Dear BRCWG Secretariat

The AMA welcomes the opportunity to make a submission on the Future COAG Regulatory Reform Agenda Stakeholder Consultation Paper. The AMA has a long standing interest in this area and while the consultation paper does not specifically cover medical practice issues, there are a number of areas where the AMA would like to see reform in regulation and reduced compliance and administrative costs.

The majority of general practices are small to medium businesses and in addition to all the Medicare related regulation and reporting, general practices are also subject to general business regulation and reporting requirements.

The AMA has raised a number of issues about regulatory reform in medical practice in previous submissions including the 2006 Regulation Review Taskforce Report (RRTR), the 2003 Productivity Commission Report into General Practice Administrative and Compliance Costs and the 2009 Productivity Commission Annual Review of Regulatory Burdens on Business.

As a result of these reviews some progress has been made in reducing regulatory burdens in a few areas of medical practice. However, the amount of regulatory burden and red tape remains excessively high without any real justification.

This year the AMA conducted a survey of General Practitioners (GPs) to determine how much of a problem red tape was in their daily medical practice. 98% of GPs partially or totally agreed that red tape was a significant concern for them (or in the language of the survey, it gave them a 'red tape headache') with a large number of respondents stating they spent up to nine hours or more each week completing red tape obligations. Every hour a GP spends doing paperwork equates to around four patients who are denied access to a GP. Within this context the AMA is taking the opportunity to reiterate some of our primary concerns in the area of regulatory burdens.
In this submission I would like to draw your attention to a few key areas:

- PBS Phone Authorisations
- Team Care Arrangements under the MBS
- Medicare Provider Numbers
- Centrelink and DVA requirements

**PBS PHONE AUTHORISATIONS**

The Government requires medical practitioners to request an ‘authority’ from Medicare Australia before prescribing certain medicines listed on the PBS. This means that each time a medical practitioner writes a prescription for an authority required medicine, he/she first needs to write to or phone Medicare for an authority number.

Medical practitioners can spend between 4 and 10 minutes waiting on the phone each time they request an authority number from a Medicare clerk. This administrative requirement does not change prescribing decisions – medical practitioners prescribe the medicines that are appropriate for the treatment of their patients.

The Productivity Commission also supports the removal of the PBS authority system. It recommended it be dropped in its *Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* in 2009, which in turn reiterated the Commission’s earlier recommendations of 2003 made in the *Review of General Practice Administrative and Compliance Costs* report and of 2006 arising from the Commission’s Regulation Taskforce review relating to general practice.

The Government argues the policy is necessary to limit the use of subsidised therapy to use where cost effectiveness has been demonstrated. It still maintains that if a medical practitioner needs to apply for an authority, it influences prescribing decisions (*Parliament of Australia Hansard, Senate Community Affairs Committee, Supplementary Budget Estimates, 21 October 2009, and Department of Health and Ageing response to written question on notice E09-187*).

In 2007, the Government introduced ‘streamlined authorities’ arrangements. Instead of having to obtain telephone or written approval from Medicare, for some authority required medicines a medical practitioner is only required to include a ‘streamlined authority code’ generated by their medical practice software for the prescription.

However, to prescribe increased quantities and/or additional repeats above those specified in the PBS schedule, the item is still treated as an ‘authority required’ item.

This is despite clear evidence to the contrary.

The Drugs Utilisation Subcommittee of the Pharmaceutical Benefits Advisory Committee reviews the utilisation of medicines following their change from ‘authority required’ status to streamlined. A utilisation report is completed after the first 12 months of the change. As of the end of 2010, three years after streamlined authorities were introduced, there has been no evidence that removing medicines from an ‘authority required’ status impacts on prescribing practices.
This is direct evidence that medical practitioners adhere to the PBS prescribing requirements and that forcing them to comply with unnecessary systems and processes simply lowers productivity without achieving any real cost savings within individual health programs.

Given the authority system is essentially a rubber-stamping exercise, and that there is no risk to government expenditure as evidenced by the streamlining arrangements, the authority system should now be removed altogether.

In the AMA red tape survey mentioned above, the need to seek authority for PBS prescriptions was a major concern with 89% of respondents stating that authority required prescriptions gave them a red tape headache. Spending often up to 10 minutes on hold is a waste of time for the GPs and patients involved and for many GPs it represents an undermining of their clinical expertise.

Reforming the need for PBS authorisations is such an obvious area for reform. The Productivity Commission has clearly investigated this and concurs with GPs that removing the authority requirement altogether (or only keeping it in place for a very limited number of prescriptions) would be an immediate reduction in regulation and red tape for GPs and their patients. Many GPs stated in the survey that they felt insulted at the need to jump through these hoops when the evidence is so clear that there is no financial or clinical justification for the authority process.

**MEDICARE BENEFITS SCHEDULE (MBS)**

The AMA's submission to the Productivity Commission Review of Regulatory Burdens on Small Business - Social and Economic Infrastructure Services provided the example of how some items in the MBS are used as a blunt rationing mechanism to discourage medical practitioners from providing more services and in some cases actively limiting the number of services medical practitioners can provide to patients and thus contain health costs. The example of MBS Item 723 is worth reiterating by comparing what is required to compete a Team Care Arrangement (TCA) referral and what is needed to complete a referral to another medical specialist.

