

Australian Medical Association submission to the National Commission of Audit

Reducing regulation

Background

The AMA has a long-standing interest in reducing the amount of regulation and red tape that medical practitioners face. We believe that it is critical for lowering overall health care costs, improving access to health services and improving health outcomes. It should be a priority for all governments.

In recent years we have proposed a number of initiatives for cutting red tape in medical practice. It is an area that the National Commission of Audit needs to consider in the context of achieving greater efficiency in providing health services and ensuring a return on the Australian Government's substantial investment in health.

The majority of general practices and other medical specialist practices are small to medium businesses. If you ask many medical practitioners, especially GPs, what takes them away from spending time with their patients, the resounding answer will be red tape and bureaucracy.

Medical practitioners must meet all the usual business red tape associated with taxation, insurance, payroll, personnel management. They must also meet additional red tape requirements to enable their patients to get access to funding provided through the Medical Benefits Schedule (MBS) and other government funding.

Medical practitioners bear a large proportion of these reporting and compliance obligations because the funding for health services is administered through the MBS and the Pharmaceutical Benefits Scheme (PBS). Doctors, especially GPs are also required to complete the documentation necessary for their patients to be eligible for payments administered by Centrelink and the Department of Veterans' Affairs (DVA). While GPs understand the need to do this for their patients, they are frustrated that governments make the paperwork complicated, unwieldy and unnecessarily time consuming. Paperwork that is completed by medical practitioners must in turn be processed by government agencies.

Though there has been some recent progress in reducing regulatory burdens in a few areas of medical practice, the amount of regulatory burden and red tape remains excessively high without any real justification. Internal AMA research shows that a large number of GPs spend up to nine hours or more each week meeting their red tape obligations. Every hour a GP spends doing paperwork equates to around four patients who are denied access to their doctor.

The AMA will outline in this submission some of our present concerns with the regulatory burdens placed on medical practitioners. Our submission draws attention to the following areas:

- PBS phone authorisations.
- Medicare provider numbers.
- Medicare payments.

- Personally Controlled Electronic Health Records (PCEHR) registration for medical practices.
- Centrelink and Department of Veterans' Affairs documentation requirements.
- Chronic Disease Management items under the MBS.

PBS phone authorisations

The PBS authority system requires medical practitioners to phone the Department of Human Services (DHS) for an 'authority' before they can prescribe certain PBS medicines. Over 120 medicines fall under this policy, including medicines used for cancer treatment and palliative care.

To obtain this 'authority', medical practitioners can choose to:

- call the DHS authority free call service.
- post an authority prescription form to DHS.
- use the DHS authorities website.

The most frequently used method is the authority free call service. Medical practitioners use their extensive medical training and experience to determine the most appropriate medicine to prescribe for their patients, yet the authority system requires them to phone a clerk for permission to prescribe. Doctors using the service are plagued by lengthy delays.

In an online survey conducted by the AMA in late 2012, thirty per cent of medical practitioners reported spending 10 minutes a day or longer waiting for calls to be answered. Time spent by medical practitioners waiting on a phone line is time lost to patient care. Millions of additional patient consultations could be provided if GPs did not have to make these phone calls.

To our knowledge, there has never been an evaluation or cost-benefit analysis comparing the 'savings' to the PBS with the Government costs of administering the policy, the costs to medical practitioners in terms of time spent complying with the requirement, and the opportunity costs to patients waiting while their medical practitioner obtains the authority.

There are around 500,000 calls made each month to the authority free call service by medical practitioners requiring an authority before they can prescribe. Based on information about free call waiting times provided to the AMA by the former Government in November 2012, an estimated 25,000 patient consultations are lost every month while medical practitioners obtain authorities to prescribe medicines. This is time that could be spent caring for patients.

