Professional Assessment for a Person – 16 Years or over

Patient's details


Name

Address

Postcode

Date of birth / / CRN

TDR



Centrelink
Linking Australian Government services

Treating doctor's report

Authority to release information

I authorise Centrelink to obtain any relevant medical information necessary to decide my qualification for pension, allowance, eligibility for employment assistance or access to the Supported Wage System from my doctor(s), or other registered medical practitioner(s) whom I have consulted, or to whom I may be referred by Centrelink upon the recommendation of a Centrelink psychologist, a work capacity assessor and/or a medical assessor; and

I give permission for any relevant medical details and clinical notes about me to be supplied to a work capacity assessor and/or a medical assessor; and

I give permission for my doctor(s) to exchange relevant information with Centrelink, and/or a work capacity assessor and/or a medical assessor about my medical conditions and any other relevant barriers impacting on my ability to participate in assistance programs in order for Centrelink to decide correct payments and suitable services and programs for myself and where relevant third parties; and

I consent to any decision of Centrelink to refer me for any further assessment necessary, upon the recommendation of a Centrelink psychologist, a work capacity assessor or a medical assessor.

Instructions for the patient

- When you make your appointment, please let the receptionist know that you will need this form completed. The time taken to complete the medical report may be claimed by your doctor under a Medicare item when included as part of a consultation. If your doctor does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the form.
- Before you give the doctor this form:
 - please see the back page for information about privacy
 - then read and sign the Authority to release information below.

Patient's signature

Date

Instructions for the doctor

This report may be used to:

- decide which payment your patient may be medically eligible for
- decide if your patient could benefit from vocational rehabilitation or training
- decide if your patient is able to enter the Supported Wage System.

Payment for your report

We have asked your patient to let you know at the time of making their appointment that they require you to complete this form. This is to ensure you have sufficient time for the examination. The time taken to complete the medical report may be claimed under a Medicare item when included as part of a consultation.

Completing this report

In this report you will be asked to provide clinical details of the patient's medical conditions. Please complete all the required parts of the form.

Returning the report to us

Please return this report and any attachments as soon as possible directly to us, or if you prefer, you can give the report and any attachments to your patient to return to us.

For information about confidentiality and disclosure of information

Please see the back page.

SA012.0209 AWT

page 1

5.6 CARER PAYMENT AND/OR CARER ALLOWANCE: HEALTH PROFESSIONAL ASSESSMENT FOR A PERSON – 16 YEARS OR OVER

The Health Professional Assessment for Carer Payment and/or Carer Allowance (where person being cared for is 16 years and over) form was only evaluated in two workshops and not everyone within these workshops had experience with this form. Therefore, the feedback presented here is very limited.

The reported time to complete the form on average ranged between 5 and 14 minutes.

However, on the whole this form was considered to be quite a good form by those who did provide feedback. There were some issues about whether those applying should actually receive a carer payment or allowance and there were particular areas of frustration with some of the questions, however it was by far the least burdensome Centrelink form evaluated in the workshops.

“I don’t find this one too bad.”

“It’s a pretty good form – you just have to put in diagnosis basically.”

“I find it a reasonable form.”

“This one of all the forms is one of the better ones – you just tick all the conditions.”

“It’s a good form.”

It was even suggested by one GP that the form allowed him to get to know his patient better. He often found out things about his patient and their abilities and activities that he might not have otherwise known or felt he could ask.

“I find things out about a patient, I wouldn’t know.”



The areas of frustration that existed in relation to this form were related to specific questions and the opportunity for fraud.

Some GPs pointed out that Section A was subjective and limited the GP in their feedback. One GP felt that this section would be more appropriately completed by the carer. Another GP felt that quite often the patient's condition was not accurately reflected by answering these questions.

"A lot of Section A could be done by the carer."

"I have found Part A insufficient. Need a little section – if you feel Part A doesn't accurately depict the case, a space to add in your additional opinion/information."

GPs also felt greater frustration with this form when they felt they were being used as a gatekeeper or when they felt that their time was wasted because the case was not appropriate for this type of financial support.

"Sometimes we get asked to fill these out when we think it is inappropriate – the person is not sick enough to have a carer, but I guess that's for Centrelink to work out."

"I feel frustrated that I'm filling in a form and they are not going to get the money."

"This form is wide open for fraud – you can make more on pension with two carers than in a job."

GPs did not offer any specific suggestions about ways to improve this form.

DEPARTMENT OF VETERANS' AFFAIRS (DVA) COMPLIANCE TASKS



6. DEPARTMENT OF VETERANS' AFFAIRS

The Department of Veterans' Affairs govern a small proportion of GPs total time spent undertaking Commonwealth compliance tasks. These tasks involve paperwork associated with health programs, disability compensation and income support. The specific forms included in this study's terms of reference were:

- The Claim for Disability Pension and/or Application for Increase in Disability Pension.
- Associated GARP Forms including 'typical' examples of a Diagnostic Report (*Primary Localised Osteoarthritis of the Left Knee*), Medical Report (*Trauma to a Joint Osteoarthritis*) and a Medical Impairment Assessment (*Lower Limb Condition*).

The burden associated with these forms was discussed in five workshops.


Familiarity with the Department of Veterans' Affairs forms varied considerably across GPs, clearly dependent on patient demographics. While some GP's treated an older patient base, including war veterans, a large number of participating GPs had not tended to the DVA needs of a patient in at least the last 3-6 months. Some had never seen the DVA forms.

The Department of Veterans' Affairs was generally viewed favourably in the eyes of GPs, largely attributed to their remuneration policy. In comparison to other departments the Department of Veterans' Affairs was considered to be more 'generous' and in-line with current rates in terms of remuneration.

"Repat are far more generous than Centrelink. Also with cooperation of authorities (authority scripts) there are less major cross examinations."

There was a question raised by some GPs as to whether others are encouraging war veteran's to make pension claims. There is a perception that some patients are asking GPs to sign illegitimate medical claims for conditions which are either unrelated to their war service or not present at all. This can place the GPs in a very uncomfortable position.

Claim for Disability Pension and/or Application for Increase in Disability Pension


COMMONWEALTH DEPARTMENT OF
VETERANS' AFFAIRS

Claim for Disability Pension and/or Application for Increase in Disability Pension

A claim and/or an application may be made by:

- a veteran (including a merchant mariner); or
- another person on behalf of a veteran (including a mariner).

Important Information

Assistance from Ex-Service Organisations
You are strongly encouraged to seek the assistance of an ex-service organisation of your choice in lodging this claim. An ex-service organisation should be able to provide you with advice on how the factors identified in the Statements of Principles may apply in your case.
Contact telephone numbers for these organisations can be found in local telephone directories or by contacting the Department of Veterans' Affairs (DVA) office in your State.

Assistance from Veterans' Affairs
Veterans' Affairs staff can also help you to complete this form.

Note: It would be to your advantage to have each condition you are claiming properly diagnosed prior to completing this form. This will help to prevent delays in the time taken to process your claim.

The Basis for Decisions
The decision on whether your disabilities are service-related is based on up-to-date medical and scientific evidence. This information is detailed in the Repatriation Medical Authority's Statements of Principles.
If your claim is for a condition not included in the Statements of Principles, it will be determined based on the best scientific and medical evidence available.

MCRS
The administration of the Military Compensation and Rehabilitation Service (MCRS) was transferred from the Department of Defence to the Department of Veterans' Affairs from 3 December 1999.
This means that MCRS staff might use information that you provide in relation to a claim under the *Veterans' Entitlements Act 1986* (VEA) if the information is relevant to a MCRS claim. All access to the DVA files will be strictly controlled on a "need to know" basis.
It is possible that your MCRS records may be accessed by DVA staff who "need to know" information in order to decide a claim under the VEA. This will only occur if the MCRS records contain information that is relevant to your claim.
There has always been an exchange of information between the Department of Defence and DVA for the purposes of offsetting benefits in dual entitlement cases. DVA has also been able to obtain access to information on the MCRS files required to determine a claim under the VEA. Such disclosures of personal information were permitted by the Privacy Act as they were authorised by law.

