RACGP

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4 May 2015

The Hon Sussan Ley MP
Minister for Health
Parliament House
CANBERRA ACT 2600

minister.ley@health.gov.au

Dear Minister

Re: Red-tape in general practice

During your attendance at the United General Practice Australia (UGPA) on 28 January 2015, UGPA outlined its concerns about the level of red-tape associated with delivering general practice services.

You advised that the Department of Health had a deregulation team in place to review such concerns, and invited the RACGP (along with the other UGPA member organisations) to make a submission regarding red-tape.

GPs are an informational link between patients and numerous government and statutory authorities. They spend an inordinate amount of time providing these authorities with a large amount of information for a wide range of patient authorised, and/or government mandated, purposes.

The RACGP has identified over 200 one-off, periodic or ongoing, administrative requirements associated with the delivery of patient care. These requirements are set by the Department of Health, Medicare Australia, the Australian Health Practitioner Regulation Agency, the Australian Medical Board and other health service and workforce regulators.

Meeting external information requirements significantly disrupts workflow and subtracts from the time GPs can spend treating patients and improving the quality, safety, efficiency and cost effectiveness of service provision.

There is a need to audit, rationalise, streamline and automate – to the greatest extent possible – the informational requirements of the various government and statutory authorities. Even in instances where red-tape is indispensable, the way compliance is met should be simplified and better integrated with general practice systems and processes.

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As a priority the RACGP asks that the federal government reduce red-tape associated with:

1. Authority requirements for medications
2. Paperwork required for General Practice Management Plans and Team Care Arrangements
3. Claiming Practice Incentive Program (PIP) teaching payments
4. State and Territory red-tape requirements.

1. Authority requirements for medications

There is a substantial amount of red-tape that GPs face when prescribing certain medicines that require an authority approval under the current Pharmaceutical Benefits Scheme (PBS). This process is currently inefficient, reflecting processes from decades past, and imposes unnecessarily onerous obligations on GPs. These obligations result in unnecessary time delays for GPs, which ultimately impacts on the efficiency of patient services.

Ideally, the RACGP would like to see the removal of authority number requirements. We appreciate that medications requiring an authority number involve significant cost. However, requiring GPs to telephone for approval to prescribe these medications (for which they are always approved) is a waste of time for the GP, and a waste of government administrative resources. The College believes that there are other ways to monitor appropriate prescribing, including the use of audit.

We understand that there is currently a PBS Authority Review underway, and would encourage serious consideration to a complete overhaul of the current system.

The RACGP submission to review of PBS authority listings from June 2014 provides further details on the above concerns and recommendations regarding the authority number red-tape.

2. Paperwork required for GP Management Plans (GPMP) and Team Care Arrangements (TCA).

Currently the *Health Insurance (General Medical Services Table) Regulations 2010* (Division 2.17) specify the requirements for GPMPs and TCAs. Under Division 2.17, there are over 30 individual requirements for GPMPs and TCAs enshrined in legislation, including specification of the following areas:

- service goals for the patient
- actions to be taken by the patient
- the content of explanation required to a patient
- content of discussion required with a patient
- copies of the plan, and who it should be given to
- inclusion of a copy in the patient's medical record
- amendments to records, and sharing of amendments with the patient.

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Red-tape surrounding these regulations is unnecessarily detailed, and does not achieve any purpose. GPs understand that they need to obtain consent, take sufficient notes, and discuss treatment options and plans in any consultation.

In raising these issues with the Department of Health, it has been indicated that the item descriptors cannot be changed in the Medicare Benefits Schedule (MBS) as they are enshrined in legislation.

Therefore, the RACGP would like to see these requirements removed from Government regulations so that appropriate changes to the item descriptors can be made as required in agreement between the Department of Health and the profession. By removing the requirements from legislation, we believe the Government and profession can work together to craft effective requirements for GPMPs and TCAs in general practice that achieve the needs of the Government as funders, the profession as service providers, and patients as the recipients of care.

3. Claiming Practice Incentive Program (PIP) teaching payments

Practice Incentive Program (PIP) teaching payments are intended to encourage general practices to provide teaching sessions to medical students preparing for entry to medical practice.

Currently, each teaching practice is required to complete an ‘attendance form’ listing the teaching sessions provided to each medical student within their practice over a specified period of time. This ‘attendance form’ is sent to the medical student’s university for transcription of the information provided by the practice into a PIP teaching payment form. This form is then stamped and signed by the university before being returned to the teaching practice.

Practice staff must then reconcile the information sent back by the university with the information in their practice records. Any errors must be noted and the form sent back to the university for correction and re-issuance.

Once satisfied with the content of the paperwork, the practice then submits the PIP teaching payment form to Medicare. Medicare then makes a payment to the practice for the teaching sessions provided. To ensure that the payments are correct, a practice manager must log onto Medicare’s online portal (HPOS) and reconcile the paid amounts.

A simpler process would be for the practice to submit the claim form directly to Medicare without involving the university. Each teaching practice holds copies of all ‘attendance forms’ which would be available for audit purposes. This change in approach would align the teaching PIP incentive payment processes to other PIP incentive payment processes, which do not require a third party to verify the information submitted.

If desired, as additional layer of compliance, participating universities could also provide teaching practices with a letter confirming that the practice is responsible for however many (named) students per semester. For example if a practice has 3 students, on continuous rotation, in 4 week blocks, for a full year – the university could provide the teaching practice with a letter identifying the students and

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teaching / supervision arrangements which the practice can attach and submit to Medicare with its PIP teaching payment claim form. This should serve as adequate information for audit purposes.

5. State and territory red-tape requirements

While state/territory and local government imposed red-tape may be beyond the Department of Health deregulation team's remit, we believe that state and territory red-tape needs to be acknowledged and possibly reviewed in partnership between jurisdictions.

This would include rationalising the red-tape associated with establishing and running a general practice. For example meeting the informational requirements of building and construction industry, the Australian Competition and Consumer Commission (ACCC), occupational health and safety regulators, and many others.

A thorough audit of the volume, time and cost associated with red-tape (for both general practices, and the government agencies that must process it) would, at the very least, reveal opportunities to improve efficiency and cost-effectiveness of GP service provision and overall administration of the healthcare system.

I hope that the above issues can be appropriately addressed by the Department's deregulation team and invite the Department to enter discussions surrounding these with the RACGP.

We thank you in advance for consideration and await your response. Please contact Mr Roald Versteeg on (03) 8699 0408 or at roald.versteeg@racgp.org.au if you have any questions or would like to discuss.

Yours sincerely,

Dr Frank R Jones
President