CAMPBELL RESEARCH & CONSULTING

General Practice Compliance Costs Case Study Project

Productivity Commission

Volume 1: Program Analysis

Final Report

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Executive Summary

Background and methodology

The Productivity Commission is investigating the impact of the administrative burden of Commonwealth government programs on general practices. One of the elements of the Commission's investigation is a series of case studies. The specific objectives of the case studies are to:

- Identify and describe the main activities and associated tasks undertaken in order to comply with Commonwealth programs; and
- Provide an estimate of the costs related to these activities and costs.

The Productivity Commission appointed Campbell Research & Consulting (CR&C) to undertake thirteen case studies to examine costs associated with the time spent by GPs, other practice staff and non-labour costs required to comply with the following Commonwealth programs:

- The Practice Incentives Program (PIP), including the cost of accreditation;
- Enhanced Primary Care (EPC), in particular Health Assessment and Care Planning;
- Requirements associated with GP Vocational Registration (VR), and the Royal Australian College of General Practitioners (RACGP) Fellowship;
- Centrelink – assessment for entitlement for disability, illness or injury payments;
- Department of Veteran's Affairs (DVA) – assessments for entitlement for pension and allowances; and
- Pharmaceutical Benefit Scheme (PBS) – phone and written authorisations.

The methods used to achieve the project objectives included an in-depth (up to four hours) face-to-face interview with the GPs and relevant staff at each practice, and collecting practice financial information. The analysis was then undertaken at two main levels:

- A qualitative analysis, investigating detailed information on the time and resources required to comply with the programs. The qualitative analysis also identified key contextual factors impacting on compliance; and
- A cost analysis, examining actual compliance cost by cost category (labour and other costs) and program.

Only one GP was interviewed in each practice. The identified costs were therefore considered on the basis of:

- Practice-wide costs relating to compliance tasks that affected all practitioners in the practice. This was primarily PIP and accreditation but also included the development of procedures for EPC and SIP.
- GP specific costs that were attributed to compliance requirements by the individual GP in the course of their work or professional development. These included Vocational Registration and costs incurred as part of the individual GP's work.

The data did not specifically include the GP-related costs of other GPs in the same practice. It was determined that the two types of costs could not be aggregated to provide a "total" compliance cost for the practice.

Findings

The findings are based on analyses of twelve practices for which complete financial information was available.

For compliance costs that are **specifically GP-related**, the study found that costs across the twelve practices were $279,722. The average cost per GP was approximately $23,310. The median cost was approximately $18,666. However, there was extensive variation in the actual and proportional compliance costs across the case studies. The actual GP-related costs varied from a low of $6,796 to a high of $42,508.

Overall, the GP-related compliance costs represent 11.5% of a GP's "share" of the operating costs of a practice[1]. The individual GP-related costs as a proportion of a GP's share of the gross operating cost of the respective practices varied between 3.6% and 33.5%.

For compliance costs that are **practice-based**, the study found that costs were $168,996. The average cost was $14,083. The median cost was similar at $13,658. As with GP-related costs, there was extensive variation in the actual and relative compliance costs across the case studies. Actual reported costs across practices varied between approximately $1,872 and $32,373.

Overall, practice-based costs as a proportion of gross operating cost of practices varied between 0.6% and 6.3%. The total reported gross operating cost of all practices was a little over 9.1 million dollars. The average gross operating cost per GP in the study was $205,430.

Practice size appears to be a critical factor in program uptake and level of compliance costs.

The five small/solo practices in the project all have relatively high compliance costs for both GP-related as well as practice–related compared with group or corporate practices. This is mainly explained by the fact that small/solo practices do not have the:

- breadth of administrative/nursing support available to larger practices to undertake or gain efficiency in many of the program activities (eg. accreditation, SIP and PIP); or
- size that can generate economies of scale.

Importantly, small/solo practices' costs are relatively high, notwithstanding their overall lower participation rate in some programs.

Practice location also appears to have some impact on the level of compliance costs, with rural practices having notably higher costs for GP-related compliance than metropolitan practices on average. Conversely, metropolitan practices have notably higher costs for practice-based compliance than rural/remote practices. The higher practice-based compliance costs by metropolitan practices is likely to be significantly influenced by the lower participation rate in programs by rural GPs, which suggests that the true cost differential between rural and metropolitan practices may be disguised by the different program participation rates.

Labour is the largest single cost category, representing nearly all (96.4%) practice-based compliance costs, and two thirds (64.5%) of GP-related compliance costs. Other costs are mainly associated with PIP (accreditation physical improvements and IM/IT investments) and Vocational Registration (travel expenses). Costs associated with GPs are the most substantial cost category, with broad variations between practices. GPs also have the highest reported hourly rates, with large variations between GPs (from $32.50 to $135.70). The lowest hourly rates for GPs tend to apply to small/solo practices. Labour costs associated with nurses are the second largest category, with substantial time required to comply with PIP, EPC and SIP. The practice manager represents the third largest category, and is involved primarily in PIP and accreditation. The presence of a

[1] The GP "share" of Gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

practice manager appears to be a critical factor to the level of participation in, and optimisation of, major programs (PIP, SIP).

PIP (excluding SIP) accounted for the most (96.4%) of practice-based compliance costs, but little (6.5%) of GP-related compliance costs, and represented 2% of gross operating cost (median). The most commonly expressed reason for participation in PIP related to the financial benefits attached to the program, rather than the clinical value of the different activities. Substantial variations exist between practices, because practices were at different stages of preparedness for accreditation.

SIP. There was limited or no participation in **SIP** activities for many practices for two reasons: first, SIP is a relatively new program (November 2001); and second GPs were very critical of the program, finding it overly prescriptive, lacking consideration for existing clinical practices, and sometimes clinically inappropriate.

EPC accounted for a small proportion (1.8%) of practice-based compliance costs, and about a third (27%) of GP-related compliance costs. EPC received many similar criticisms to SIP relating to its complex implementation, lack of adaptation to rurality, and inappropriateness in areas of high acute patient loads. Health assessments and care plans were the most commonly used items.

Vocational Registration was a notable contributor to costs for most GPs, but had no costs at the practice level (median $6,250 per practitioner per annum). It represents approximately 31.7% of GP-related compliance cost. The range of compliance costs between GPs can be explained by the fact that many GPs undertake more vocational activities than needed to meet *minimum* requirements (eg. one GP undertook the RACGP Fellowship exam although the practitioner was already registered). Also, some Continuing Professional Development activities are more costly than others.

Centrelink costs varied across practices with a reported median cost of $1,768, and 11.3% of GP-related compliance costs (though no practice-based costs). The variations between practices appear to be due to the volume of activity (number of completed forms) rather than the time required to complete each form. Centrelink forms were a source of universal frustration and were perceived to have have limited or no clinical benefit. Workload could be reduced if Centrelink retained the recipients' medical history and reports made on an exception/changed status basis.

DVA costs were relatively low (2.3% of practice-based compliance cost) and for four GPs, DVA forms were too rare for them to give an estimate of time required for completion. Again, variations in costs relate more to the number of forms completed than to the time required to complete them. DVA forms were not reported to be a source of frustration because they are rare and adequately remunerated.

PBS costs are mainly associated with phone authorisation, being the simplest and fastest means of approval. Written authorisations are seldom used because they are considered to be administratively cumbersome. PBS authorisations were reported to be 11.0% of GP-related compliance costs. Most GPs reported that authorisations took between one and two minutes. Therefore, volume tended to be the main compliance cost driver for PBS.

Conclusion

The identified/ reported compliance costs appear to be a significant contributing factor to the operating costs of most GPs and practices based on these case studies. To be properly understood, the compliance cost analysis must be placed in the larger context of general practice, with consideration for the following factors:

- The level of frustration and dissatisfaction associated with some programs may not be proportionate to their actual compliance costs. In particular, SIP and EPC are often negatively perceived for being overly prescriptive and inappropriately influencing the GPs clinical decisions-making *process*, which most doctors find offensive and inadequate. In

comparison, a program such as NPS attempts to measure the clinical decision *outcomes*, which is more acceptable to, and supported by, GPs.

- There is a cumulative effect of paperwork. Each program may be acceptable by itself, however the accumulation of all the programs, plus the paperwork for other activities required to comply with state programs and professional activities, becomes problematic.
- GPs feel that some programs make them responsible for an increasing range of issues, including patients', other health providers' compliance. This is in the context of increased burden of medical liability and eligibility for benefits, which adds to the stress of the profession.

Table 1: Program perceptions

PROGRAM	PERCEPTION
➢ Accreditation ➢ Centrelink and DVA forms ➢ PBS authorisations	– Bureaucratic obligation – Necessary burden
➢ After Hours Care ➢ Rural Loading Payments	– Depends on practice structure and location – Payments perceived as compensation / support
➢ NPS ➢ Teaching ➢ Vocational Registration	– Positively perceived because benefits to clinical practice and no obligation to participate (Choice) – Programs measure the outcomes. – Payments not a primary consideration
➢ SIP ➢ EPC	– Overall negative perception because financial obligation to participate and limited/questionable benefits to clinical practice - Programs impose a framework on processes. – Payments seen as practice income, resented because offensive

1 Background, Objectives and Methodology

On 5 July 2002, the Parliamentary Secretary to the Treasurer asked the Productivity Commission to undertake a research study examining the administrative and compliance costs associated with Commonwealth programs that impact on general practice. The aims of this research study are twofold:

- Identify and describe the main activities and associated tasks undertaken in order to comply with Commonwealth programs; and
- Provide an estimate of the costs related to these activities and costs.

A broad range of consultations has already been undertaken by the Commission, including consultation of interested parties, a pilot survey of GPs, focus groups and an advisory committee.

As a major part of this research study, the Productivity Commission has commissioned a series of thirteen Case Studies to gain insights into the nature and the magnitude of the costs of complying with selective Commonwealth programs and policies. Campbell Research & Consulting (CR&C) was appointed to undertake the Case Study Compliance Cost Project.

The policies and programs that the Productivity Commission wished to examine are:

- The Practice Incentives program (PIP), including the cost of accreditation;
- Enhanced Primary Care (EPC), in particular Health Assessment and Care Planning;
- Requirements associated with GP Vocational Registration and the Royal Australian College of General Practitioners (RACGP) Fellowship;
- Centrelink – assessment for entitlement for disability, illness or injury payments; and
- Department of Veteran's Affairs (DVA) – assessments for entitlement for pension and allowances.
- Pharmaceutical Benefit Scheme (PBS) – phone and written authorisations.

1.1 Objectives

The overall objective of the Case Studies project was to provide specific, detailed information about the activities undertaken by GPs and other personnel working in general practices in order to comply with key policies and programs.

Specific objectives were to:

- Identify and describe the main activities and associated tasks undertaken; and
- Provide an estimate of the costs related to these activities and costs.

An important part of the project was to identify, understand and describe any additional factors impacting on the processes undertaken to comply with the programs and on the differences observed between practices.

1.2 Method

Two considerations were critical in the design of the Case Studies method:

- The need to collect compliance costs data that were as accurate as possible; and
- The importance of subjective factors in the GPs' appreciation of the administrative burden of the specific programs being examined.

To address these two considerations, CR&C developed a methodology combining several elements.

1.2.1 In-depth interviews

A series of in-depth interviews were conducted with several members of each practice participating in the project. Typically, the interviews included the practice principal and the practice manager. When appropriate, other relevant members of the practice were also interviewed (e.g. practice nurse, registrar, and receptionist). In total, the interviews for each practice lasted up to four hours.

During these interviews, the activities in each individual practice to comply with the programs and the practice members' perceptions of the programs were discussed in an in-depth manner. The discussion comprised three main components:

- Contextual information about the practice, including location and socio-economic profile of the patients seen by the practice;
- Level of participation in each program, description of the activities undertaken to take part in the programs, and estimation of time and other resources spent on the programs; and
- Overall issues relating to each of the programs. The GPs were asked to share their general perceptions and opinions of the various programs, and were invited to make suggestions for improvements to the programs.

All the interviews were conducted by CR&C executives, and were audio-recorded. They took place in November and early December 2003.