D3582 - 08/01 - P1 of 11

6.1 CLAIM FOR DISABILITY PENSION AND/OR APPLICATION FOR INCREASE IN DISABILITY PENSION

Overall, there was little awareness of this form, suggesting it is potentially being filled out elsewhere, especially where the GPs were however aware of the associated GARP forms, but not the initial claim form.

Those familiar with the form feel that it is generally not a difficult form to fill in. In ideal terms, the majority of the form is filled out by the patient, that is the veteran, leaving the GP's requirements minimal.

"The veteran usually fills it in very well. I just have to fill in the medical diagnosis."

[GP who completes this form on average once a week, Deer Park Workshop]

This was not however understood by some GPs in the workshops who were unfamiliar with the form and whose initial reactions were associated with it being a difficult form to fill in. They did not understand that the patient had an initial responsibility.

While the form itself does not pose any specific difficulties or frustrations for GPs familiar with the form – *"I don't have any problems filling in this form...it might take a while, but it won't be a hassle. They make an appointment for a longer consultation"*, some of its associated processes do, as follows:

- **Pressure Placed on GP to Sign the Form**

Ethical dilemmas are raised where a patient arrives with a form filled in either by themselves or with the assistance of others including claims of medical conditions which are not necessarily apparent or are not specifically related to the veteran's war service.

"I really hate this form. It's not the form itself. Usually the veteran comes in unannounced. They go to the RSL and speak to them about the pension. They will then come in with the medical diagnosis filled out. It's the advisor that puts words into their mouths and it's not really what they would complain of. They ask you to sign it and not give a diagnosis."

“Medical Diagnoses’ are usually pencilled in by some helpers, suggesting the veteran has the condition which may or may not be true.”

“I’m under a lot of pressure to sign it.”

“I’m under extreme pressure to say it is a service related issue.”

Some doctor’s both seriously and cynically claimed to learn new things about their patients when receiving this form.

“I generally find out a lot of things about the patient that I never knew. You find out that they have a problem.”

- **Number of Conditions Listed to Extend Pension**

Some GPs raised concerns about the frequency at which their patients return with additional Disability Claim Pension Forms in an effort to increase their pension - *“Often they will come in every few months looking for a single reason to add to their pension”*.

On some occasions, in the one form, the patient will have numerous conditions recorded. A couple of cynics suggested that those advising the Veterans on how to complete the form are telling them to write as many conditions as possible *“so at least they’ll get the pension for one of them”*.

In one group, a GP expressed his belief that the veterans should receive a one off pension regardless of their subsequent medical conditions since their service. He felt that they deserved to be compensated for their service. This would *“avoid their continual attempts to source money from the taxpayers”*.

- **Unfamiliarity with Patient**

The completion of the form can become difficult where a new patient visits the GP. The time associated with tracing past medical records and diagnosing the patient can be substantial. On a number of accounts, GPs must trust the veteran in relaying the necessary information.

“New to practice, not familiar with patient’s conditions where do I start. Can only go on what patient is telling me. Finally am I being honest or misled.”

Some GPs refuse to fill in the forms for new patients, as well as where patient's medical conditions listed in the form are not perceived as genuine. This places the GP in a difficult and uncomfortable situation, and further encourages the patient to visit yet another new doctor.

- **Separation of War Related Versus Other Source of Condition**

Some GPs reported difficulty in understanding the exact cause of the condition. There are difficulties associated with distinguishing between war related and other sources for the development of a condition.

“Relating or separating any related issues from war serving related difficulties.”

“Assessing inter-related but separate problems due to war service (army service).”

- **Patients Visits Without Warning**

On some occasions, this form is brought in by a patient without prior warning. Where the time requirement is great, this situation can result in a delay in seeing other patients, or the need to ask the current patient to schedule an alternate appointment.

How long does this form take to complete?

For those familiar with this form the time taken to complete it was generally perceived as reasonable. The times recorded varied considerably across GPs, ranging from 2 minutes up to 45 minutes.

Ideally, the patient visits the GP leaving only the GPs section to be filled in - *“This only takes about 2 minutes”* [GP who completes one of these forms weekly]. Another GP who spends a longer 20-25 minutes on this form stated that he schedules the patients into a 30 minute consultation. This GP spends the time reviewing the patient's section before completing their own.

A further GP who claimed to take 5-6 minutes, similarly claimed to *“spend time looking through the patient's part, going through the notes and filling it in”*.

Overall, the variables that influence the time spent completing the Claim for Disability Pension and/or Application for Increase in Disability Pension, include:

- The extent to which the form has been filled in, including its level of accuracy.
- Familiarity with patient and/or their conditions.
- Number of conditions covered in the form.
- Extent to which the claims can be trusted without further investigation or sending the patient to a specialist.

What are the opportunities for improvement?

Those familiar with the **Claim for Disability Pension and/or Application for Increase in Disability Pension** were given the opportunity to mention any ways in which the government can reduce the burden associated with the form. The following suggestions were made:

- Require a case manager to help the patient in completing their section correctly and accurately.

“Veterans’ Affairs have case managers – some RSL’s have officers. They advise you on how to fill out these forms. They should be required to do this otherwise the patient fills things out wrong and it’s a big waste of time.”

- Clearly indicate to the doctor what they are responsible for.

“Separate out doctor’s part of the form, that is, flag it better.”

- Ensure there is ‘best practice’ for how the RSL representatives handle the process.

“The government to inform RSL regarding who is actually filling in the form, that the RSL advisors should not create medical diagnoses for the veterans.”

- Employ medical officers to handle this process and alleviate the burden on General Practice.

“A government medical officer to assist. Simply send a summary of the patient’s current medical records (computerised) to add to a form completed by the clerical staff.”

6.2 ASSOCIATED GARP FORMS

A greater number of GPs were familiar with the associated GARP forms, as compared with DVA's Claim for Disability Pension and/or Application for Increase in Disability Pension form. This was an interesting finding in that it had been earlier assumed that the GARP forms are sent to the treating doctor in response to their submission of the Claim for Disability Pension and/or Application for Increase in Disability Pension form. It became apparent that there were other sources involved in the completion of the initial form.

It is assumed that these original claim forms are being completed and signed by DVA or RSL medical representatives. Alternatively, the patients are visiting a different doctor who has signed the form and authorised the release of subsequent GARP forms.

As such, in the main, a set of GARP forms will often arrive at GP's practices from the Department of Veterans' Affairs - *"forms just arrive"*. The number of forms and the variation of forms *"is always different"*, depending on the specific conditions and the number of conditions for which the original claim form was submitted.

What time commitment is required for the Associated GARP forms?

The number of forms requested for completion will obviously impact on the total time associated with this DVA compliance task. As such, GPs were asked to provide an estimate of the time taken to complete a 'typical' set of GARP forms. This typical set included 3 forms for the one condition, as mentioned earlier. GPs were asked for the average time taken to complete each individual sheet. The time was said to range across 2 minutes to 20-45 minutes. On average however, they were thought to take around 5-10 minutes each.