The medical profession has developed long-standing, sensible and efficient arrangements for referring patients from GPs to other medical specialists. A GP will prepare a letter of referral for a patient, which includes only the information that is relevant to the specialist's consideration of the patient's care needs. The specialist will subsequently ensure that the GP is kept informed of the patient's treatment and ongoing care needs. These arrangements work well and ensure that the patient's care is delivered in a coordinated and comprehensive way.

Compare this with the requirements set out in the TCA item (MBS Item 723) that was introduced into the MBS in 2005, which provides patients with a rebate to access GP referred allied health services. TCAs (item 723) requirements as stated in Medicare's quick reference guide for GPs\(^1\) are as follows:

• Explain to the patient the steps involved in the development of the TCAs and record their agreement to proceed.
• Consult with at least two collaborating providers, who will provide a different kind of treatment/service to the patient.
• Prepare a document describing treatment and service goals for the patient, treatment and services that collaborating providers have agreed to provide, actions to be taken by the patient and specify a date to review the TCAs (MBS Item 732 - recommended every 6 months).
• Discuss with the patient the collaborating providers who will contribute to the TCAs and provide treatment/services.
• Offer a copy of the TCAs to the patient, give copies of the relevant parts of the document to the collaborating providers and add a copy of the document to the patient's medical records.

In addition:
• A multidisciplinary team for the purpose of TCAs is defined as a GP plus at least two other health or care providers who will be providing ongoing treatment/services for the patient (each of the health or care providers must be providing a different type of ongoing treatment/services).
• TCA collaboration must be based on two-way communication. Preferably this communication would be oral (telephone or face to face), however, if this is not practicable, it can be through an exchange of faxes or email (ensuring privacy of patient information is safeguarded). The collaboration should relate to the specific needs and circumstances of the patient and must include advice from providers on treatment and management of the patient.

Noting that these points come from the "quick reference guide", it is clear that the above requirements are unnecessarily prescriptive and convoluted, thereby imposing extra red tape and unnecessary paperwork and ignore the reality that GPS often have long established relationships with local allied health providers and know what services are available relevant to a patient's care needs.

As the AMA has stated in other submissions, prescriptions such as those listed above ignore the fact that doctors are highly trained and educated health professionals bound by strict codes of professional conduct and ethical practice. Such prescriptive guidelines (and Item 723 is just one example) undermine doctor's clinical expertise and do not aid the quality of care or enhance patient access to care.

The AMA continues to reiterate that what is needed is a much less prescriptive approach to drafting items in the MBS that simply requires a medical practitioner to perform a service consistent with accepted professional standards of practice - which would stand up to scrutiny through a peer reviewed process.
A SINGLE MEDICARE PROVIDER NUMBER

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, particularly as a matter of urgency or in emergencies. It has a major impact on GPs who provide locum assistance in several locations.

The AMA has called for 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.

The Productivity Commission’s Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services (August 2009) reiterated the AMA’s view with the recommendation:

The Australia Government should implement...
- Introducing a single provider number for each general practitioner²

It is now time that the Government acted on this recommendation and introduced a single provider number for each general practitioner.

CENTRELINK AND DVA 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% of GPs agreed that Centrelink forms were the source of a headache for them (and over 68% of respondents said the same for DVA forms).

Back 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 Costs³ relating to the completion of Government required forms is provided in the box below:


³ Productivity Commission, General Practice Administrative and Compliance Costs: Research Report, March 2003. ppxxx-xxxi
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.

While Centrelink and DVA have made some progress in moving to simplifying forms and making them electronic, the frustration voiced by GPs in the AMA Red Tape survey indicates that there is still a long way to go in this area. GPs state that there is a great deal of duplication in the information they have to provide, the information often needs to be repeated (even including basic demographic information) each time a patients presents to the
GPs with another Centrelink or other form to be completed. While many forms are now electronic, there is still a widely held view among GPs that the forms are overly complex and the templates are not easy to use.

Many GPs stated that after spending a considerable amount of time completing the forms for Centrelink, they were doubtful as to how much Centrelink used and abided by the information and recommendations provided by the GP.

Clearly much more work can be done to simplify all Government forms, including ensuring that demographic and medical information that is unlikely to change can be saved in the forms so that it does not have to be completed each time a patients presents to the GP. Further work can be done in ensuring that the information required is clearly clinically relevant and utilised appropriately by Centrelink and DVA.

OTHER AREAS OF CONCERN

A number of other areas causing ‘red tape headaches’ were specifically mentioned by GPs in the AMA survey. These included:

- Road Traffic Authority/Driver Licence test requirements in the State/Territory jurisdictions
- Accreditation requirements
- Insurance paperwork (travel, life insurance).
- In particular, third party and Work Cover requirements gave GPs red tape headaches (over 84%). As these requirements differ between jurisdictions it is certainly an area where reform could be introduced to streamline and ensure consistent arrangements across the country.

I would be happy to discuss any aspect raised in this submission and particularly if you would like further information about the results of the AMA’s red tape survey, please do not hesitate to contact me. I can be contacted directly on 02 6270 5488 or email whough@ama.com.au

Yours sincerely

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