There is ample evidence that this burdensome administrative requirement is unnecessary:

- the Productivity Commission has identified the PBS authority system as an unnecessary administrative burden for medical practitioners and recommended its abolition.¹

¹ *Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services 2009. Review of General Practice Administrative and Compliance Costs 2006.*

- a Department of Health (DoH) review demonstrated there was no impact on prescribing behaviour from moving PBS authority medicines to streamlined arrangements.²
- of the 6.4 million calls to the authority free call service in 2008-09 only 2.8 per cent did not result in an authority being provided.³
- DoH has not provided evidence to demonstrate that the PBS authority policy deters medical practitioners from prescribing PBS medicines outside the PBS restrictions.⁴

The authority system imposes an administrative burden on the vast majority of medical practitioners who do the right thing, in order to potentially defer the few who may seek to prescribe outside the PBS requirements.

The Government can make a significant improvement to the productivity and efficiency of the medical workforce in Australia by removing the PBS authority system.

Medicare provider numbers

Under the current rules governing access to Medicare, GPs are required to apply for and obtain a separate provider number for each practice location at which they work. Many GPs work in more than one practice and many work in hospital and other community settings.

In addition to the red tape burden this creates for GPs, it has other implications in terms of practices obtaining staff, especially at short notice or in emergencies. It has a major impact on GPs who provide locum assistance in several locations.

The Productivity Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* (August 2009) backed the AMA's view with the recommendation that the Australian Government should implement a single provider number for each GP.⁵

The AMA has previously recommended the introduction of a new Medicare provider number system under which:

- medical practitioners retain a single national provider number; and
- each practice location in Australia receives a location specific identification number.

It is a solution worthy of the National Commission of Audit's consideration.

² *Streamlined Authority Initiative Review* 2009.

³ Senate Community Affairs Committee. Answers to questions on notice. Health and Ageing Portfolio. Question: E09-187. 21 October 2009.

⁴ Senate Community Affairs Committee. Answers to questions on notice. Health and Ageing Portfolio. Question: E09-187. 21 October 2009.

⁵ Productivity Commission. *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*. August 2009. p323.

Streamlining Medicare payments

Every day, medical practices ascribe MBS item numbers to, and lodge claims on behalf of their patients for, tens of thousands of medical services. This not only enables patients to get access to Medicare rebates with little effort, but it also enables DHS to process in excess of 310 million patient rebates each year quickly and with very little administrative cost to the taxpayer.

It is unfortunate that this service provided by the medical profession and medical practices on behalf of Government has engendered the parlance that doctors bill Medicare for their services. In fact, the medical profession sees itself as a business partner of government in processing Medicare rebates for the Australian community.

There is a challenging policy environment for the Medicare program with long held but contestable beliefs within government about electronic payment of Medicare rebates.

One ‘innovation’ that the medical profession has been seeking for some time is for patients to be given the right to assign their Medicare benefit direct to the service provider regardless of the existence or not of a patient co-payment. This would mean that where a medical service is ‘patient billed’, the patient’s Medicare rebate would be paid into the medical practitioner’s account and the only transaction through the patient’s bank account would be the co-payment to their doctor.

While the Medicare Easyclaim system was a genuine attempt to provide efficient electronic claiming, it is needlessly complicated by the legal requirement for Medicare rebates for patient-billed services to be paid into the patient’s bank account. In an electronic age, most people would see little need for the number of electronic transactions that currently occur with patient-billed services, both within government systems and in medical practices.

PCEHR registration for medical practices

There is a tendency for DoH to over-regulate medical practice participation in health programs. The implementation of the PCEHR is a case in point. The AMA was advised by DoH in late-May 2013 that 80 per cent of PCEHR participant application forms had been incorrectly completed by medical practices.

There is no doubt that this error rate is because of the complex legal framework created by DoH and that medical practices are required to take on new legislative roles that have not been a feature of medical practice. This activity has been resource intensive for medical practices and DHS. If other medical practices and healthcare organisations are going to participate in the PCEHR, the registration arrangements must be streamlined and proportional, which in turn will reduce the DHS resources needed to undertake the registration process.