As with the Claim for Disability Pension and/or Application for Increase in Disability Pension form, the variation in time is dependent on:

- Familiarity with patient and/or their conditions. This is based on the amount of time the GP needs to spend investigating the condition, reading medical records and tracking down medical records from elsewhere to complete the form.
- Number of conditions covered in the forms upon which to claim.
- Level of trust in the claim where the GP has not been involved in the submission of the Claim for Disability Pension and/or Application for Increase in Disability Pension form. Where it is believed that the case is not genuine, the GP is often required to conduct in-depth physical examinations or refer the patient for tests or to a specialist.
- Value placed on the forms. Those placing little ethical value on the form will allocate less time to its completion. The value placed in the system, along with previous experience, will govern the amount of detail provided in the forms. This will thus impact on the overall time taken to complete the form.

The time at which the GP decides to complete the form varies according to personal preferences. The majority of GPs tend to complete them during a patient's consultation. On the other hand, some prefer to avoid doing it during their consultation time, and instead complete the forms after hours and may consult with the patient for a short period of time only to clarify any necessary issues. This is only possible where the GP is familiar with the patient and their conditions. The financial reimbursement allows these GPs to justify the out of hours input which is viewed as acceptable.

Where a GP prefers to fill the forms in during a consultation, as filling in the forms may take up to 1 or even 2 hours, a key issue is finding 4 consecutive consultation times free in which to book the patient in. Generally this is hard to do (especially in rural areas) and the patient must wait a substantial amount of time before they can have the forms filled in.

What are the areas of difficulty and frustration with these forms?

The time associated with completing the GARP forms evidently leads to frustration. While the financial compensation provided to the GPs for each sheet completed alleviates this frustration somewhat, some frustrations and difficulties remain apparent.

In the main, the frustrations and difficulties, also associated with time requirements are specifically attributed to the:

- **Large Number of Forms Arriving at Once**

The number of conditions for which the veteran is claiming a pension for directly impacts on the number of associated forms that are sent to the GP for completion. The conditions themselves will also determine this overall number of forms. Some GPs did express a sense of frustration at receiving 10-15 forms to fill out at once. As such, it can be an extremely time consuming process.

“Forms often arrive with multiple conditions therefore there are large numbers of forms to fill in”.

- **Repetition**

The set of forms received from the Department of Veterans' Affairs were perceived as repetitive, with a number of GPs not necessarily understanding the difference in objective between each of the Medical Report, Medical Impairment Assessment and Diagnostic Report. Where numerous conditions are being claimed for simultaneously, and three forms can be sent per condition, there is also thought to be repetition across conditions.

“It is very repetitive.”

“The repetitive nature of the questions.”

“Too many questions. Asked information could be more easily obtained using better questions”

“Length. Repetition between conditions.”

- **Unfamiliarity with the Patient and/or the Condition/s**

Unfamiliarity with the patient and the condition/s for which the GARP forms have been received can slow the time associated with the forms' completion. This is mainly where the initial Disability Pension Claim form has been completed by someone other than the GP.

For a GP seeing a patient for the first time, or discussing a condition with the patient for the first time, without having all their historic medical records, some of the questions can be difficult to complete. This is especially in relation to questions about the clinical onset of the condition, and of any previous medical investigations and treatment.

“Lots of questions and need to consolidate answer. Impairment form usually asks questions that can't be answered from the file, sometimes necessitating another consultation.”

Further frustrations and to a certain extent difficulty associated with the GARP forms have centered on specific **technical issues with the forms**:

“Fitting my appraisal of the conditions into the specific answer required.”

“Very time consuming form with minute details. Does not allow our appraisal of the situation.”

“Comments are expected. Condition often requires more thought and a thorough explanation or reason why choice is made.”

“Very wordy, quite time consuming.”

“Requires a list of detail and sensitive answers from the patient.”

The Medical Impairment Assessment was specifically perceived as comprising “*subjective questions*”. A number of questions ask about the patient's physical state and ability, for example questions 1 to 7. For these questions, the GP is relying on the patient to provide an honest answer. Further, the patient's condition can appear very different in the context of a medical consultation where the aim is to receive a pension, as opposed to outside the consultation time.

While there is a general comprehension of the overall aim of the associated GARP forms, the reasoning behind the “*precise details requested*” was raised as questionable.

“There is sometimes difficulty interpreting what is asked of.”

The associated Post Traumatic Stress Disorder forms and the “*Embarrassment*” form were considered to be specifically frustrating and difficult forms.

As with the Claim for Disability Pension and/or Application for Increase in Disability Pension form, there is a large amount of **pressure placed on GPs** to complete these forms in a way that will allow patients to gain or increase their pension.

“It’s a big scam. A small percentage are actually justified.”

There are some perceived issues with the system as a whole. One GP felt that veterans should just be given the pension without this process, as was earlier mentioned. As a result of the process, it is felt that money is being wasted that would be more beneficial if the veterans were automatically given the money. Many of the conditions presented were questioned as being invalid including having incurred the condition during service and as a result felt it was a waste of tax payers’ money to pay GPs for filling out a large variety of forms just to ensure the patient gets something. As such, as mentioned in association with the Claim for Disability Pension and/or Application for Increase in Disability Pension form it was suggested that all veterans are provided with a pension and that the DVA should be disbanded for this purpose.

For some, there is little value placed on the system. For these people, the forms are not necessarily difficult to complete, however are seen as a “*useless waste of time*” and thus create a sense of frustration and burden.

GPs are however generally satisfied with their requirement to complete the forms due to the associated remuneration. The difficulties and frustrations related to filling out the numerous forms involved are lessened by the remuneration from the Department of Veterans’ Affairs. GPs aware of the GARP forms were most definitely aware of such financial compensation per GARP form completed for a specific condition or numerous conditions.

What are the opportunities for improvement?

Some suggestions provided by GPs to assist in the reduction of the forms' burden included:

- **Reducing the repetition associated with these forms.**

"It only takes a couple of minutes for each form but it could be better collated and organised. You could do it in the form of a referral – it's just paper shuffling."

"Reduce duplication of conditions (same condition may currently require 2 forms)."

"Streamline the questions into one form per condition."

- **Providing GPs with the opportunity to provide a medical report.**

"Make form more "free-form" so GP can provide personalised consultancy. The details make the 'interrogation' of the veteran an insult to their war service."

"It would be better to compose an essay on the patient – they never really fit into the boxes. Our own genuine appraisal."

- **Veterans should be allowed to claim for one condition only.**

"Ask for a single diagnosis." [This is in contrast to allowing Claims for numerous conditions.]

- **"Better remuneration."**

- **A "Department of Veterans' Affairs doctor" should hold responsibility for the forms.**

"This would need to be in response to a report submitted by a GP. This way the information will be more objective".

DEPARTMENT OF HEALTH & AGEING (DHA) COMPLIANCE TASKS



7. DEPARTMENT OF HEALTH & AGEING

The Department of Health and Ageing govern a high proportion of Commonwealth compliance tasks assigned to GPs. These range from larger programs including the Practice Incentives Program (PIP) to smaller requirements including the Commonwealth Hearing Services program.

The specific terms of reference of this study include the analysis of three compliance tasks currently under the jurisdiction of the Department of Health and Ageing. These have included the 'Australian Childhood Immunisation Register – Encounter Form (IMMU-2)', the 'Pharmaceuticals Benefits Scheme RPBS Authority Prescription', as well as the 'Application for a Hearing Services Voucher for Adult Applicants' (2647).

Each of these compliance tasks are deemed high volume tasks, and were investigated in detail throughout the workshops. GPs were particularly familiar with the 'Australian Childhood Immunisation Register – Encounter Form (IMMU-2)' and the 'Pharmaceutical Benefits Scheme RPBS Authority Prescription', as approximately 1.1 million and 3.2 million are consecutively completed across Australia annually.

The volume of 'Applications for a Hearing Services Voucher for Adult Applicants' completed each year is substantially lower with around 89,000 completed on a yearly basis. Due to time restraints across the ten 'Compliance Workshops', a lower priority was placed on this form, and as such was discussed across fewer workshops.