Despite the time allocated for the interviews and despite the full cooperation of the participating GPs and practice staff, not all programs could be explored in the same depth. Indeed some practices did not take part in some of the programs at all. However, the consultants conducting the interviews ensured that all programs were covered at least once across the thirteen case studies. Furthermore, in agreement with the Productivity Commission, priority was given to the PIP and the EPC programs, which were the most complex programs.

1.2.2 Financial information

Detailed financial and administrative information on the practice was collected. It included:

- The practice Income and Expenditure statement for 2001/2002
- The actual cost categories used by the practice to record expenditure (i.e. chart of accounts) and the expenditure against these cost categories for 2001/2002;
- The actual annual salaries/wages/remuneration levels, or hourly rates for the personnel involved in the compliance activities; and
- The EFT for each GP or member of staff.

Very stringent measures were taken so that the participating GPs could be confident that this information would be used with the utmost confidentiality. In particular, this information was not made available to the Productivity Commission, government or any other party. Reports provide summary information, and do not identify practices or employees.

1.2.3 Quality Assurance

Once completed, each Case Study report was forwarded to the individual practices. This allowed the participating GPs and practice managers to check that the:

- Information collected was accurate; and
- Reports had been comprehensively de-identified.

Practices were invited to send their comments and amendments back to CR&C.

1.2.4 Logbook

Prior to the in-depth interview, a **logbook** was sent to the practices, so that GPs could record the activities, time and resources devoted to the programs during a three-day period.

An example page from the logbook is shown in Figure 1. For each program, the GP was asked to estimate:

- The number of times staff had engaged in activities associated with each program;
- The time taken to complete the activity;
- The personnel involved in completing the activity; and
- The resources (equipment, upgrading, training) required to complete the activity.

Figure 1: Example logbook page

Enhanced Primary Care	Task	Time spent (min) and Personnel involved		Other resources required
		GPs time	Other staff's time (specify)	Please describe
Health Assessment	EG. Home assessment	-	Practice nurse – 60 min	Car – petrol – medical consumable
	1			
	2			
	3			
	4			

The logbook was used mainly as a reminder to help GPs prepare the interview as most of the programs examined were complex, or did not require action on a daily basis. The data obtained from the logbook was used to complement the interview information.

1.3 Case Studies Stratification

The case studies were recruited in Victoria, Western Australia, and South Australia. The recruitment process focussed on the following characteristics:

- Practice size and type: small/solo (1-2 GPs), Group, and Corporate Practices;
- Practice location: inner metro, outer metro, rural/remote; and
- Practice accreditation status and participation to the PIP.

Case studies were focused on characteristics of general practices that provided for a more representative sample including:

- Solo practices (GP);
- Female GP; and
- GPs currently undertaking their Vocational Registration.

The final distribution of the case studies gave a balance of regions and ownership structures (Table 2).

Table 2: Distribution of case studies

	Small/Solo	Group	Corporate	Total
Inner Metro	CS4	CS8 CS12	CS5	**4**
Outer Metro	CS3	CS1 CS7	CS9	**4**
Rural and Remote	CS2 CS11 CS10	CS6 CS13	-	**5**
Total	**5**	**6**	**2**	**13**

1.4 Recruitment

Recruitment of practices was undertaken by telephone from the Campbell Research & Consulting offices in Melbourne. An information package including an introduction letter from the Productivity Commission and a project description was e-mailed or faxed after the initial contact was established.

The assistance and cooperation of Divisions of General Practice (at the national, state and local levels), of the RACGP and of GP Education Australia facilitated the recruitment process. However, despite this assistance, a $300 incentive and reassurance about the confidentiality of all information collected, the recruitment was a lengthy process in several cases.

In total, 40 practices were contacted before fourteen[2] were recruited for the case studies. Six Western Australian practices, 25 Victorian practices, and nine South Australian practices were contacted. A higher response rate was achieved in Western Australia (83%) compared with South Australia (34%) or Victoria (20%). An overall response rate of 35% was obtained[3].

The most commonly stated reason given by practices for refusing to participate were:

- Too busy *"snowed under already";*
- Too much work involved to participate *"onerous";*
- Concerns about the use of the financial information provided;
- Concerns that this would be *"another research project that does not change anything"*; and
- Not enough reimbursement for time involved to participate;

[2] The fourteenth case study with a South Australian practice was cancelled because the project quota had been reached.

[3] This response rate is relatively high for a research project involving GPs and is explained by the support given by the peak body organisations' representative who sometimes participated actively to the recruitment process.

The number of calls and refusal rates for each state is detailed in Table 3.

Table 3: Practices contacted & refusal rates

	Contacted	Refused	Recruited	Response Rate
WA	6	1	5	83%
VIC	25	20	5	20%
SA	9	6	3	33%
TOTAL	**40**	**26**	**14**	**35%**

1.5 Data analysis

The analysis of the findings integrated two distinct methodologies:

- Qualitative data analysis; and
- Compliance cost model analysis.

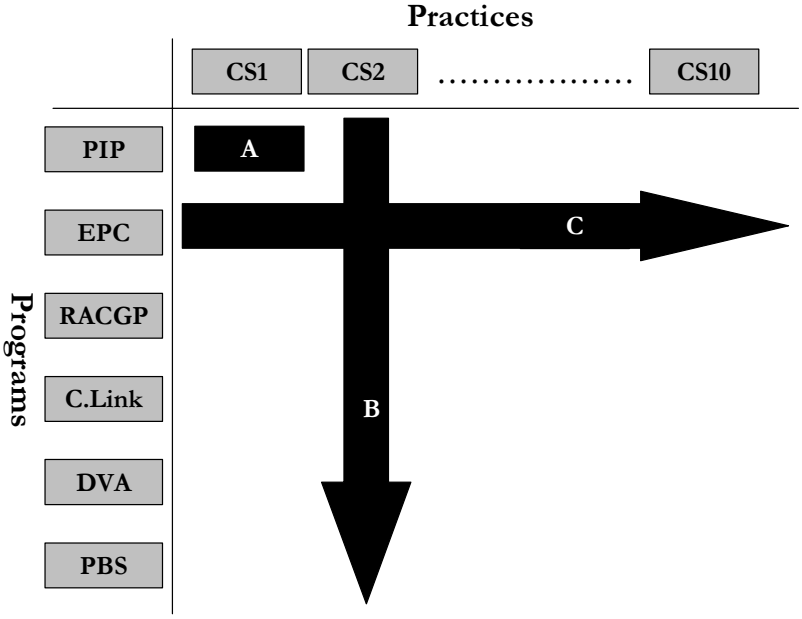
1.5.1 Qualitative data analysis

The qualitative information collected during the interviews was subjected to a thematic analysis and gives substance to the compliance cost analysis.

The data obtained in the interviews was analysed on three levels (Figure 2).

- Information and opinion regarding each program was examined for each practice (A).
- Overall issues regarding compliance for each practice were examined by collating information *across each program* (B); and
- Overall issues regarding compliance for each program were examined by collating information *across each practice* (C).

Figure 2: Levels of Analysis



For each case study, the activities developed by the practice in order to comply with each program were identified and described. Additionally, contextual information was collected to help identify any other factors likely to impact on the activities undertaken to comply with the programs.

An activity map was constructed for each program, whenever this was appropriate. Activity maps are a diagrammatic representation of the individual activities involved in a process. Essentially, activity maps summarise:

- Who undertakes each of the activities that make up the process;
- The order in which these activities take place;
- How long each of these activities take to complete; and
- Any other resources that might be required to complete the process.

Activity maps were constructed for each program for each practice (where the practice took part in the program and where a full account of that process was obtained). When the activities undertaken in order to comply with the programs were very straightforward and limited (eg. Centrelink form completion), an activity map was not deemed necessary.

For each program, one or several activity maps were constructed, drawing from the common activities and tasks developed by the individual practices. The program analysis also describes the differences observed for each program between practices, and the contextual factors that may contribute to explain these divergences.

1.5.2 Compliance cost model design and analysis

The cost model was designed around a few key principles, including:

- The model is **simple** and sufficiently **flexible** to be generally applicable to all general practices;
- The cost model is transparent in its assumptions and methods;
- All material costs are captured;
- The costs captured relate only to the direct requirements of administration and compliance; and
- The methodology enables comparative analysis.

The elements incorporated in the model conformed to the following principles:

- Identification of the *elements* relating to compliance in each of the six programs. This was essentially an inventory of compliance requirements. (The cost analysis for the SIP program is reported separately, notwithstanding it formally being part of PIP.)
- Identification of all material *activities* that relate to each of the cost elements, being sure to adequately define the activities to avoid "double counting" of activities (or costs) across different elements in the same program or with other programs.
- Identification of a common ledger of *cost categories* that adequately reflect the cost elements and costing activities.
- Mapping of the costing elements/activities to a common ledger of costs. Each activity was mapped to the most appropriate cost category item. The cost categories were divided between recurrent and capital cost items. The cost category items were sufficiently comprehensive to capture the activity costs in a meaningful manner.
- Identification of a consistent approach to the costing of the elements and activities.
- Identification of the relative costs of compliance compared to the total practice costs.

The general approach enabled a comparative analysis to be undertaken:

- Across each of the programs;
- Across different cost categories; and
- A comparison between different types and/or locations of general practices.

The cost data available from general practices was not uniform in its content. Practices had different accounting treatments and "charts of accounts" from which the practice costs were derived. The model derived costs for hourly rates for all labour categories from information that was provided as total remuneration, salary, or hourly costs; with or without on-costs. The assumptions for cost derivation with respect to labour costs are identified in each case study.

Insufficient financial details were provided for one case study (Case Study 12). This prevented undertaking a cost analysis for this case study. It was only possible to determine the cost of the time provided by staff on the programs.

1.6 The team working on the project

To conduct this project successfully, Campbell Research & Consulting put together a team of experienced, senior consultants.

Stephen Campbell, Managing Director, has undertaken a large number of projects with GPs, including the Benchmark study of Locum and Deputising services conducted while he was Project Director at RAMIS Corporation in 1994, and the National Profile of General Practices, conducted by CR&C in 1995. He was responsible for quality assurance, overseeing the project, drawing the strategic recommendations, and presenting the results. He also conducted some of the GP interviews.

Dr Isabelle Favre has over 15 years experience in conducting research in the health and social areas. Importantly for this project, she has managed the CR&C Business Models for General Practice project and has a broad expertise of general practice issues. She was the Project Director and was in charge with the overall management of the project, with conducting the interviews, with the reporting and with presenting the results and the strategic recommendations.

Peter Axten, Director of Axten Associates, has over 20 years experience in the health sector including over seven years as a consultant. Peter has been involved in numerous reviews and evaluations of health care programs and organisations preparing feasibility assessments, cost-benefit analysis, financial evaluations and regulatory impact statements, in addition to specific assignments that estimate the costs associated with agency compliance to government requirements. His role was critical in this project, and he was responsible for formulating the cost analysis methodology, for managing the analysis of the results, and for reporting and presenting the cost information.

Aileen Loi has over six years consulting to the health sector. Aileen is an accountant who specialises in the health sector.

David Spicer was the research assistant for this project. He has provided support in all research tasks including recruitment, note taking, write-up of some case studies, and quality assurance of deliverables.

This team ensured that the maximum technical and field expertise were dedicated to the successful achievement of the project.

1.7 How to read this report

This report is Volume 1 of the draft final report for the Case Study Research Project. Volume 1 presents:

- The qualitative analysis of each program (Section 2), including activity maps where relevant;
- The cost analysis by practice type, cost category and program (Section 3).

Volume 2 presents the qualitative and cost analysis for each thirteen case studies.

Please note that no financial information could be obtained from Case Study 12. Therefore, the cost analysis could not be undertaken for this practice, and the comparative cost analysis undertaken for the other case studies used twelve (and not thirteen) case studies as the basis for comparison.