Centrelink and DVA documentation requirements

An ongoing area of concern for GPs is the completion of Centrelink and to a lesser extent DVA forms. In the AMA’s 2011 red tape survey, out of all the items included in the survey, completing Centrelink forms gave GPs the biggest “red tape headache”. Over 91 per cent of GPs agreed that Centrelink forms were the source of a headache for them (and over 68 per cent of respondents said the same for DVA forms).

In 2003, the Productivity Commission made a number of findings in relation to the collection of information by GPs for government departments including Centrelink and DVA.

A summary of some of the findings and recommendations made in the Productivity Commission research report general practice administrative and compliance costs relating to the completion of Government required forms is provided in the box below.⁶

Finding 6.4

The Department of Family and Community Services/Centrelink and the Department of Veterans' Affairs differ in their approach to remunerating GPs for similar tasks, particularly in relation to the preparation of medical reports.

Finding 6.5

There is confusion among some GPs regarding eligibility for payment to complete Department of Family and Community Services/Centrelink forms.

Finding 6.3

To the extent that the Government chooses to remunerate GPs for providing medical information, the relevant Department or agency should fund the payments out of its own budget.

Finding 6.4

Consistent principles for remunerating GPs should be adopted between (and within) departments and agencies. This does not require identical payment schedules.

Finding 6.8

There does not appear to be a standard approach by departments and agencies to designing forms and collecting information from GPs.

Finding 6.9

The extent to which information technology is used for GP administrative activities differs among Commonwealth departments and agencies, and among GP practices. The reliance on paper-based systems is still extensive.

Recommendation 6.7

Departments and agencies should examine options to accelerate the use of information technology in reporting by GPs, including integrating forms into computer software used by GPs, and allowing more forms to be submitted electronically when there is net benefit.

Finding 6.10

Some GPs face a tension between discharging a duty of care to their patients, retaining their patients and meeting the requirements of some programs. This can be a source of stress and anxiety for these GPs.

Recommendation 6.8

When a department or agency is asking GPs to supply information, it should focus its requirements on medical diagnoses based on clinical evidence.

Though Centrelink and DVA have made some progress in moving to simplifying forms and making them electronic, the frustration voiced by GPs in our red tape survey indicates that there is still a long way to go in this area.

⁶ Productivity Commission, *General Practice Administrative and Compliance Costs: Research Report*, March 2003. pp xxx-xxxii.

We note that both Centrelink and DVA have worked well with the AMA to find areas to reduce paperwork and simplify electronic completion of documentation. Nevertheless, GPs still tell us that the lack of integration with practice software means that the completion of forms still presents a significant compliance cost.

Overall, simplifying forms and integrating this into practice software systems will enable medical practitioners to focus on their core activity of providing high-quality health care to their patients, rather than spending time and resources on unnecessary paperwork. We expect that removing the excessive administrative burden would also enable the Government to redirect departmental resources to front-line services.

Chronic Disease Management items under the MBS.

As the Australian population ages GPs are increasingly treating older patients with more complex care needs.

The chronic problems most often treated by GPs are hypertension, diabetes, depressive disorder, cholesterol-related disorders, chronic arthritis, oesophageal disease, and asthma. Many older patients suffer from two or more chronic conditions, complicating diagnosis and management.

Chronic disease must be well managed and coordinated to reduce its impact on patients' health and well-being, and on health expenditure. With more than half of all potentially preventable hospital admissions due to chronic conditions, there are significant benefits in ensuring access to timely and clinically necessary health care.

The chronic disease management (CDM) Medicare items on the MBS enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care.⁷

These existing chronic disease management arrangements however, are too limited, cumbersome, difficult for patients to access, and are wrapped up in red tape and bureaucracy. The DHS compliance program consistently targets these items because they contain significant regulation of non-clinical tasks, making them easy audit activities with recoveries for minor administrative infringements that are unrelated to the quality of care provided.

The increasing burden of chronic disease has a significant cost impact on Australia's health system. With preventable admissions costing over \$1.3 billion a year there is an incentive for Government to support more coordinated care in order to keep people out of hospital by better caring for them in the community.