Exclusive in nature and comprising differing perceived levels of burden, each of these three forms have been discussed individually in the following three sections of the report.

Australian Childhood Immunisation Register – Encounter Form

19

Australian childhood
immunisation
register

7001/IMMU-2

DO NOT REMOVE COVER SHEET BEFORE IMPRINTING.
PLEASE PRINT CAREFULLY. USE THIS AS A GUIDE ... DO THIS ☒ NOT THIS ☒

- This form is used to record details of immunisations administered in Australia to children under the age of 7 years.
- Immunisation Encounter forms (IMMU-2) must be submitted with an Encounter Header form (IMMU-1).
- Please use a **Medicare number** and **reference number** to identify a child wherever possible.
- If a **Medicare number** is not available, the child's full name, address, date of birth and gender is required.
- If you are immunising the child for the first time and you have sighted documentation indicating that this child has received the birth dose of Hepatitis B vaccine, please cross the box marked 'Yes' and provide the date the vaccine was administered.
- Vaccine brand names not listed on this form may be recorded in the **Other** box.
- If the child is Aboriginal or Torres Strait Islander, **parental consent** must be sought before placing an 'X' in the box provided.
- A more comprehensive list of instructions can be found in the 'Instruction sheet on how to complete the ACIR Encounter forms'. This includes a list of vaccine brand names acceptable for recording in the **Other** box.

Designed 04/00

LEIGH MARCON

FOID BOTH ENDS FINLY - FULL TO SCISSORS

7.1 AUSTRALIAN CHILDHOOD IMMUNISATION REGISTER - ENCOUNTER FORM

The Australian Childhood Immunisation Register – Encounter Form is perceived to pose only a minimal burden on General Practice - *“The immunisation form is fine, there’s no problem with it”*. General Practices are extremely familiar with this form, claiming to complete one at least every one to two weeks. In the main, the GPs claimed to complete one at least once a week. Some claimed to complete one at least daily.

While it may be evident that GPs feel ultimately responsible for the submission of these forms, in many cases it is not solely the GP involved:

“This is a good one because other people can help out.”

“The reason we like that form is because someone else is doing it.”

Some GPs admitted that their nurses are able to complete the forms, totally excluding the GP from the process. In other instances, the GPs notify the nurse or practice manager of the immunisation given and they take responsibility for the form’s completion. Alternatively, GPs may complete the form itself, but hand it over to their receptionist to take an imprint of the patient’s Medicare card.

“I just tell the receptionist what is given.”

“My staff do it now. They bring in the vaccines and I verify it, but they do the bookkeeping of what’s been given....the nurses.”

“Treatment room sister does that. There is no signature necessary.”

“My practice nurse fills it in.”

“The part that I fill in takes less than a minute, the girls fill in the administrative side... the address... and all that... I just fill in the vaccine and they probably spend a couple of minutes doing the rest of it”.

"I tick, tick, tick, then initial it, or the nurse can do it, or whoever."

Some sole practitioners or those without any additional medical assistance, noted that they complete the form themselves, however believe it to be of little burden - *"I fill it all out by hand and it takes me about a minute"*.

As such, irrespective of the staff involved in the completion of the Australian Childhood Immunisation Register – Encounter Form, the time taken to complete the form itself is very little and is not generally seen as difficult or frustrating - *"This form is one of the simplest ones to fill in"*. One GP described the *"simple"* process as *"tick, tick, tick the boxes and the girls put the Medicare card through the vouchers"*. There was a general consensus that this form was *"fine"* and *"easy to fill out"* - *"There is no problem with it, it would take me no more than a minute"*.

"Just 30 seconds to tick the boxes and my receptionist would use the imprint."

"It takes me 30 seconds and then the receptionist staff just swipes the Medicare card over it. I just cross the box."

While around three-quarters of participating GPs claimed to fill in the 'hard copy' form, there were a group who prefer to complete the form electronically. Where EDI was utilised by a GP or their staff, the overall time requirement further lessened.

"These days we don't fill out this form, we fill it out on the computer... You just tick what vaccine was given. If you give DTP, Phendrix and Polio, you just have to tick those three and submit, and that's it."

A handful of GPs commented on the *"trail of the paperwork which makes the difference"*. Admitting that completing the form itself takes only seconds or minutes, the paperwork associated with this one form increases the time requirements.

"It is the totality of the process which can be a problem not just this one forms."

“There are the medical notes which need to be completed in addition to this form to make an entry, then you have the patient’s yellow book and invariably there’s going to be an addition or a variation, and that could be a nightmare because you have to trace back the history records to confirm that it was actually given in your practice....It’s not always straightforward and it can become a lot of paperwork.”

A frustrated GP felt that the “*trail of paperwork*” created a proportionately greater sense of frustration than the amount of paperwork itself: *“May I hasten to add that the temper that ensues after an episode like this is out of proportion to how long it takes to fill in the form”*.

A few others mentioned the additional administration time associated with the organisational side of finding the form – *“The form itself takes only 30 seconds or so to complete, but it’s the getting and finding the form”*. Where the GPs are completing the form themselves, they need to either arrange for the receptionist to bring in the form, or to locate the form themselves.

Despite overall satisfaction with the Australian Childhood Immunisation Register – Encounter Form, the following further **difficulties and frustrations were raised**:

- Concerns about the “**pale coloured ink**” used on the Australian Childhood Immunisation Register – Encounter Form were raised.

“The ink is so weak that you can’t see it on the form.”

“I wish they would use a darker ink or a better contrast. It is hard to read.”

“It needs to be darker, it’s hard to read.”

- There were a number of reports of **missing forms** and consequent inaccuracies in the Register’s information system. Batches of forms were reported as being lost -

“Sometimes when we fill in the form, you know you have sent the form off, but the system says that we haven’t”.

“The frustration for us is where the patients get reminders that the vaccination needs to be done, and you know damn well that you submitted the form. So there is an increasing problem in the system.....That’s what I find the only problem is with the system.”

“What sometimes happens is they get lost and the patient says I know I was in here 18 months back, and I know you did it, and you know that you’ve filled it out but it’s gone astray.”

There is a sense of frustration associated with these missing batches and the consequent need to prove that the vaccine was provided along with the requirement of re-submitting the original form.

In response, it was suggested that *“it might be nice to have, or maybe there is one, a copy the doctor can keep”*. This would enable GPs to clearly verify that the vaccination was given – *“We’ve had a lot of them, but people say they haven’t been done, and I know that I do them... writing that I’ve done it and actually having a copy is a different thing. It’s just more concrete”*. Others felt that this should not be necessary as the vaccination is recorded in the patient’s medical records and in the immunisation health centre book.

Such inaccuracies associated with the system, mean that not only are some people notified regarding vaccinations unnecessarily, however it also means that *“some patients miss out on being notified or their records aren’t notified”*.

- Frustrations can be incurred where a **patient’s immunisation history is not readily available**, particularly with dealing with new patients or those who attend multiple sites (or from overseas) for vaccinations. It can be very difficult getting accurate information from these parents – *“where a parent comes without their child’s ‘blue’ book and you’re not familiar with the child, that’s abit of a problem with the box where it says ‘Have you seen their birth dose of Hepatitis B?’ It’s pretty specific what they ask”*.

Similar frustrations are felt where there are omissions on immunisation records, due to the process involved in following up the details.

There was also a claim that differences across States existed in immunisation schedules, making it difficult where patients move from an alternate State – while in one State the child may not yet need the vaccine, but in the new State they may. It was suggested that the schedules should be consistent across Australia.

“Some patients miss out on being notified. A lot of patients that aren’t local people. We fill it in anyway, but don’t know if we need to fill it on.”