1.8 Acronyms and abbreviations used in this report

Table 4:	**Acronyms and abbreviations used in this report**
#	Number
~	About, approximately
ACIR	Australian Childhood Immunisation Register
AGPAL	Australian General Practice Accreditation Limited
ATSI	Aboriginal and Torres Strait Islanders
CPD	Continuing Professional Development (the most recent term for CME)
CME	Continuing Medical Education
CR&C	Campbell Research & Consulting
CS	Case Study
DMMR	Domiciliary Medication Management Review
DVA	Department of Veterans' Affairs
EFT	Equivalent Full Time
EPC	Enhanced Primary Care
GOC	Gross operating cost
GP	General Practitioner
GPEA	General Practice Education Australia
GPII	General Practitioner Immunisation Initiative
IM/ IT	Information Management & Information Technology
NPS	National Prescribing Service
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentive Payment
PM	Practice Manager
QPI	Quality Process Improvement
RACGP	Royal Australian College of General Practitioners
RRMA	Rural, Remote and Metropolitan Areas Classification
SA	South Australia
SES	Socio Economic Status
SIP	Service Incentive Program
TDR	Treating Doctor's Report
Vic	Victoria
WA	Western Australia

1.9 Disclaimer

Please note that, in accordance with our Company's policy, we are obliged to advise that neither the Company nor any member nor employee undertakes responsibility in any way whatsoever to any person or organisation (other than the Productivity Commission) in respect of information set out in this report, including any errors or omissions therein, arising through negligence or otherwise however caused.

2 Program Analysis

The aim of this section is to describe key compliance issues associated with each program across the thirteen case studies. An activity map describing the main tasks relating to each program is also presented for each relevant program.

A number of key issues have emerged from the qualitative analysis of the case studies and should help understand the cost analysis by presenting critical contextual information. Whereas the cost analysis records the actual staff time and capital resources required to comply with the programs, the qualitative analysis presents factors that may play a determining role in GP compliance and their level of satisfaction with the programs. They shed additional light on the reasons for the growing concerns expressed by GPs about the increasing burden from paperwork and other government requirements.

2.1 Overall issues

2.1.1 The practice size plays a critical role on the program up-take and compliance

Larger practices (group or corporate practices) are able to benefit from more extensive and cost effective administrative and clinical support. For programs such as the PIP or EPC, this support is critical to be able to establish systems and procedures that are essential to program participation. This support is also central when implementing/delivering the programs because they require electronic screening of patients, recalls and considerable administrative management.

Larger practices are also better positioned to participate in the PIP and EPC program because their size allows for economies of scale. The PIP and EPC program require initial investment (in terms of time and capital) that yield better return if they are used by a large number of GPs.

2.1.2 Different programs cause different levels of frustration

The debate around "government red tape" is best understood by analysing the actual dollar cost required to comply with each program. In the context of the levels of frustration and dissatisfaction caused by the programs is a critical factor to fully understand the impact of compliance costs.

GPs had different attitudes towards the programs. The attitudes were determined by the perception of the program and its relevance to clinical practice**Error! Reference source not found.**.

Table 5: Program perceptions

PROGRAM	PERCEPTION
➢ Accreditation ➢ Centrelink and DVA forms ➢ PBS authorisations	– Bureaucratic obligation – Necessary burden
➢ After Hours Care ➢ Rural Loading Payments	– Depends on practice structure and location – Payments perceived as compensation / support
➢ NPS ➢ Teaching ➢ Vocational Registration	– Positively perceived because benefits to clinical practice and no obligation to participate (Choice) – Programs measure the outcomes. – Payments not a primary consideration
➢ SIP ➢ EPC	– Overall negative perception because financial obligation to participate and limited/questionable benefits to clinical practice. – Programs impose a framework on processes. – Payments seen as practice income, resented because offensive.

Centrelink forms, DVA forms, PBS authorisations, immunisation, accreditation (eg some sections of the procedure manual)

These programs cause GPs some frustration because they feel that compliance brings little value to their work. They feel that the programs mainly use their authority as GPs, rather than their clinical skills. When doing this work, they are working for bureaucratic organisations rather than their patients. As such, GPs feel they are just *"jumping through the hoops"* and that these bureaucratic tasks are taking more and more of their time as a result of the *"bureaucratisation of society"*. Some considered that *"It is bureaucracy gone mad"*.

However, in most cases, GPs perceive these programs as a necessary burden to ensure high professional standards for payments made by government toward meeting the patient costs of medical treatment.

The level of reimbursement was also an important factor that determined GP's level of frustration. DVA forms, which were often perceived as bureaucratic, did not cause the same level of irritation as Centrelink forms. This was partly because the reimbursement by DVA was considered adequate, and partly because DVA forms are not as frequently seen as Centrelink forms.

Another common source of frustration associated with these programs arises when GPs feel that their efforts to comply with the programs could be eased by better organisation by the bureaucratic body who initiates the forms and maintains the registers. Integration with medical software used by practices is seen as desirable.

Rural Loading and After Hours Care payments

These PIP activities relate to practice location and practice structures. Decisions on location and delivery of after-hours care were generally made before these payments were introduced. Therefore the payments are unlikely to substantially affect the decision making process. The payments are perceived positively, as compensation and support.

NPS, Teaching, Vocational Registration

These programs and activities are perceived positively because they benefit the GP's clinical practice. Furthermore, they are not compulsory and offer a range of options to chose from, leaving GPs with considerable freedom of action. Payments received for undertaking these programs are not, in most cases, a primary consideration. The programs seem to have enough intrinsic value in themselves to justify GP participation.

Interestingly, the NPS program is received positively by most GPs because the approach to clinical practice-monitoring it adopts is based on *outcome measures*, rather than *process measures*. NPS activities operate using an *audit* approach, where GPs' activities are examined, and advice is given to GPs on how to improve their activities when optimal outcomes are not achieved. This is perceived as being less prescriptive and more constructive than programs such as EPC and SIP.

SIP and EPC

GPs have a number of concerns in relation to EPC and SIP, the programs that caused the most irritation among most GPs interviewed. The irritation is because GPs tend to resent programs that impose a framework on their practice without consideration of the practices' circumstances and GPs' clinical judgement, as is the case with SIP Asthma and care plans. Typically, SIP and EPC focus on framing the process of disease management, which the GPs resent as interfering with their freedom and ability to make appropriate clinical decisions. They argue that what counts is the disease management outcome. GPs' concerns are reinforced by the fact that they feel increasingly compelled to undertake these programs because the practice income (and sometimes survival) is dependant on the payments obtained from participating. Therefore, payments associated with these programs are often resented and perceived as offensive.

2.1.3 Onus of responsibility is on the GP

GPs feel that they are increasingly responsible for a range of issues on which they have only limited influence (such as organising allied health provider to take part in care planning). This additional responsibility for care that may not be under their direct control is said to add to the stress of the profession and to their feeling of being under more and more pressure.

2.1.4 Cumulative effect of paperwork

There is a cumulative effect of paperwork on GPs' frustration levels. Each paperwork activity may be justified and would not raise much concern by itself. However when added together, GPs feel that they spend increasing amount of time away from what they see as their core function, patient clinical care.

One has to add the activities relating to state-specific programs, information sent by GPs representative organisations (eg. Divisions, RACGP, AMA), and professional journals to the activities necessary to comply with the Commonwealth programs examined for this research project. Additionally, two programs were identified as a particularly burdensome: WorkCover, and completing Patient Assistance Transport Scheme (PATS) forms for rural GPS.

2.1.5 Improvement areas

Although GPs universally wish for a reduction of paperwork in their practice, few suggestions for improvement were made. Suggestions that were made are of a general nature, including:

- Some improvement could be made by a better integration of medical software used internally in the practice and externally with Commonwealth agencies and allied health providers;
- Time and frustration would be prevented if Centrelink kept track of the recipients' medical history;
- The availability of electronic submission of forms;
- Some GPs questioned the relevance of the geographical classification (RRMA classification);
- Finally most GPs, rural GPs in particular, would appreciate changes to the prescriptive nature of SIP and EPC activities, to make them outcome (rather than process) oriented.

2.2 Accreditation

Since January 2001, participation in PIP required practices to be accredited, or registered for accreditation. Because the Compliance Costs Project aims at examining the PIP in particular, all the practices recruited had already achieved accreditation.

The activities associated with complying with the accreditation process are divided into three main stages:

- The initial accreditation process;
- The maintenance of the accreditation; and
- The re-accreditation process.

Typically, practices included in the case studies were within the first cycle of accreditation. There were three practices that were re-accredited or undertaking re-accreditation (Table 6).

Table 6: Stage in accreditation cycle

Case Study	Practices in initial accreditation cycle	Practices in re-accreditation cycle
CS1		
CS2		
CS3		
CS4		
CS5		
CS6		
CS7		
CS8		
CS9		
CS10		
CS11		
CS12		
CS13		

The initial accreditation is by far the most costly stage across all case studies. In general, the most substantial cost is the time invested by the practice managers and practice nurses or the GPs to establish and implement the practice procedure manual. In some instances, extra administrative staff had to be hired specifically to take charge of the process. The major costs are not related to capital investment or changes to the practice's existing physical structure, although these non-labour costs can be substantive.

Once the initial accreditation is achieved, the resources required to maintain the accreditation are more limited. Accreditations required less time for multi-site practices, and re-accreditation was anecdotally estimated to be 20% to 25% of the time of initial accreditation. Annual maintenance of accreditation consisted mainly of the nurse's or practice manager's time in checking and maintaining the medical equipment and consumables, and in undertaking tasks related to the accreditation administration.

The re-accreditation of the practice mainly entailed an update of the procedure manual, patient surveys, and some time dedicated to prepare the practice for the surveyors' visit. Re-accreditation was said to be less demanding because it mainly involved updating *existing* systems and procedures, as opposed to implementing new ones. However some GPs expressed concerns that the standards may be raised for each re-accreditation.

A number of key issues were reported in relation to the accreditation process:

- For all practices, the process of accreditation was reported to be costly and *"draining";*
- Although some of the practices considered that accreditation genuinely added value to their work and standards, most reported that it was mainly a bureaucratic process that forced practices to demonstrate the standards that they already had in place;
- Even for the strongest supporters of accreditation, the process and the requirements were perceived to be excessively constraining. Some of the requirements were said to be overly stringent and unnecessary for good clinical care;
- A number of practices felt compelled to undertake accreditation in order to remain in business, because PIP payments are an essential component to maintaining sufficient revenue for the practice. The PIP payments are linked to the practice being accredited; and
- The newly established practices had developed their facilities with the accreditation requirements in mind. This reduced structural costs required by the accreditation process.