⁷ Chronic Disease Management (CDM) Medicare Items. Department of Health.
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement>.
(accessed 14 Nov 2013.)

The Coordinated Care Trials in Queensland in 2008 demonstrated that coordinated care reduced hospital admissions by up to 25 per cent, reduced inpatient costs by 26 per cent and improved their quality of life. The trial demonstrated that when all costs are included (MBS, PBS, hospital etc.), service provision costs can be reduced by eight per cent.

Though Australia has moved to implement more structured arrangements through Medicare to tackle chronic and complex disease, these arrangements could be significantly improved through the removal of red tape, streamlined access to GP-referred allied health services, funding for other support services, and the adoption of a more proactive approach to managing the care of individual patients.

Earlier this year, DoH was conducting a review of the CDMs. The AMA understands an objective of this review was to find ways of streamlining the referral process and reducing other red tape associated with these items; however, this review stalled just prior to the election and nothing has happened since.

The AMA believes that there is significant scope to improve the operation of CDMs and is urging the Government to work with the AMA to develop sensible reforms that support the provision of quality medical care and improve access to care for patients.

Reforming the Medicare Local network

The AMA has long recognised the need for a robust structure to improve the coordination of primary health care services, to support GPs to provide patients with access to allied health services, and to address gaps in the primary health care system.

The previous Government introduced Medicare Local model in 2011 in an attempt to address this need. This resulted in the establishment of a bureaucracy of 62 Medicare Locals. The evidence to date is that the current Medicare Local model is struggling to meet these goals for reasons including their size and governance arrangements.

The AMA hopes that the upcoming review of the Medicare Local network will analyse and assess their administration to check on the appropriateness and effectiveness of their role in coordinating primary health care delivery. Before scarce resources are directed to Medicare Locals, it needs to be established how they will support the central role of general practice, how they intend to identify local health needs and fill service gaps, drive improvements in primary health care, and ensure that services are best tailored to meet local community needs.

We are raising the issue in this submission because primary care services must be delivered in a cost-effective way that is supportive of general practice, and not become yet another layer of health bureaucracy. A case in point is the delivery of after-hours care, a key component of primary care and an indicator of quality general practice. Many Medicare Locals have indicated they will simply act as a conduit for the after-hours funding being directed towards them. This simply duplicates administration and wastes precious resources. The AMA also understands that some Medicare Locals have also set up after hours services that compete directly with readily accessible existing services.

The work of the National Commission of Audit is being conducted in an environment where funding for health is limited. Every funding component must be well spent, and the opportunity cost of a better spend elsewhere should be taken into account.

Summary of key points

- The excessive regulatory and administrative burden placed on medical practitioners must be simplified and relaxed.
- Reducing the amount of regulation and red tape that medical practitioners face is critical for lowering overall health care costs, improving access to health services and improving health outcomes.
- The AMA recommends that:
 - the PBS authority system is abolished to enable improvements to the productivity and efficiency of the medical workforce in Australia.
 - medical practitioners retain a single national Medicare provider number and each practice location in Australia receives a location specific identification number.
 - Medicare payments are streamlined by enabling patients to assign their Medicare benefit direct to their service provider.
 - registration arrangements for the Personally Controlled Electronic Health Records are streamlined to reduce the administrative burden on medical practices and to encourage a greater take up of the facility.
 - paper-based and electronic government forms are simplified and integrated into practice software to reduce the time and resources spent by medical practitioners on unnecessary paperwork, and to ensure that the information required is clinically relevant and utilised appropriately by the requesting government agency.
 - chronic disease items in the Medical Benefits Schedule are restructured to enable the elimination of red tape, and to better align the items with clinically relevant practice.
 - Medicare Locals are reformed to ensure that they are supportive of general practice, identify local health needs and fill service gaps, drive improvements in primary health care, and ensure that services are best tailored to meet local community needs.