The time associated with completing the “longer form” where those from overseas haven’t yet been registered in Australia, was further raised as frustrating.

- While there were very few spontaneous concerns about the overall purpose of the form, one GP seemed unclear of the purpose of the form where international visitors were involved.

“We have a lot of overseas patients who aren’t Medicare people and we usually fill in these forms as well, but I really don’t know how applicable it is, we don’t get a payment for it, but they still need to go to Kinder. So I don’t know what happens to it. For us, it’s a bit of a waste of effort.”

Others argued that the aim of the form is to not only “get the children to kinder”, but also to keep the register up to date.

- Some **technical concerns** were raised. Despite a space being provided for ‘other’ vaccines, a concern was expressed by one GP about the space available on the form in anticipation of newly developed vaccines.

“I don’t see any problem with this form, except it’s a little bit confusing when they talk about P-vax, F-tida. Strictly speaking your not supposed to substitute them. It’s a very straightforward form.

“Similar names of two immunisation.”

“It might be worth putting a box under the ‘Have you seen the Hepatitis B one’. They say you can tick ‘yes’, but they don’t say you can tick ‘no’. It doesn’t really make it clear whether you have forgotten to fill it out, or if you deliberately didn’t want to tick ‘yes’.”

- A further frustration surrounded the **additional time required where changes to vaccines and schedules occur**:

“Need to fill in the immunisation health centre book....sometimes there are changes to the vaccines and to the protocol, and it’s got to be double checked by the girls. New vaccines come out, new schedules come, it depends on whether something has been altered within recent time, in terms of the scheduled recommendations.”

While GPs have acknowledged that a limited burden is imposed on them by the Australian Childhood Immunisation Register–Encounter Form, a **few suggestions** were provided as a means of reducing the form’s few associated frustrations and difficulties:

- *“Use **darker ink**.”*
- One GP recommended the implementation of a system whereby **one entry could be made to record the information into the patient’s medical records**, the yellow book and IMMU-2 - *“You would probably invent one form...Your’e recording the same vaccination in three different places for the same patient”*.
- The government should ensure that *“previous **immunisation histories of patients are more accessible** for when patients have previously been to other health centres, GPs etc, and have left their immunisation books behind”*.
- The way in which the Australian Childhood Immunisation Register is operated is perceived as needing improvement to **avoid sending “inaccurate things to patients for their research, which they then phone us [GPs] about”**.

- **Clear records that the vaccine has been provided** were perceived as important. As mentioned above, this may include a carbon copy of the original form. One GP was particularly favourable of the method used to record the provision of the flu vaccine in the patient's medical records.

"When the flu vaccine season comes around, we have an older population and do over 1,000, you pull the sticker off the little bottle and slap it in the patient's history. It's then very obvious that it has been given. Those pull off stickers are just great."

Another benefit of the pull off stickers included that you don't have to write in the numbers and expiry date. Others however opposed this by claiming that they *"are trying to have a paperless surgery, this doesn't help us"*. This 'sticker' system was seen as more efficient where computerised medical records were not being maintained.

- There was a suggestion by one GP that the ***"Infant and Community Welfare Departments"*** should be responsible for this Immunisation Childhood Immunisation Register form.

Pharmaceuticals Benefits Scheme RPBS Authority Prescription

PBS - RPBS Authority Prescription 01945067
Not valid unless authorised by delegate

PRESCRIBER'S
NAME: _____
ADDRESS: _____
TELEPHONE: _____
PRESCRIBER No: _____

Patient's Medicare no: _____
Patient's name and address: _____
First name: _____ Family name: _____
Postcode: _____

☐ Tick box for return to patient

Pharmaceutical Benefits Enrolment number: _____
☐ Safety Net (Treatment Card holder (not a concession card)) ☐ Concessionary or dependent, RPBBS beneficiary or Safety Net Concession Card holder

AUTHORISATION IS REQUESTED FOR THE FOLLOWING
☐ PBS prescription from State Manager, HIC, or
☐ RPBS prescription from the Authorised Delegate of the Repatriation Commission

☐ Brand Substitution not permitted

CANCELLED
Pharmacist/Patient copy

Only one item per form

Dosage directions: _____
Quantity: _____
No of repeats: _____
Signature of prescriber: _____
Date: ____/____/____

☒ TBC / DVA use ☐ QUANTITY ☐ REPEATS ☐ PHONE/DELEGATE AP

I certify that I have received this medication and the information relating to any entitlement to free or concessional pharmaceutical benefits is not false or misleading.

Date of supply: ____/____/____ Patient's or agent's signature: _____

Agent's address: _____

Please note: The information recorded on this form, including your Medicare number and details entered by Coromandel and by the Commonwealth Department of Veterans Affairs, will be used to assess your entitlement to benefits under the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme, and to determine payments due to pharmacists. Your Medicare number is being collected and is required for use, in addition, with your consent, the pharmacist or doctor may share your Medicare number for use on future prescriptions. The collection of this information is authorised by the National Health Act 1966 and is usually disclosed to the Commonwealth Department of Health and Ageing, and Department of Veterans Affairs. If you require additional information please contact your nearest Medicare office or the Department of Health and Ageing web site. Information: prescriptions are also available from Medicare offices and from pharmacists. A008 (04/02)

Disease or purpose for which benefit required or clinical justification for use of item:

Patient's age if under 18 years: _____

7.2 PHARMACEUTICALS BENEFITS SCHEME RPBS AUTHORITY PRESCRIPTION

To obtain an authority prescription, GPs are clear that they must provide certain information to the Health Insurance Commission, including the patient's Medicare number, the patient's medical condition, the medicine prescribed and the GP's PBS prescriber number. The GPs are also required to fill in a hard copy script or are alternatively able to complete the form electronically. Phone approval may be sought, or a hard copy script may be sent directly to the HIC for approval. The most common means of seeking authorisation was via a telephone call within the patient's consultation. The form was most commonly completed electronically. In the main, GPs are required to seek authority prescriptions at least daily.

Overall impressions of the PBS authorisations compliance task are varied.

"It's a script – it takes a little longer than usual, but there is nothing wrong with the form."

"Doing the form is just a script. Ringing up to get authority from someone who is non-medical is a nuisance. If we're not the right people to make the decision, we shouldn't be practicing medicine."

"Don't have any problems with this form. I don't have worries getting authorisation over the phone."

"Confidentiality issues are being driven into GPs and then the GP is calling a stranger and telling them the diagnosis (they may even know the person). There are confidentiality issues."

"In general terms, it works OK."

"Rejections are rare, so why do we do it."

The time associated with seeking an authorisation script remains the sole functional responsibility of the GP. There is perceived to be no room for assistance by other staff members. GPs do see themselves as the most appropriate person to hold responsibility for this compliance task, however they are not necessarily satisfied with the process as it currently stands.

What is the time associated with the Pharmaceutical Benefits Scheme Authorisations?

The authorisation process is generally completed within an approximate 2-3 minute period, which is generally viewed as acceptable.

Importantly, while some GPs were able to give fairly accurate representation of the time on hold, speaking with a representative and completing the script, others had not considered this time before and generally expressed the process as taking less than 5 minutes. The largest proportion of this time is spent talking to an operator at the HIC. The length of time spent on hold is perceived to have fallen significantly over recent times, and in the main is not seen as an issue.

“Very seldom do you have to wait on hold. Talking to a person on the phone is also quite simple. It’s actually quite an efficient system.”

One GP raised the belief that the time taken to complete an authorisation script should also take into account the time taken to explain the process to the patient. In this case, the process was seen as more lengthy.