Figure 3: Accreditation Process Map

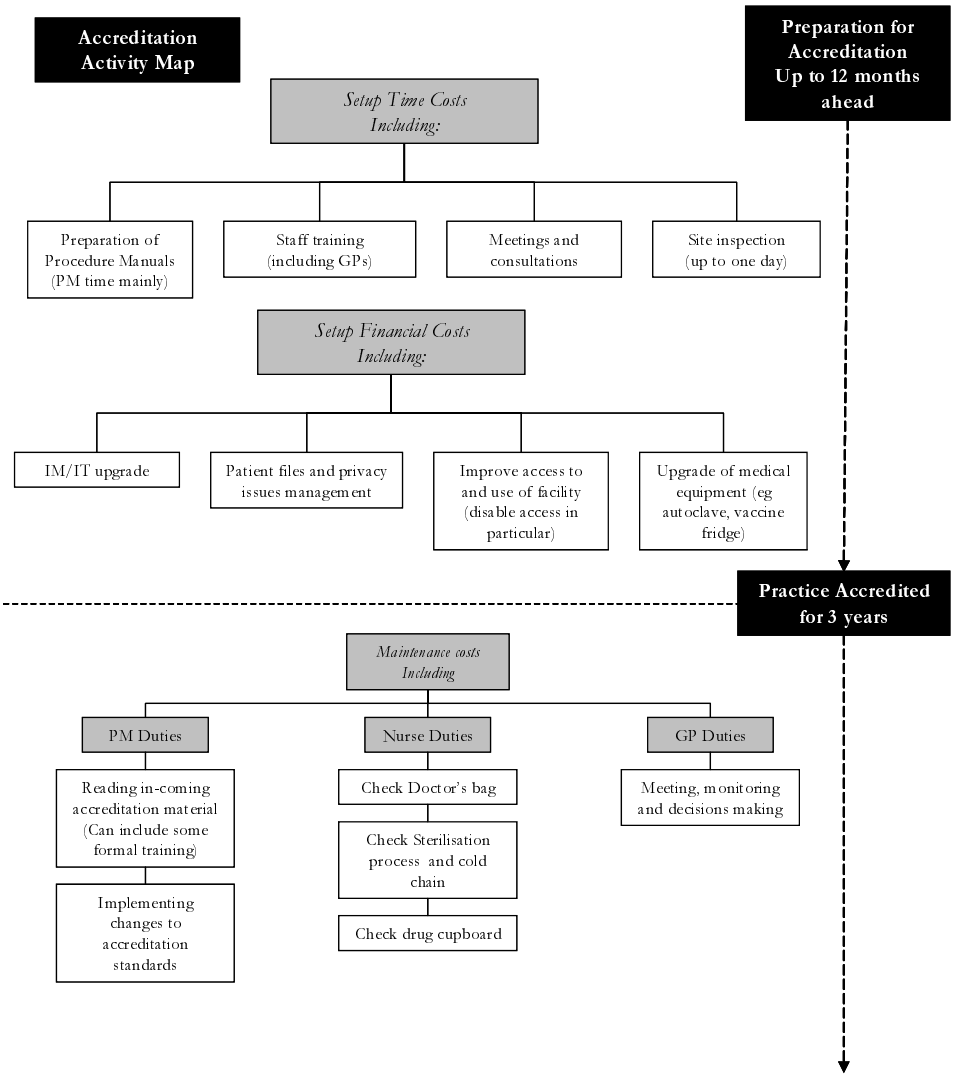
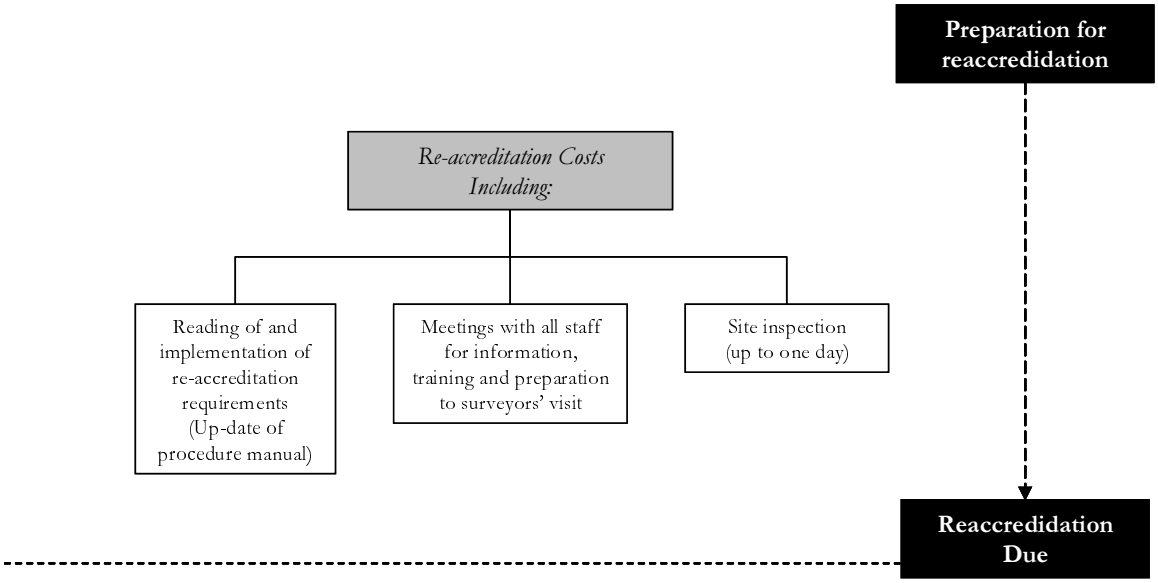


Figure 4: Accreditation Process Map Continued



2.3 PIP

All GPs included in the case studies participated in PIP except for one practice that left the Program until the practice achieved accreditation. The GPs considered that the PIP had major consequences on the practice income. Although some recognised the intrinsic value of the PIP elements, most felt compelled to join PIP in order to maintain a sufficient revenue stream. PIP is a necessary component for financial viability of some practices in the project.

Some mentioned their fear that because general practices are becoming dependent on PIP income, PIP requirements will become more and more stringent, making the GPs increasingly powerless and compelled to comply, no matter what they may think of the impact of PIP on their clinical practice.

Another concern was that many of the PIP elements are not designed for smaller, rural practice. The PIP is considered to require a considerable level of administrative and clinical support, which only larger practices can afford and/or provide.

PIP activities such as SIP and Teaching are not adapted to small or isolated practices, where there is a lack of allied health care providers, and where teaching opportunities are more difficult to provide.

Finally, although most GPs were in favour of a preventative approach to primary care, many stressed that when there is a shortage of GPs in the area, the demand for acute care is too high for them to be able to dedicate the time necessary to programs such as EPC.

There were no outstanding concerns in relation to the administration of the PIP. The initial application was said to be time-consuming, however this happened prior to the observation period (July 2001 - June 2002). Overall there were no major issues with calculation of HIC payments or delays in payment reported by the practices in the project.

2.3.1 After hours care and rurality

Overall, after-hours care and rurality were not perceived to be overwhelming issues in terms of compliance costs. This is because they relate to factors that are largely determined by the environment in which the practices already operated and by the GP's lifestyle choices already made. These factors are unlikely to be critically influenced by the level of payments received through the PIP. Rural loading payments are automatically determined by the practice location. In general, after hours care arrangements have only required minor changes in order to comply with the PIP.

For both programs, PIP compensation was not taken into consideration when choosing a practice location or determining after-hours arrangements, because the impact of these decisions on the GPs' career and lifestyle far outweighs any compensation GPs may receive from PIP. Therefore it could be said that the compliance costs for these two elements are minimal because, in most cases, the decision making process is not determined by the allocation of payments[4]. The methods of determining eligibility may be questioned by some (eg zoning system for rurality). However, payments relating to practice-based elements were perceived favourably as *support and compensation*, rather than as a survival necessity or an obligation to comply.

2.3.2 IM/IT

Most practices established or upgraded their IT systems using the initial Commonwealth grant (1999). The computerisation of the practice is considered a requirement for today's general practice. Therefore the subsidies received are seen positively, as an *incentive* to undertake the computerisation earlier and faster than would have been possible otherwise.

However, there were concerns expressed by a couple of practices that they were becoming more and more dependent on IT. This means that, notwithstanding PIP incentives, they have to carry the costs associated with IT maintenance and upgrade, which can be considerable in particular where none of the practice's staff is interested or skilled in clinical computing and where most IT issues need to be out-sourced.

Clinical computerisation was considered by most to have the potential to bring improvement to the practice management and to the GPs' clinical practice. Improvement is still impeded by:

- The cost of establishing electronic databases from existing information sources;
- The cost of training administrative and clinical staff (including GPs) to use electronic systems (eg. prescribing software, advanced function to undertake recalls electronically);
- The need to create new procedures to replace manual systems of verifications (eg. make sure that all GPs do check the pathology results);
- The lack of integration with existing on-line forms and software.

The support provided by the Divisions and other representative organisations was reported to be useful and appreciated by the practices when they started to address these issues.

2.3.3 Immunisation Incentive program

The Immunisation Incentive program was primarily implemented by the nursing and administrative staff. GPs' time and involvement is limited to completing the Immunisation Register form after the vaccines are administered. The practice needs to provide the Immunisation Register with up-to-date and complete information on the immunisation status of children under five in order to be eligible for PIP payments.

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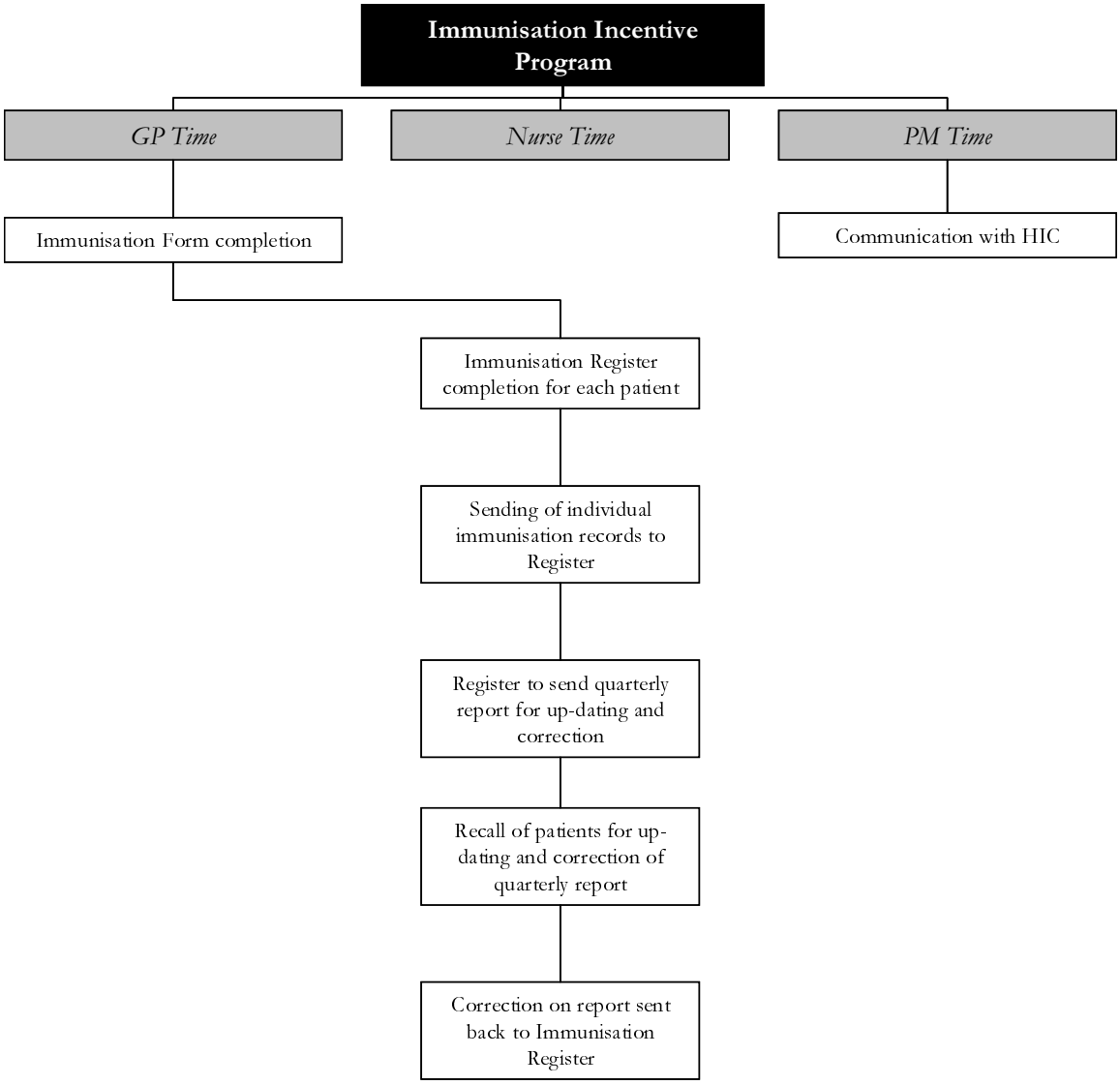
[4] For one case study however, the presence of PIP payments allowed to practice to resume its contract with a locum service, which it could not afford to pay beforehand.

Complying with this program was described as relatively burdensome by the staff responsible, because of the time necessary to correct and adjust the quarterly Immunisation Register report. Some practice managers complained that it is their responsibility to supply the Immunisation Register with correct and complete information even when the patients have not conducted their full immunisation course with the practice. The process of tracking down the immunisation history can be complicated and very time consuming.

Some Divisions are providing support for practices in cleaning and updating immunisation records.

