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The Hon Josh Frydenberg MP
Parliamentary Secretary to the Prime Minister
Parliament House
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Dear Mr Frydenberg

Thank you for your invitation to provide you with advice in relation to areas where the Government could remove unnecessary red tape.

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.

Over the years we have proposed a number of initiatives for cutting red tape in medical practice and these have been endorsed in a number of reviews commissioned by former Governments. Unfortunately there has been only modest progress on red tape reduction, with resistance to greater progress appearing to be based on a misguided view within some parts of Government that red tape is a way to constrain health care costs.

This is a very poor approach to health policy that contradicts efforts to achieve greater efficiency in the provision of health services. It also fails to recognise the rigorous professional standards that govern medical practitioners and our strong focus on quality, safety and evidence based practice. I hope your Government can take a different approach so that access to care for patients can be improved.

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).

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. Outlined below are a number of areas where the Government could make meaningful change and significantly address the compliance burden on medical practice and help ease this problem.

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.[i]
- the 2005 *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business* recommended the abolition of the PBS authority system.
- a Department of Health (DoH) review demonstrated there was no impact on prescribing behaviour from moving PBS authority medicines to streamlined arrangements.[ii]

- 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.[iii]
- DoH has not provided evidence to demonstrate that the PBS authority policy deters medical practitioners from prescribing PBS medicines outside the PBS restrictions.[iv]

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. The Department of Health is currently undertaking a review of the PBS Authority Required medicines, but at this time we are not expecting that a complete overhaul of the system will be the outcome of the review.

Medicare provider numbers

Under the current rules governing access to Medicare, medical practitioners are required to apply for and obtain a separate provider number for each practice location at which they work. Many medical practitioners 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 medical practitioners, it has other implications in terms of practices obtaining staff, especially at short notice or in emergencies. It has a major impact on those 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[v], as did the *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business.*

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.

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 contribution. 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 payment of the balance 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. To date, we are not aware that any steps have been taken to streamline the registration process. In addition, there is no planned activity for DoH to review the ongoing purpose and need for the legislative roles that have been conferred on medical practices in relation to the PCEHR.

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 following box.[vi]

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 in 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.

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.[vii]

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.

These arrangements could be significantly improved by aligning them with clinical practice and removing red tape, including less complicated processes for GPs to refer patients to allied health services.

The DoH is now conducting a review of the CDM items. The AMA understands an objective of this review is to find ways of streamlining the referral process and reducing other red tape associated with these items. The AMA believes that there is significant scope to improve the operation of CDM items and we hope this latest review will lead to the development of sensible reforms that support the provision of quality medical care and improve access to care for patients.

Co-payments

In the context of red tape and compliance, the Government is committed to the introduction of a $7 co-payment for GP, pathology and diagnostic imaging services.

The Government's proposed model will be a substantial red tape burden for medical practices. The AMA commissioned modelling of the red tape (additional administrative) costs of the proposed co-payment, with a particular focus on the costs that will be encountered by general practices. This report can be accessed on our website at https://ama.com.au/ama-report-red-tape-burden-governments-medicare-copayment.

It found the estimate of the additional red tape burden would be between $1.41 per service and $1.61 per service. Assuming similar unit costs in pathology and diagnostic imaging, the aggregate dead-weight cost on the economy of the Government's model is between $274 million and $313 million in the first year (2015-16), rising to between $289 million and $331 million by 2017-18.

The AMA does not oppose the introduction of a co-payment and has put forward an alternative model for the Government's consideration. Our model would impose far less red tape as it relies on existing systems and does away with the complicate thresholds proposed by the Government. Details of the AMA alternative can be accessed on our website at https://ama.com.au/amas-alternative-medicare-co-payment-plan.

The AMA welcomes the Government's commitment to red tape reduction and I would be pleased to meet with you to discuss any of the measures outlined above should require a further briefing.

Yours sincerely

A/Prof Brian Owler
President

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[i] *Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services 2009*. *Review of General Practice Administrative and Compliance Costs* 2006.
[ii] *Streamlined Authority Initiative Review* 2009.
[iii] Senate Community Affairs Committee. Answers to questions on notice. Health and Ageing Portfolio. Question: E09-187. 21 October 2009.
[iv] Senate Community Affairs Committee. Answers to questions on notice. Health and Ageing Portfolio. Question: E09-187. 21 October 2009.
[v] Productivity Commission. *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*. August 2009. p323.
[vi] Productivity Commission, *General Practice Administrative and Compliance Costs: Research Report*, March 2003. pp xxx-xxxi.
[vii] 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.)