It was noted that while in the context of one authorisation, 2-3 minutes is not a significant period of time, however for a number of GPs, numerous authority scripts are required daily. As such, one GP prefers to complete the hard copy form and send them in to the HIC directly – *“If I rang for every authorisation, it would add 30-40 minutes of work per day”*.

Additional time is sometimes required where the GP is unaware of the exact wording of the condition for which the prescription is required. Where the script is undertaken via means of hard copy, it can take time to search for this wording. However where the script is produced electronically, they have to *"simply click on the name of the drug, and it's already there"*.

The customer service operator responsible for the phone call is also said to influence the length of time taken to seek authorisation.

The number of scripts required was also viewed as a factor impacting on the length of the authorisation process, as was the level of service and support provided by the HIC call centre staff.

Where a repeat script is concerned, the time taken to seek authorisation may be slightly shorter. Typically, once the script has been initially authorised there is less likelihood of the HIC staff disputing the request.

A further factor impacting on 'compliance time' is associated with the completion of a hard copy script which is sent into HIC for approval. It involves completing the lower section of the form, where the GP is required to note the 'disease or purpose for which benefit required or clinical justification for use of them' and are asked to record some additional details. This process is not however often utilised. There was however one query regarding the need to record the GPs telephone number twice on the same form – *"both at the top and at the bottom of the form"*.

For those practices using the computerised version of the PBSA the entire process is seen as more efficient causing less burden on GPs time and energy. Not only does it provide the exact name of the condition, it also saves the time it takes to manually fill in the form. It also provides information on the number of repeats left on a script and potentially saves time for multiple authorisations (though not all GPs were aware of how this was done).

"Using Medical Director it is very quick."

Having the patient's Medicare card available was also seen as speeding up the system.

It is important to note that once the authorisation has been provided, the compliance task of completing either the hard copy or electronic script is not significantly different to the time taken to prepare a general script. The GPs generally spend time preparing the script while they are waiting for the authority to be passed.

What are the frustrations and difficulties associated with the Pharmaceutical Benefits Scheme Authorisations?

While it is clear that the authorisation process is not overly time consuming for the GP, that is not to say that all GP's feel that the time associated with the frequently required authorisations is entirely reasonable or necessary.

GPs spontaneously raised a number of frustrations associated with the processes' time requirements, along with staffing and process related issues. However, overall this process was not rated as frustrating quantitatively. The process was not viewed as difficult.

Staffing Issues

- **Needing to Seek Approval from Non-Medical Staff**

GPs are aware that the HIC Call Centre Staff are not medically trained, referring to them as “clerks” on a number of occasions. Some GPs felt it was inappropriate to be contacting a person with limited medical knowledge to seek authorisation for a script.

“This is an obnoxious sort of thing. The fact that I have to ring a clerk to get authority.”

“There are issues with the process and their level of competence.”

It is sometimes felt that these staff are out of their depth, especially where they do not accept authorisations. They sometimes have difficulties in understanding the reasoning behind the GPs requests and consequently dispute it, where they are not straight-forward.

“Where a patient doesn't fit within a particular precise category and I have to argue with a non-medical bureaucrat who has no knowledge of the condition.”

“The people at the other end are not trained. They’re just bureaucrats. They have to get the pharmacist on duty.”

Where a dispute occurs between a “clerk” and the GP, the time taken on the telephone obviously increases.

- **Customer Service of HIC Call Centre Staff**

Mixed reviews became apparent on the quality of customer service and support for the service. The majority of GPs acknowledged that they are familiar with the members of staff, as the staff are with the GPs – referring to each other by name.

GPs were able to quote the names of those with a reputation for inflexibility in the process of seeking authorisations, those who they have difficulty understanding and conversely those who were particularly helpful. It was mentioned that when they make initial contact with the staff, the length of the phone call is clearly determined by the staff member assigned. In one workshop, a GP felt that the DVA staff were more “easy going” than those at the HIC.

- **Flexibility of HIC Call Centre Staff**

The HIC call centre staff tend to vary in terms of their flexibility.

“It all depends on who you get at the other side – sometimes there is a pedantic person. I had a difficulty with an operator – out of depth – not accepting authorisation – argued back and forth – some can be more than obstructive. They can cross the boundaries – there are issues in the process and their level of competence.”

While the GPs are required to use the exact words of the condition and the requirement for medication, some are less strict than others.

- **Language Barriers associated with HIC Call Centre Staff**

Across a number of groups, issues relating to language barriers were raised. In some cases, there were difficulties in understanding the accents of the call centre staff members.

“Where non-English speaking staff are involved, it takes abit longer (on the phone), which is just about all of them.”

“Some are easier to understand than others.”

Process Issues

- **Burden Associated with Repeat Authorisation Scripts**

The procedure of gaining authority from the HIC for a repeat script was raised as a frustration amongst a number of GPs. This is especially where chronic or terminal illnesses are concerned.

“I don’t see why we have to write it up each time. If it was authorised last time why can’t I just write a number on a normal script.”

“They should trust us as professionals. Should change the authorisation to be pro-active not reactive – therefore don’t require authorisations for medication for those needing repeats.”

GPs also raised frustration with the inconvenience of ‘lost scripts’. Where repeats have been allocated on a script, unless the original script is cancelled through the HIC, it is impossible to seek authorisation for the new script. Often GPs are unaware as to whether or not scripts have any repeats remaining. Very few GPs were aware of the ability to electronically check whether any repeats were left on the lost scripts. For those previously unaware, this was a useful tip.

- **Seeking Multiple Authority Scripts**

Amongst GPs completing their authority scrips electronically, there was confusion as to the capacity of the computer program to enable more than one script to be completed at a time. Those with greater technical knowledge were able to confirm that there was a way around this issue, avoiding the need to log off the system between each script.

In relation to the completion of the script manually, there was some frustration associated with the need to *“fill in the patients details for every authority”*. This was seen as *“very cumbersome”*.

- **Breach of Patient Privacy/ Process of Explaining Diagnosis In Front of Patient**

GPs are aware of their obligation to relay the condition for which the authority medication is being requested over the telephone to a non-medical *“clerk”*. This not only breaches a patient’s sense of privacy, yet can also cause embarrassment or unrest for a patient.

One GP recalled a situation whereby their patient has a serious and socially embarrassing condition which was relayed over the telephone to an HIC staff member who was familiar with the patient. With the introduction of the Privacy Legislation and the regulations imposed on General Practices regarding release of information without patient permission and release of pathology and radiology results to patients over the telephone, this process appears to be contradictory.

“In this day and age, in terms of privacy, we are calling people that are not medically trained and you are reading out to someone ‘schizophrenia’. Privacy is an issue.”

“Can’t rely on providing nursing home medications over the telephone, but can tell a stranger about a diagnosis.”

Genital Herpes was most commonly recognised as prompting an embarrassing situation where repeated in front of a patient. Even though it is a clear requirement of the process to relay a patient’s condition over the telephone, some GPs admitted to *“cutting corners”* without having to mention the exact condition.

“I object to exposing the diagnosis over the phone in front of the patient, I say ‘the patient complies with the authorisation!’”

While for some HIC staff this was acceptable, others demanded that the GP relay the actual condition over the phone, otherwise refusing to provide authorisation. In some situations the HIC would *“break the law”* and say *“Is that for [condition]?”*. This assists in avoiding patient embarrassment.

Similarly, the mention of Schizophrenia in front of a patient or another condition which the patient may not know they have been diagnosed with as yet, may create a sense of unrest between the patient and doctor.

“I object to exposing the diagnosis over the phone and in front of the patient, for example schizophrenia. So I say ‘the patient complies with the authorisation requirements.’”

One GP also felt it was a breach of the patient’s privacy where the GP is requested to write the patient’s diagnosis on the bottom of the script. This is required where the hard copy script is sent to HIC for approval.