Figure 5: Immunisation Incentive Program Process Map



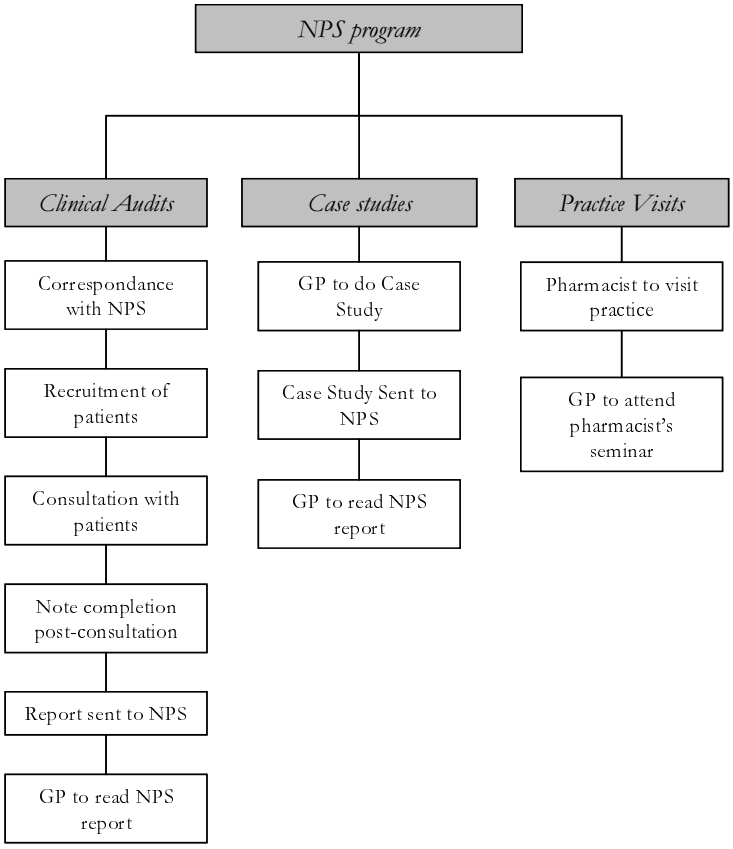
2.3.4 NPS Program (Quality Prescribing Initiative)

Practices are eligible for PIP payments if they participate in three NPS activities per year, including one clinical audit[5].

NPS activities were generally described by the GPs as being well designed and providing useful, constructive feedback on pharmacotherapeutic practices. (Only one GP described the program as *"too time consuming and not worth the dollar"*.) Interestingly, most GPs were unsure of whether or not they were receiving PIP payments for their NPS activities. Their participation in the activities seemed to be motivated as much by the inherent value of the program as by the payments (or CPD points) attached to it. The time spent on complying with NPS activities was seldom raised as an issue because the GPs acknowledged the benefits of the program, and also because they did not feel obliged to participate in the program if they did not wish to.

However, one GP reported that he did not participate in this PIP program because of his failure to motivate other GPs from the practice to take part (PIP payments are based on the level of participation of all FTE GPs in a practice). The quota requirement of the NPS program to be eligible for PIP payments may work as a disincentive to undertake the program when there are concerns that the quota won't be reached.

Figure 6: NPS Process Map



[5] "NPS clinical audits may also be eligible for clinical audit points under the RACGP Quality Assurance and Continuing Education Program. Clinical audits produced by other providers that focus on pharmaco-therapeutics may also be recognised by the NPS as a QPI activity eligible for PIP". (Source NPS website). Because of the overlap of clinical audits across two programs (PIP and CPD), GPs may have mentioned clinical audits under one or the other programs. In order to avoid double counting, we have analysed the activity within the program described by the GP interviewed.

Some GPs were annoyed that incentives are attached to activities, which they considered should be undertaken by all GPs as part of good clinical practice.

Clinical audits were the activity most commonly undertaken by the GPs interviewed. Practice visits, where a pharmacist comes to the practice, were less often reported, probably because this activity is not yet widely available.

2.3.5 Teaching

The take-up of teaching by GPs had little to do with the incentives included in the PIP for participating in the activity. Teaching is an activity that GPs undertake because:

- They enjoy it and find it gratifying;
- They think it is their duty to reciprocate what they themselves were able to access as students; and
- In areas were there is a shortage of GPs, they see teaching as an indirect recruitment procedure. They expect that registrars will come back to work with them once their training is complete.

These motives far outweigh the incentive provided by the PIP. Furthermore, the level of payments ($50 per session) was reported not to reflect the costs associated with teaching, and therefore would not act as an incentive to take up teaching.

The fact that overseas trained doctors are not included in the PIP teaching element was reported to be unjustified and discriminating against rural practices that rely heavily on overseas trained doctors as a major part of service provision.

2.3.6 Service Incentive Payments (SIP)

In November 2001, five new incentives were introduced as part of the PIP. They relate to:

- Diabetes;
- Asthma;
- Mental health;
- Cervical screening; and
- The employment of practice nurses in rural and remote Australia.

The majority of the practices examined took limited part to the SIP initiative. Of the thirteen case studies, practices that did participate in the initiative were mainly large or corporate practice, supported by administrative and clinical staff.

A number of concerns were raised in relation to these new incentives, and may explain that a number of GPs are reticent or decide not to comply with the program.

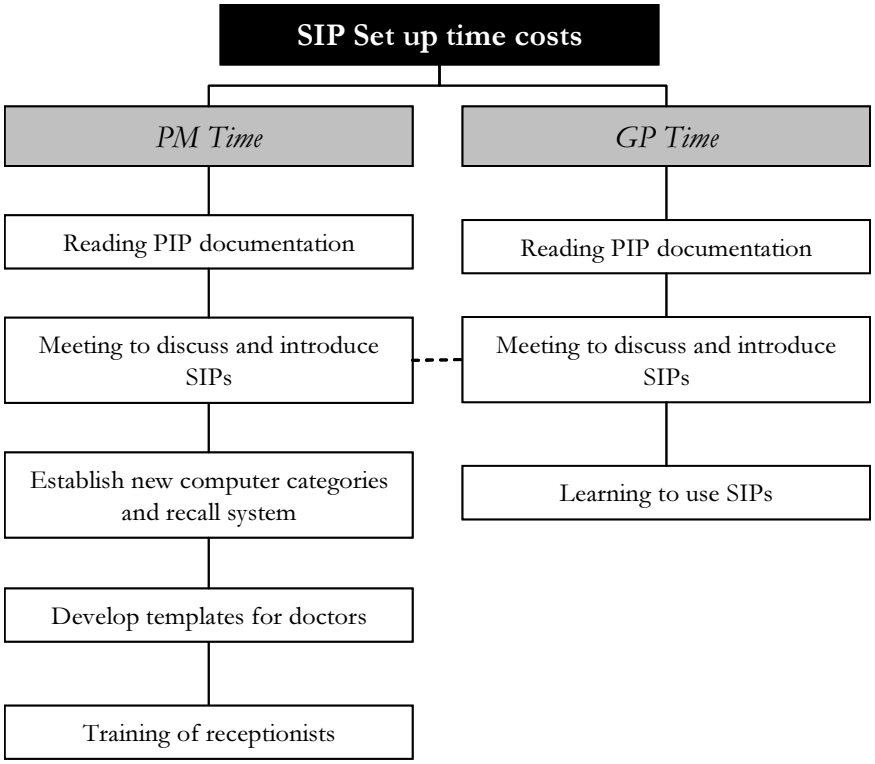
Some GPs disapproved of government initiatives that try to impose or prescribe clinical practices upon GPs. SIP initiatives were seen as overly-prescriptive, because they have a specific framework to which GPs have to conform, even if the framework contradicted their medical knowledge and clinical practice. Therefore GPs may find the SIP initiatives offensive because they imply:

- That GPs do not have adequate clinical practices; and
- That they need to be told (and paid) by the government to work adequately.

GPs reported more positive attitudes toward initiatives that adopt a different approach, such as:

- Peer auditing of their clinical practices;
- Rewarding GPs when their clinical actions and decisions deliver adequate results; and
- Advising GPs they do not produce the expected outcomes (such as the QPI).

Figure 7: SIP Program Set-up Process Map



A number of GPs were critical of the clinical pathways suggested by the SIP initiatives. For instance, they did not think that it was necessary to undertake three visits in order to establish an efficient Asthma care plan, especially since their asthma patients are seldom patients they see for the first time. They felt that the third visit was often not medically justified, and a waste of HIC and patient resources.

The SIP framework was not considered to take into account the existing patient-doctor relationship. The program appeared to assume that all asthma and diabetes patients are new patients, with no pre-existing medical history, and who can be treated in the same, straightforward manner. Conversely, SIP requirements penalise GPs if patients do not comply with all aspects of the recommendations (eg. do not answer to recalls or do not attend repeat visits), which GPs think is beyond their responsibility. GPs reported that SIPs are typically designed for large urban practices that see a large number of patients, rather smaller practices relying on a local, regular and well-known patient-base.

Some GPs also stressed that cervical SIPs have rewarded previous poor medical practice, and penalise good GPs. GPs delivering good continuity of care would not allow patients to go without cervical screening for four years.

Finally, all GPs, even when they recognised the clinical value of SIPs, considered that SIPs were complicated to undertake and required a high level of administrative support. GPs who do not benefit from practice support feel that they are not able to undertake the SIP initiatives easily. SIP initiatives require developing electronic systems and undertaking patient recalls, which are more easily achieved with the support of a nurse or practice manager. Because of the systems and procedures that are necessary to carry out SIPs, practices that do not undertake a large number find them time consuming, and therefore may decide not to go to the trouble of claiming SIP payments.

Figure 8: SIP Program Process Map

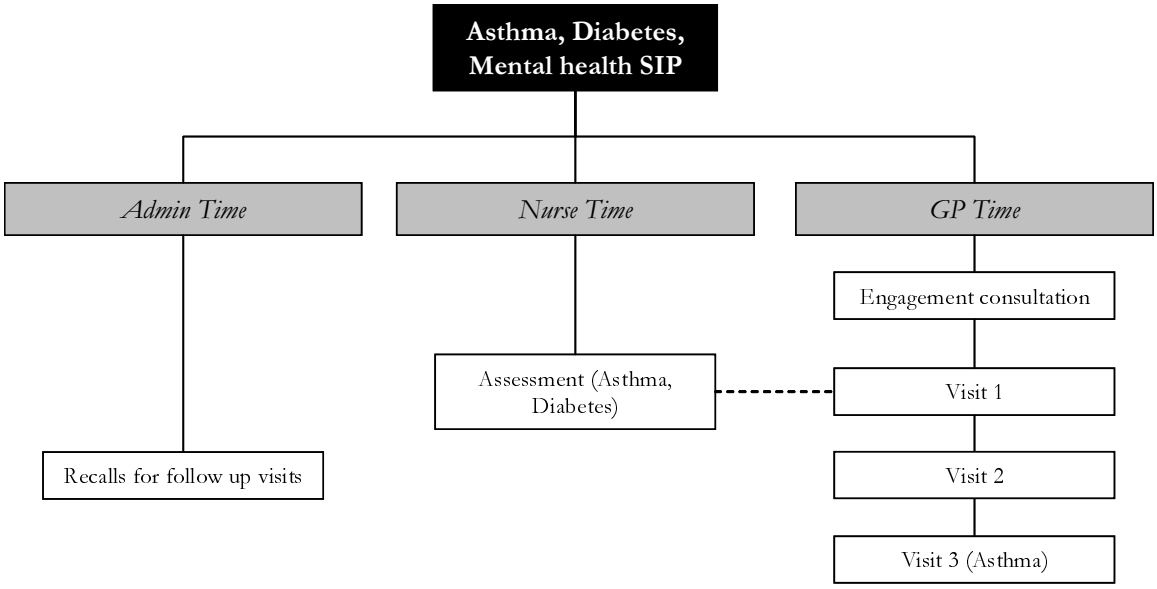
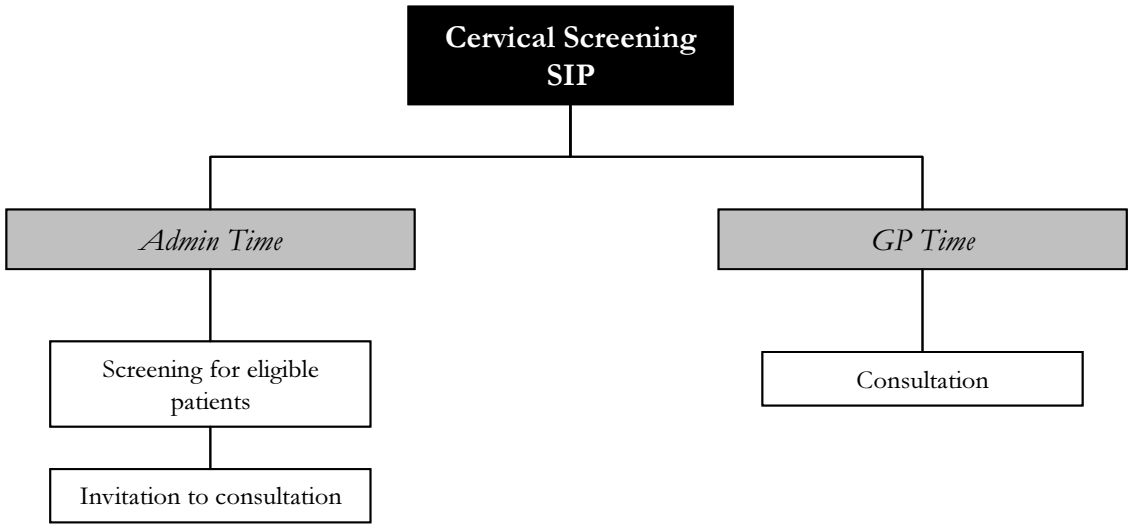