- **Questioning of GPs Authority**

Amongst some, there was some confusion as to the purpose of the authority process. Some felt that it was a means of *“checking up”* on the GPs. As medical professionals, they believe that they should not necessarily need to seek authority from a third party, particularly where this third party are a group of non-medical call centre staff.

Some felt that the system was in place to ensure that the GPs prescribed the correct medication and to avoid *“corruption”* and *“black market prescriptions”*. In a couple of the group discussions, there were doubts raised as to the trust placed in GPs to prescribe the most appropriate medication. However, these GPs felt that those inclined to prescribe inappropriate medication are those who *“are likely to lie on the phone anyway”*.

- **The Phone Call**

While not seeing it as a great difficulty or frustration, the simple requirement of picking up the phone and making a call was seen as a little inconvenient. While the time requirement is not great, *“it is still time”*. Some saw the phone call as a *“complete waste of time”*.

“Time taken that could be spent on relevant things other than jumping through unnecessary bureaucratic hoops.”

Understanding of the Pharmaceutical Benefits Scheme Authorisations’ Purpose

Amongst a proportion of GPs, an understanding of why such an authority system is in place was clear - *“I think realistically it does save money... doctors hate being on hold [doctors are less inclined to prescribe a drug which they need to spend time attaining authorisation for]”*.

Some, while claiming to understand the reasoning behind the system, felt that there was little value associated it.

“No value -just red tape saying right things to a person on other end of phone treating doctors as idiots that can’t make proper choices.”

“The whole process appears unnecessary.”

“It’s a stupid thing anyway, it’s a way to persuade you not to prescribe too many drugs.”

“Completely unnecessary – thus is a budget management momentary not medical management there are better ways.”

“This requesting an authority is a clerical process related to cost.”

“Waste of time. I am a professional asking permission of a non-professional to prescribe a medication that I feel is appropriate in my medical professional opinion.”

Some others remained unsure as to the reasoning behind the process. A clear understanding of the processes intentions may assist in reducing some of these frustrations.

What improvements can be can to the Pharmaceutical Benefits Scheme Authorisations Process?

During detailed discussions regarding the Pharmaceutical Benefits Scheme authorisations process, a range of specific suggestions to reduce its associated burden were raised:

- Some GPs felt it would be appropriate for them to **talk to “medical people”** when seeking authorisation.

“For people with medical training to answer these phones and a senior pharmacist who can have authority to make decisions.”

- **“Multiple requests cannot be done on the same form – why can’t we do it on one form.”**
- **“The form is fine, but we need to find a way of putting the diagnosis on there masked so the patient can’t see** (where hard copy forms are completed and sent to the HIC for approval).”
- A large proportion of GPs do not agree with the need to seek authorisation for repeat scripts - **“I don’t see why we have to write it up each time. If it was authorised last time why can’t I just write a number on a normal script”**. This is specifically in the case where a “chronic non-resolving illness” is concerned.

“Initial authority only – there is no need for a phone call every 6 months – if it is an on going chronic condition.”

“Make the authority a “once only” – the diagnosis will be unlikely to change when the same drug continues to be used.”

“Have a permanent number assigned to that patient for that prescription indefinitely so only one authority is required for chronic conditions.”

“Single approval number for each patients with a chronic condition. Get rid of authority system. GP’s can be trusted to prescribe appropriately.”

“Limit the number of medications on authority.”

- Others suggested that while they are satisfied with the concept of seeking approval, that this **should be sought electronically without the requirement of a phone call.**

“Could be done electronically without needing operator.”

“Should say this in our system immediately.”

- Others felt the **authority system should be entirely abolished.**

“Get rid of authority.”

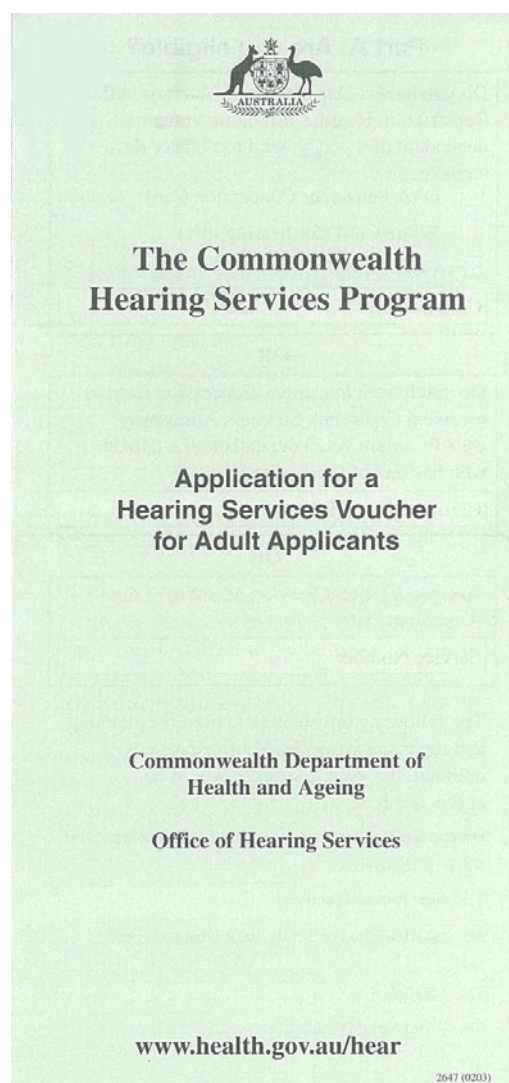
“They should have trust in the family physician to prescribe according to the accepted rules.”

“A good way to save money is to do away with the whole system.”

“If they allowed us to make the judgement. I think they’d save a lot more money.”

There were some who were satisfied with the system and provided no suggestions for change - *“please don’t change this simple system”.*

Application for a Hearing Services Voucher for Adult Applicants



7.3 APPLICATION FOR A HEARING SERVICES VOUCHER FOR ADULT APPLICANTS

The burden associated with the Application for a Hearing Services Voucher for Adult Applicants was assessed in three groups. Generally, this form was well liked as it took little time to fill out and was very simple.

“Like this one.”

“It just requires one signature on one line.”

“Its simplified and its good – it takes 30 seconds to fill in.”

“Simple for the patient too.”

The time generally taken to complete this form ranged from 30 seconds to 5 minutes of the GPs time. In the main, the patient has completed their section of the form, and as such, the time required is simply a signature. The patient does not often need help completing their section.

Overall, there were no great frustrations and difficulties associated with this form. One GP did however question the requirement of a GP to be involved in the process, despite the short time commitment involved. The GP alternatively felt that the patient should be required to visit a hearing specialist.

There was however a concern raised involving a Victorian company suggesting to potential customers that they should take advantage of the scheme. This resulted in the GPs experiencing an influx of these forms. Patients would arrive, and would be sent for a hearing test, and the result of the test would be negative – the patients did not have hearing problems. Thus, even a straightforward program was seen to be a target for fraud.

Again, the concern regarding the accumulation of all the smaller time commitments was raised as a frustration. A rural GP noted that *“people who get sick on the spot, you don’t see”*. The appointments become filled by patients requiring form filling or signing, as opposed to treating patients.

8. ADDITIONAL ISSUES

In addition to the evaluation of the high volume forms, GPs were given a brief opportunity to express any other particular forms or programs which they found particularly burdensome or frustrating. Given the limited time devoted to additional issues, we would not suggest that this is a complete list or picture of additional forms or programs which create a burden for GPs. It is also important to note again here that it is the proliferation of forms and the increasing areas of compliance tasks that is creating the greatest distress and burden.

“It’s the trail of paperwork, not just the paperwork itself.”

Additional forms or programs raised as issues in the workshops included:

- Public Housing Priority Forms
- Taxi forms
- Adverse Reactions and Notifiable Diseases
- Psychiatry Services
- Report Drug Addicts/Doctor Shoppers
- Mobility Allowance
- Child Disability Allowance
- Area of Needs Status (for rural locations)
- RTA Drivers Medical
- PIP Accreditation, EPC
- Nursing Home Medication Sheets (Regular Re-writes)
- Ambulance Form

An additional document has been provided to the Productivity Commission in relation to the limited feedback obtained in relation to the paperwork and programs listed here.

APPENDIX A – Moderator Guide

MODERATOR GUIDE GP COMPLIANCE WORKSHOPS

1	Australian Childhood Immunisation Register – Immunisation Encounter Form (DHA)
2	Pharmaceutical Benefits Scheme Authorisations - RPBS Authority Prescription (DHA)
3	Treating Doctor's Report (Centrelink)
4	Medical Review – Disability Support Pension (Centrelink)
5	Medical Certificate (Centrelink)
6	Disability Pension Claim form and Associated GARP forms (DVA)
7	Application for a Hearing Services Voucher for Adult Applicants (DHA)
8	Carer Payment: Doctor's Medical Report For A Child – Under 16 Years (Centrelink)
9	Carer Allowance: Treating Doctor's Report For A Child – Under 16 Years (Centrelink)
10	Carer Payment And/Or Carer Allowance: Health Professional Assessment For A Person – 16 Years Or Over (Centrelink)

HAND OUT INITIAL QUESTIONNAIRE FOR GP'S TO COMPLETE AS THEY ARRIVE.

AS RESPONDENTS ARRIVE, THEY WILL BE ASKED TO COMPLETE SECTION A OF THE QUESTIONNAIRE. WHERE RESPONDENTS ARRIVE LATE, THEY WILL BE ASKED TO COMPLETE THE QUESTIONNAIRE AT THE END OF THE WORKSHOP.

Introduction (5 minutes)

- Thank for attending the workshop.
- We will be here for an hour and ½.
- Introduce self and 'notetaker'. We are from MB a market research company, today we are here to talk with GP's predominantly about paperwork.

- What we will be doing for the next hour and a half is having a bit of a chat about paperwork and compliance tasks, looking at some specific forms and filling out some brief questionnaires about the forms.
- We will be audio taping this evening, I have sheet that I will pass around which gives your permission for us to provide this audio tape to the Productivity Commission. You will not be identified other than by first name and your participation will be totally confidential.
- Two way mirror – today we have some people behind the mirror who are also involved in the research project.

PASS AROUND SIGN-OFF SHEET

Warm-up (10 minutes)

- Have respondents pair-up and introduce themselves. Let them discuss the number of years as a GP, number of hours practiced each week, how many practices do they usually consult at on a weekly basis, number of GPs in practice/s, any other staff members?
- *Most people know that GPs see and treat patients. We also know that you are involved in a large amount of paperwork and form filling on a regular basis. We have been told that for some time, Australian GPs have expressed concerns about the increasing burden on them arising from paperwork and other government requirements. As such, in response to this, the Commonwealth Government has asked for an independent assessment of GPs' compliance costs associated with Commonwealth programs in particular, and to advise on ways to reduce these costs. You have been invited to share your views with us.*
- The questionnaire asked you about increase of compliance tasks over recent years, i.e. things which you are required to undertake as part of your job. How do you feel about the level of paperwork you are involved in at the moment? How much of your day or week, would you say is taken up by paperwork? Do you feel this has increased significantly?
- We are here on behalf of the Productivity Commission, who is an independent advisory board to the Commonwealth Government. We are specifically here to get feedback from you on one particular area – Commonwealth Government Paperwork/ Forms (these are forms such as Centrelink, Department of Health and Ageing and Department of Veterans' Affairs forms) and in particular the amount of time it takes to complete them. We understand that this is only a proportion of the paperwork you are all obliged to complete as part of your jobs, however there are other studies looking at other areas of compliance.
- This evening we'd like you to just focus on Commonwealth Forms. **Therefore, your attendance this evening and your open and honest feedback is very much appreciated and will ultimately benefit you.**

Evaluation of Each Form

We are going to be discussing a range of Commonwealth Compliance Forms tonight. We will be discussing each form in turn. First, let's look at Form _____ – the _____ Form.

PASS OUT FORM BOOKLETS AND AWARENESS QRE SHEET

Please pull the form out of the plastic sleeve and have a quick look at it.

- Do you recognise this form?
- How frequently do you fill it out?
- How long does it take to fill out usually? If more than one person involved, include how long it takes each person individually.

READ OUT DESCRIPTION OF FORM

Awareness Qre: Demonstrate how to fill out. Please make a note in the first row of whether or not you are aware of the form. If you are aware of it please mark how frequently you would fill it out.

For the next 10 minutes we will be talking about this form. For those of you who aren't aware, please bear with us for the next 10 minutes or so.

For those who are aware:

- Tell me a bit about this form.
- What is the purpose of the form, is this process/purpose valued?
- How long does it take you to fill out? (Prompt for 'real' estimates, prompt for each part of process)
- Is this form easy to fill out? Why/why not? What is the main source of difficulty? If filled out by someone else in the practice, who and why – what is the process?
- Is it a frustrating form/process? What is the main source of that frustration?
- Do you think you are the appropriate person to provide this information? If not, why not? Who is more appropriate? Why?
- Do you feel there are ways of reducing the burden of this form? (within the practice, government) What are practical ways of doing this? Ideas? Barriers?

Now I'll have you fill out a brief questionnaire. I'd like you to think carefully about the first two questions and give as accurate an estimate as possible of the time it takes to complete the form (Additional explanation as needed for various time questions)



GP's FILL OUT QUESTIONNAIRE

As you will notice, the questionnaire just asks you to note the things we have already talked about, this is so we can make sure we have your individual answers to these questions. The section at the end also allows you to give any additional feedback or comments about aspects that we may or may not have discussed.

Now we will go on to the next form.

REPEAT FOR EACH OF THE FORMS.

Additional Opportunity To Air Concerns (5 minutes)

You will now have the opportunity to air concerns about a further Government policy or program (Commonwealth, State and Territory or Local) which you feel is most burdensome (that we have not yet discussed), and which causes you great frustration. You will be asked some questions about your experience with this burden and your thoughts on how you feel it can be reduced. If no response spontaneously and respondent is unsure of what the question is asking for, please say: For example, are there any other forms, processes or procedures which cause you concern.

ASK RESPONDENTS TO HAVE A QUICK THINK ABOUT THEIR MOST BURDENSOME TASK AND EXPLAIN THAT THEY WILL NEED TO FILL IN A QUESTIONNAIRE INCLUDING THE SAME ISSUES DISCUSSED IN RELATION TO THE OTHER FORMS.

ASK EACH PERSON FOR THEIR RESPONSE. THEN ASK THEM TO GO AHEAD AND COMPLETE THE QUESTIONNAIRE.

IF RESPONSE REFERS TO A SINGLE TASK/FORM/PROCESS/PROCEDURE [E.G. WORKERS COMPENSATION, TAXI FORMS, DISABLED PARKING PERMIT FORMS] PLEASE ASK THEM TO FILL IN THE QUESTIONNAIRE FROM QUESTION D1.

IF RESPONSE INVOLVES A PROGRAM WHICH INVOLVES NUMEROUS TASKS, ROLES AND STAFF MEMBERS [E.G. PIP PROGRAM OR ENHANCED PRIMARY CARE PROGRAM (EPC)], PLEASE ASK RESPONDENT TO FILL IN THE QUESTIONNAIRE FROM QUESTION D8.