Figure 9 Cervical SIP Process Map



2.4 Enhanced Primary Care (EPC)

Although in general, EPC items are more familiar to GPs than SIPs, a number of the comments made about SIP initiatives also apply to EPC items, in particular to health assessment and care planning. It should be noted that, unlike SIP items, EPC items were rarely criticised for their lack of clinical value. On the contrary, EPC items were often recognised as clinically and financially beneficial, being *"good preventative tools"*. The nature of the GPs' concerns related to the inappropriateness of EPC items to the circumstances of their practice, rather than the intrinsic clinical value of the items.

- The main concern of GPs and other practice staff related to the fact that EPCs are complex to set up and to carry out, and require developed systems and procedures that are more accessible to larger, urban practices;
- Some GPs and practice staff questioned the financial benefit of EPC items once the set-up and administration time required to carry out the items is taken into account. Some said

that the costs involved in carrying out care EPC items (care planning in particular) often outweigh the clinical benefits;

- GPs report that they cannot undertake time-consuming health assessment or care planning when they have a high number of patients waiting to be seen for more acute problems. This is especially true of practitioners working in areas where there is shortage of GPs.
- EPC items are not suitable for isolated practices, because most of the allied health providers required to comply with the items are not easily accessible in smaller country communities;
- Additionally, care planning requires the cooperation of a number of health providers, which some GPs may find hard to achieve or require a lot of administrative follow-up;

Health assessment and care planning were most commonly used by GPs. Case conferences were said not to be appropriate for most general practice situations, except when patients are in a nursing home, because of the difficulties involved in gathering several health providers at a set time. Few GPs had undertaken a Domiciliary Medication Management Review (DMMR) before, often because of the lack of existing relationship with an accredited community pharmacist.

Figure 10: EPC set-up process map

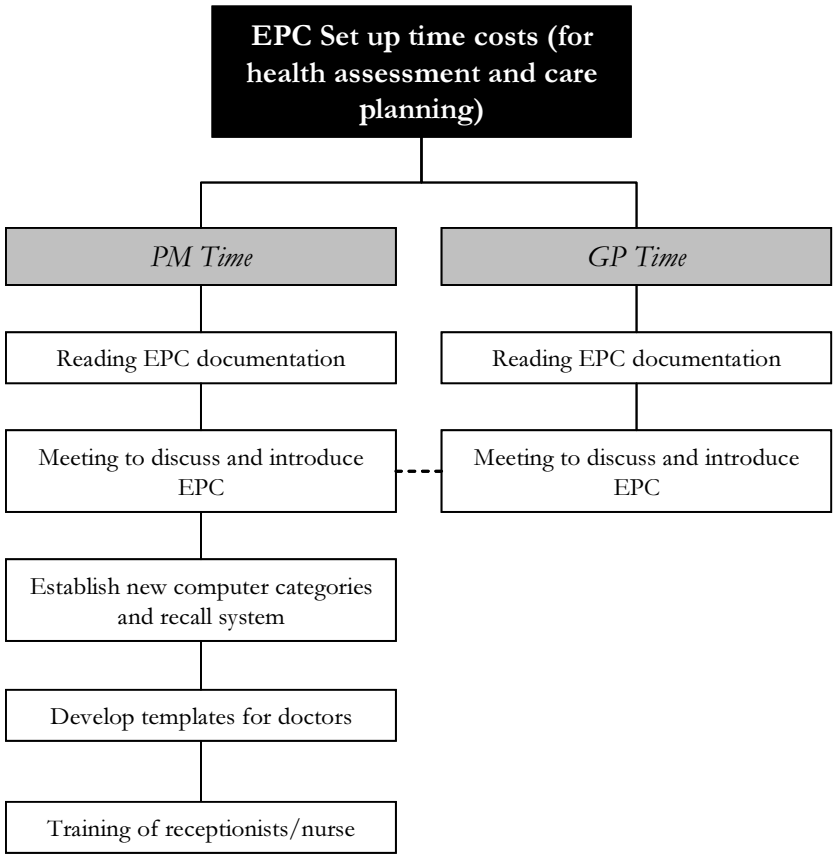


Figure 11: SIP Health Assessment process map

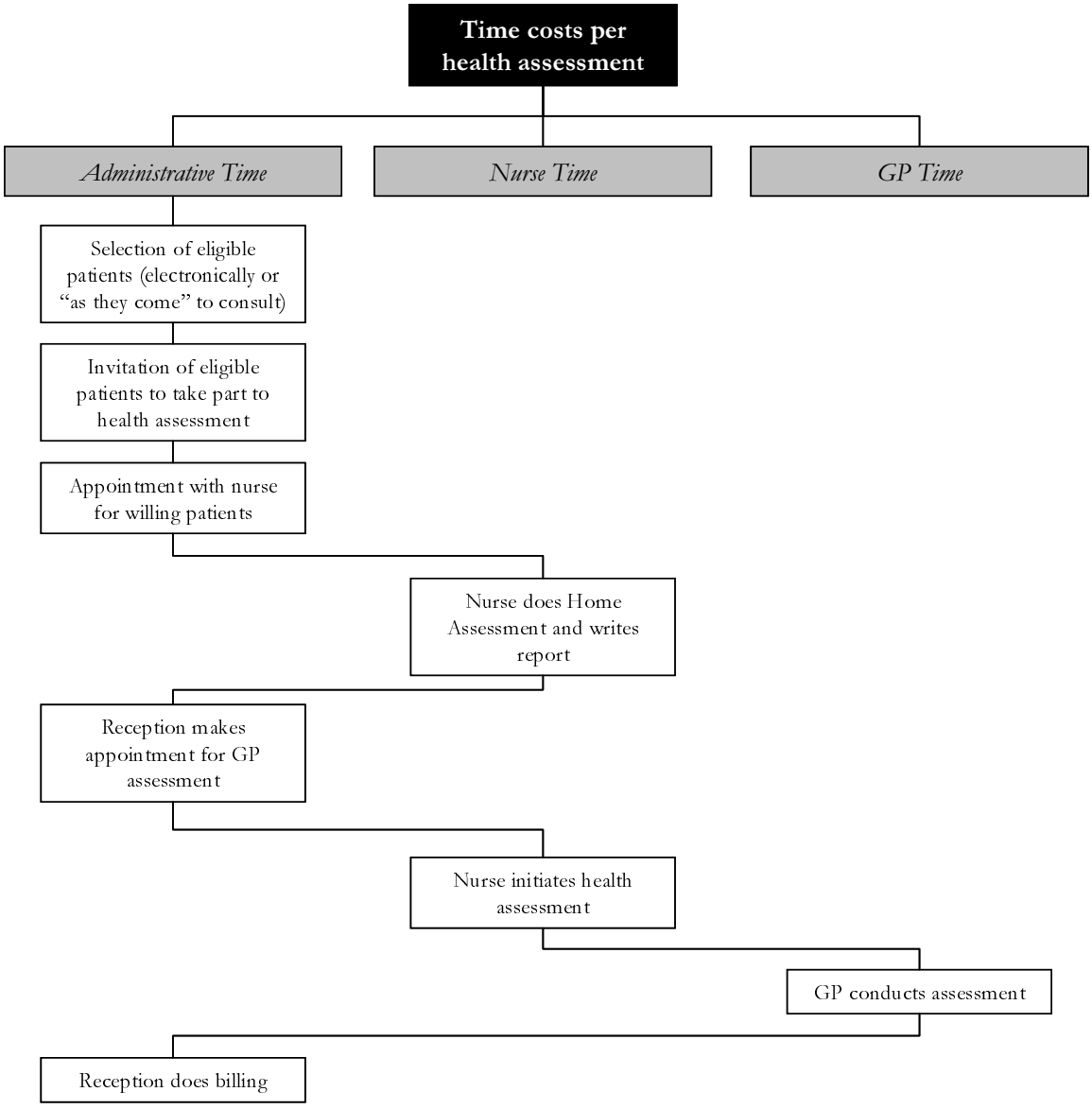


Figure 12: Care Plan process map

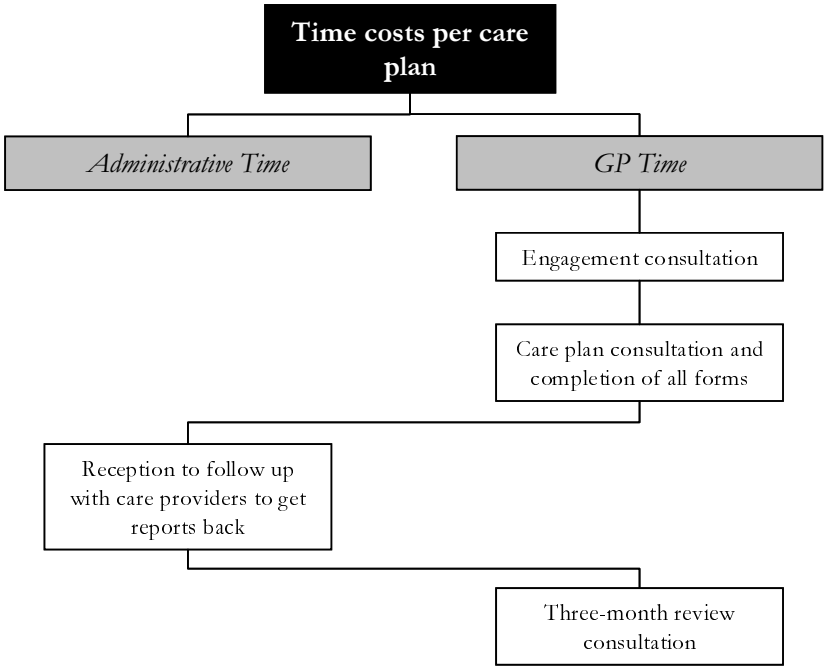
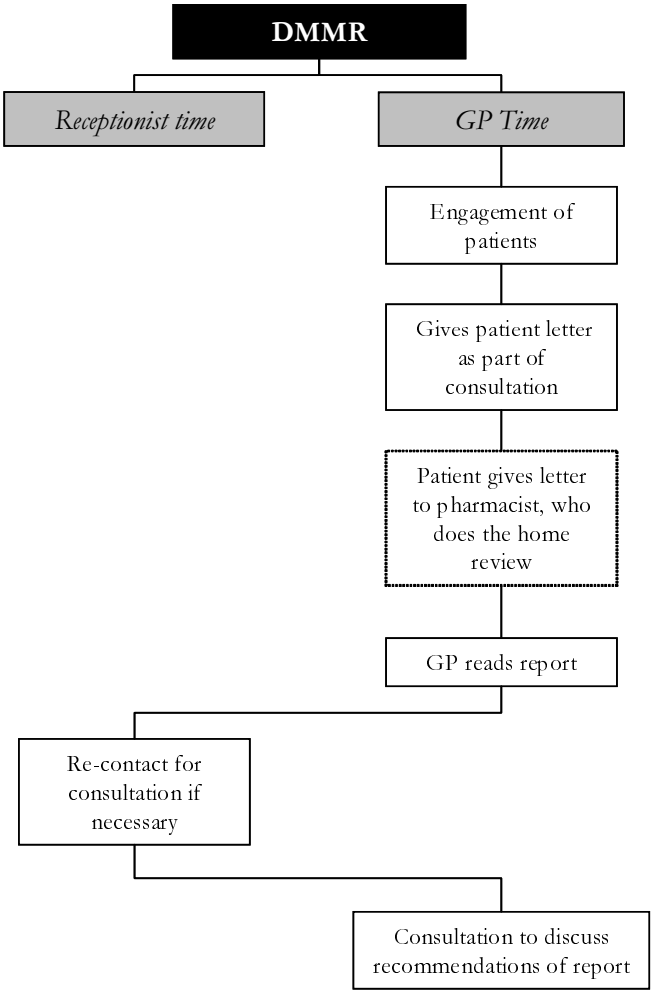


Figure 13: DMMR process map



2.5 RACGP Fellowship

Most GPs interviewed had not undergone fellowship training, as they had been eligible under the "Grandfather Clause". None of the GPs had obtained their fellowship in recent years. However, reliable estimates of RACGP fellowship requirements were given by two GPs:

- In CS13, the GP had benefited from the "Grandfather Clause", but chose to undergo the RACGP exam for their own interest;
- In CS12, the GP interviewed was a registrar. Detailed information on the time and resources required to comply with the program were collected from the registrar and the practice manager; however no financial information was obtained for this practice.

A minority of GPs had decided not to maintain their RACGP Fellowship once vocationally registered.

2.6 Vocational Registration and Continuing Professional Development

Continuing Professional Development (CPD) is still largely known as Continuing Medical Education (CME) among GPs.

All but one (CS12) of the GPs interviewed were vocationally registered practitioners. GPs participated in a number of CPD activities to maintain their eligibility for Vocational Registration. These activities include:

- Attending lectures, seminars, and conferences;
- Undergoing clinical audits;
- Attending peer review meetings; and
- Completing medical journal questionnaires.

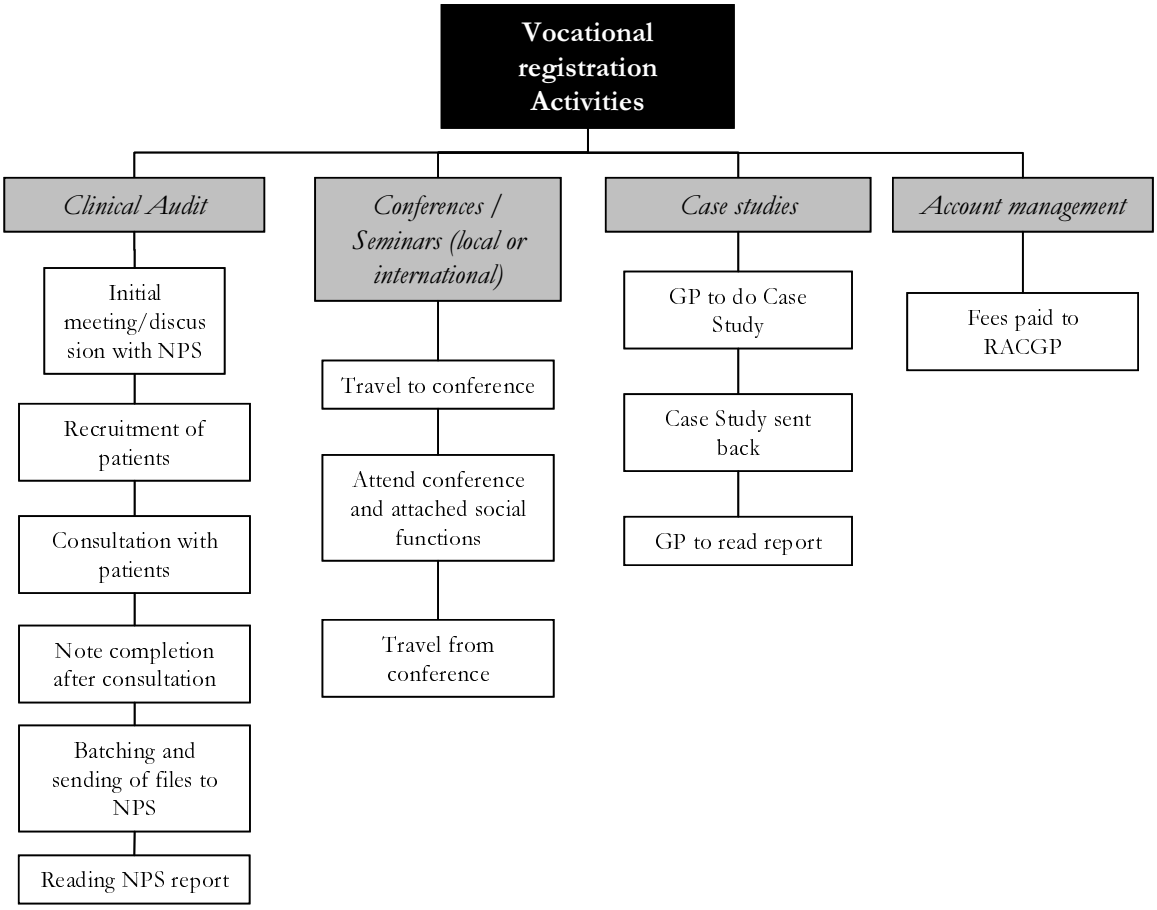
Most GPs acknowledged the benefits associated with these activities in terms of maintaining a current, up-to date knowledge base. On this basis, GPs generally indicated that they would participate in CPD activities, irrespective of Vocational Registration requirements.

The cost of participation in these activities, in terms of both time and financial outlay, varied substantially. Factors contributing to the variation in cost and time include:

- The location of the activity, and consequent travel and accommodation costs;
- The type of activity (ie. conference, questionnaire or seminar); and
- Whether or not the activity was sponsored (eg. by a pharmaceutical company or Division).

It was noted that rural GPs are disadvantaged because there are few subsidised activities in rural areas. The issue of points assigned to activities was also identified as contentious. For example, a 1-point meeting was noted to take up two hours of GP time, due to travel, even in the metropolitan area.

Figure 14: Vocational Registration Process Map



2.7 Centrelink

2.7.1 Key Issues

Completing Centrelink forms was reported as a frequent activity in most practices. Generally, assessments were undertaken as part of a consultation. The consultation itself has not been included as a compliance cost since GPs are reimbursed at least as much as the Medicare rebate for the consultation.

The completion of Centrelink forms raised considerable frustration among GPs. GPs understand the necessity of Centrelink forms to establish entitlements. However, they resent having to undertake what they perceive as mainly a "clerk" role, where they have to follow the patient's or Centrelink officers' instructions so that their patient can receive Centrelink benefits.

Furthermore, GPs felt that the administration of Centrelink forms could be improved if a range of issues were addressed. In particular, reducing the length and repetitiveness of the forms (Sickness Allowance and Disability Allowance TDR forms in particular).

Issues of concern included:

- A report must be completed every two years even if a patient has a permanent, unchanging disability;
- The information required is both too vague (not focusing on the condition of the patient) and too detailed (demanding information that is not related to the patient's condition);
- A complete history must be provided with each report, even when it has been previously provided (ie, Centrelink does not keep a record of the patient history);
- The process is particularly burdensome for patients with complex, multiple diagnoses; and
- GPs reported that as many as six forms were sometimes required for one patient in a single year. If the patient alternated between sickness and disability allowance, the situation was further complicated.

It is notable that GPs considered the recently revised forms to be worse than the old forms, requiring an additional 10 minutes to complete.

Reading the information packs provided for each Centrelink program was also identified as time consuming.

Computerisation was seen as a step forward but the lack of integration with Medical Director and other medical software was identified as a problem. The Centrelink software does not integrate with practice management software, requiring duplication of information.

2.7.2 Disability Allowance Forms

Most GPs indicated they would fill out three to four Disability Allowance forms per week. It was reported that a comprehensive approach to these forms would require an hour to fill out. However, most GPs indicated spending between 12 and 20 minutes filling out these forms. Photocopying previous forms was a common tactic to reduce time.

2.7.3 Sickness Allowance Forms

The time spent completing Sickness Allowance forms ranged from 5 minutes to 20 minutes. Most GPs would complete 2 to 3 forms per week. However, one GP reported doing 1 to 2 per day.

2.7.4 Carer Payments/Carer allowance Forms

GPs perceived no distinction between Carer Payment forms and Carer Allowance forms. Reported time taken to complete these forms ranged from 5 minutes (for a subsequent form) to 20 minutes. In general, GPs reported that they completed these forms about twice per month.

2.7.5 New Start/Youth Allowance Forms

New Start Allowance forms were encountered infrequently by most GPs. Some GPs were unsure what these forms entailed, as they reported never having completed one. Time taken to complete these forms ranged from 5 to 10 minutes.

2.7.6 Mobility Allowance Forms

Mobility Allowance forms were also unfamiliar to some GPs, and were encountered infrequently (once or twice a year) or not at all. They require about 5 minutes, on average, to complete.

2.8 Department of Veterans Affairs

Most GPs reported being adequately remunerated for completing DVA forms, and as such they were not considered problematic. However, they were described as long and complex, and a waste of time as most veterans had full medical cover with the DVA Gold Card. Time taken ranged from half to one

hour, except for one GP who reported they take him only 5 minutes. Some GPs had no DVA patients at all.

2.9 PBS

2.9.1 Phone authorisations

PBS phone authorisations were common for all GPs. The reported frequency ranged from seven to 30 calls per week. Time taken ranged from one minute to seven minutes. Only one GP expressed concerns regarding phone authorisations. He felt the PBS operators often asked inappropriate questions.

2.9.2 Written authorisations

Most GPs avoid writing PBS authorisations. Although the paperwork typically takes only a few minutes, it was described as a convoluted process, requiring the patient to come to the practice before the end of his treatment to order the repeat prescription. The process of authorising restricted drugs was also reported as problematic by one GP, taking up to 10 days to finalise.

3 Activity and Cost Item Analysis

The cost analysis is undertaken at three main levels:

1. ***Overview***, which provides aggregated costs and overall assessment.
2. Analysis of ***Program***.
3. Analysis of ***Cost category***.

There are thirteen case studies that form the compliance cost project. The following cost analysis is based on twelve of these case studies. Insufficient financial information was provided by one participant in the study (CS12) to enable the minimum level of cost analysis.

3.1 Key assumptions

The main assumption has been that only costs assessed to be directly associated with actual compliance requirements have been included in the analysis. Other key assumptions include:

- Labour costs associated with accreditation preparation and surveys that were borne within the practices' current accreditation cycle were included in the costs. The identified costs were then annualised over three years, being the duration of accreditation. These costs were not amortised to reflect present day costs of prior year expenditure as the amounts are deemed to be immaterial.
- Technology costs, whether part of accreditation or not, were annualised over three years to reflect the likely life of the asset, unless the costs were specifically identified as annual costs.
- Major capital improvement was annualised over a two-year period. Minor capital improvements, refurbishment and equipment costs were annualised over five years being the likely life of assets in the sector.
- Vocational Registration of general practitioners requires a specified number of "points" over a three year cycle to retain registration, GP costs associated with Vocational Registration were almost universally identified by practices for the previous twelve month period. Therefore, the identified costs did not need to be annualised over the Vocational Registration cycle. One case study only effectively completed the three years points within the previous year. These costs were not annualised in order to maintain a consistent treatment of costs across the case studies and to reflect the costs associated with sitting the RACGP fellowship examination. There is a related issue that several GPs reported time/costs for Vocational Registration in excess of the minimum number of points necessary to maintain Vocational Registration. The study reported all legitimate Vocational Registration costs. This approach was preferable to selectively omitting the costs of some Vocational Registration activities. However, it would suggest that the report has the tendency to over-estimate Vocational Registration costs required to meet *minimum* compliance.
- Labour costs were identified as, or converted into, hourly costs by the practice-based on the remuneration/salary. Where practices advised of annual salary or remuneration, the derivation of hourly rates have been determined by assuming 260 working days per annum and eight-hour days for all GPs and support staff. The hourly rates include all on-costs. Where practices did not include on-costs in the salary data, and where on-costs could not be directly determined from the *Income & Expenditure* statements for each staff member, an on-cost of 13.5% has been applied to the hourly rate for compulsory superannuation, payroll tax and workers' compensation).

- The reported level of remuneration/salary by practices for GPs may not reflect the total incomes for the GPs in question. The GP income is a function of the remuneration derived from the medical services provided directly by the practitioner (which is captured in all cases), income from the business of the medical practice (which is included to the extent known), income from other professional services and land holdings (not included in the estimate of rates), and distributions from Trusts (which are unknown in all cases). The extent to which GPs choose to split the income from these sources is variable and makes comparative analysis problematic.
- The gross operating cost is the identified recurrent expenditure from the *Income & Expenditure statement* for 2001/02 for all practices. Some more detailed expenditure information has been provided directly by the practices on request. Additional information was derived from the *Payroll Activity Summary* report for 2001/02 for two practices.
- One practice did not provide the minimum income and expenditure information necessary to undertake meaningful (comparative) analysis of the practice. This case study has been excluded from the analysis.

3.2 Overview

The compliance costs for the twelve case studies for which sufficient financial data was available varied considerably as might be expected.

The total practice-based compliance costs for the twelve practices were $168,996. The average cost was $14,083. The median cost was $13,658 or 2.0% of gross operating cost. Actual reported costs across practices varied between approximately $1,872 and $32,373. Overall, practice-based costs as a proportion of gross operating cost varied between 0.6% and 6.3%.

For compliance costs that are specifically GP-related, the study found that the total costs were $279,722 for the twelve practices. The average cost per GP was approximately $23,310 or 11.5% of a GP's "share" of the operating costs of a practice[6]. The median cost was approximately $18,666 or 8.1% of a GP's "share" of the operating costs of a practice. There was extensive variation in the actual and proportional compliance costs across the case studies. The actual GP-related compliance costs varied from a low of $6,796 to a high of $42,508. The individual GP-related costs as a proportion of a GP's "share" of the gross operating cost varied between 3.6% and 33.5%.

[6] The GP "share" of Gross operating costs has been estimated by dividing the gross operating costs by the number of EFT GPs in the practice. The total reported gross operating cost of all practices was a little over 9.1 million dollars. The average GP's 'share' of gross operating cost in the study was $205,430.

3.2.1 Proportional cost for labour and other costs

Nearly all (94%) of the practice-based compliance costs were associated with PIP (Figure 15), while a small proportion were associated with SIP (4%) and EPC (2%).

Considering all compliance costs for GP-related expenses (Figure 16), Vocational Registration accounted for one third (32%), EPC 25% while Centrelink, PBS, SIP and PIP each accounted for close to one tenth of the compliance costs for individual GPs.

Figure 15: Practice-based compliance costs by program

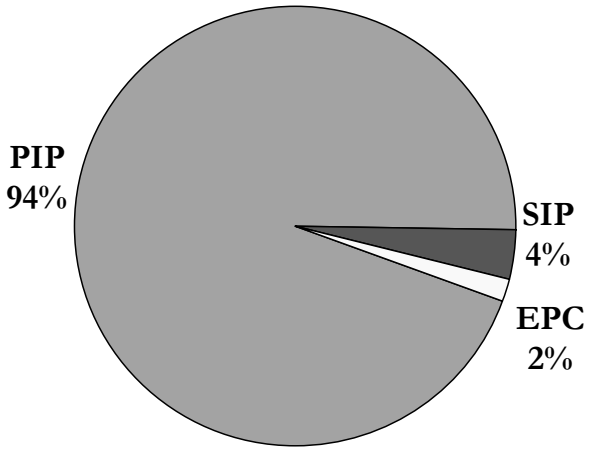
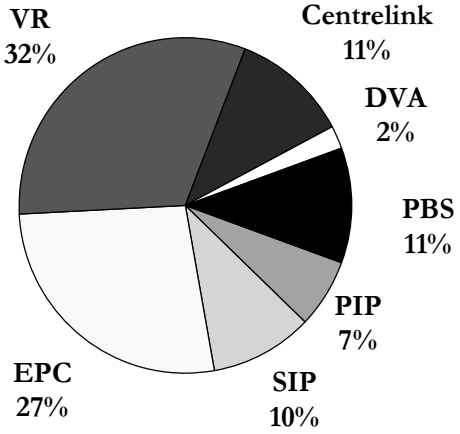


Figure 16: GP-related compliance costs by program



Practice-based compliance costs were mostly distributed over four main cost categories. Just over one third (36%) of practice-based compliance costs were non-labour costs (identified as annualised expenses in Figure 17), with GPs only accounting for one fifth (20%) of practice-based compliance costs.

Practice managers and practice nurses accounted for 39% of practice-based compliance costs, reflecting the high proportion of PIP and accreditation work that is delegated to non-GP staff members.

For GP-related compliance costs, labour categories accounted for nearly all (96%) of the reported compliance costs (Figure 15), while non-labour costs accounted for 4% of total compliance costs. The costs associated with the GPs are the single most significant cost category (86%).

Figure 17: Practice-based compliance costs by cost category

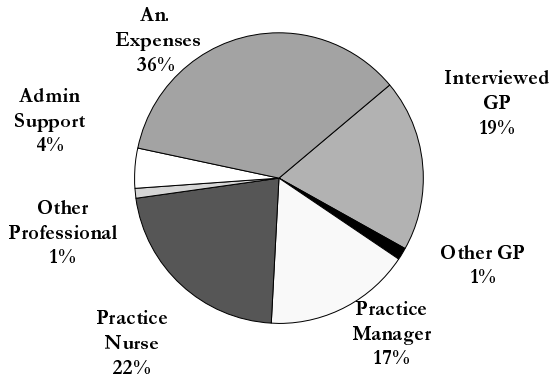
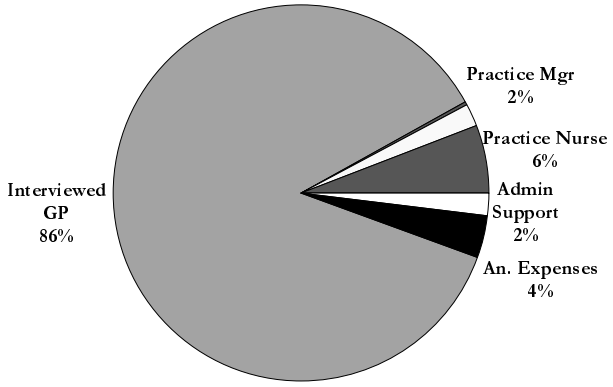


Figure 18: GP-related compliance costs by cost category



Analysis of the practice-based compliance costs by *program* revealed substantial variation (Table 7).

Table 7: The sum of practice-based compliance cost for all practices

Program	Practice Cost							Total	% of practice-based compliance costs
	Labour						Annualised Expenses		
	Interview-ed GP	Other GP	Practice Manager	Practice Nurse	Other Prof.	Admin			
PIP	$30,762	$2,144	$25,499	$32,353	$2,137	$7,384	$59,574	$159,852	94.6%
SIP	$488	$0	$776	$4,527	$0	$24	$360	$6,175	3.7%
EPC	$1,163	$0	$1,688	$65	$0	$52	$0	$2,970	1.8%
Total	$32,413	$2,144	$27,963	$36,945	$2,137	$7,460	$59,934	$168,996	100.0%
% of practice-based compliance costs	19.2%	1.3%	16.5%	21.9%	1.3%	4.4%	35.5%	100.0%	

When analysed by cost category, non-labour costs were the largest component accounting for over one third of practice-based compliance costs. Most of the remainder was accounted for equally by GPs (19.2% by interviewed GPs and 1.3% by other GPs), practice nurses (21.9%) and practice managers (16.5%).

- The PIP (including accreditation) dominating the practice-based costs. PIP contributed approximately $159,852 or 94.6% of total practice-based compliance costs. Just over one third (37.3%) of PIP costs were non-labour costs, primarily associated with accreditation.
- Approximately one fifth (20.6%) of the PIP costs were associated with time spent by GPs (accounted for both the interviewed GP, who was usually the principal of the practice and

other GPs in the practice). Practice nurses (20.2%) and practice managers (16.0%) accounted for similar proportions.

- SIP and EPC together accounted for 5.5% of practice-based compliance costs.
- SIP contributed $6,175 or 3.7% of the practice-based compliance costs. The bulk (73.3%) of the practice-based SIP costs was associated with practice nurses. Only a small proportion (7.9%) was associated with GPs.
- EPC accounted for $2,970 or 1.8% of practice-based compliance costs. These costs were primarily associated with practice managers (56.9%) and GPs (39.2%).

Analysis of the GP-related compliance costs by *program* revealed substantial variation (Table 8), with:

- Vocational Registration being the largest single item. Vocational Registration contributed approximately $88,734 or 31.7% of total GP-related compliance costs;
- EPC costs are estimated to be approximately $75,592, or 27.0%;
- GP-related costs for PIP, Centrelink and PBS are each estimated to account for close to one tenth of the GP-related compliance costs with:
  - PIP estimated to be $18,299 across the twelve case studies, or 6.5% of GP-related compliance costs;
  - SIP, estimated to be $28,197 across the twelve case-studies, or 10.1% of GP-related compliance costs;
  - Centrelink amounts to $31,596 or 11.3% of GP-related compliance costs;
  - PBS provided an estimated $30,825, which is 11.0% of GP-related compliance costs; and
- DVA provided the least cost of the programs with $6,477 or 2.3% of GP-related compliance costs.

Table 8: The sum of GP-related compliance cost for all GPs

Program	GP Cost							Total	% of GP-related compliance costs
	Labour						Annualised Expenses		
	Interview-ed GP	Other GP	Practice Manager	Practice Nurse	Other Prof.	Admin			
PIP	$10,754	$573	$3,934	$2,378	$0	$661	$0	$18,299	6.5%
SIP	$25,595	$0	$452	$1,239	$0	$834	$77	$28,197	10.1%
EPC	$56,869	$0	$1,212	$12,849	$0	$3,511	$1,150	$75,592	27.0%
VR	$79,655	$0	$69	$138	$0	$33	$8,840	$88,734	31.7%
Centrelink	$31,560	$0	$36	$0	$0	$0	$0	$31,596	11.3%
DVA	$6,318	$0	$0	$0	$0	$159	$0	$6,477	2.3%
PBS	$30,800	$0	$0	$0	$0	$25	$0	$30,825	11.0%
Total	$241,551	$573	$5,703	$16,604	$0	$5,223	$10,067	$279,720	100.0%
% of GP-related compliance costs	86.4%	0.2%	2.0%	5.9%	0.0%	1.9%	3.6%	100.0%	

The compliance costs analyses by *cost category* also demonstrated significant differences:

- For practice-based costs, total labour associated with compliance is $109,062 or 64.5% with "other expenses" such as capital refurbishment, IT, travel and accommodation etc making up the remaining 35.5% of costs. "Other expenses" were mainly identified as part of accreditation for practice-based cost.
- For the GP-related costs, the total labour associated with compliance is $269,653 or 96.4%, with other annualised expenses making up the remaining 3.6%. Not surprisingly, GPs themselves were, the single largest contributors, accounting for almost 86.4% of all GP-related compliance costs. "Other expenses" were mainly identified for EPC and Vocational Registration activities.
- Practice managers and practice nurses in particular, are significant contributors to compliance costs. Practice-based costs are 38.4% and GP-related costs are 7.9%. The larger the practice the more significant the role of practices managers and nurses. It is notable that all categories of staff tend to be involved in PIP and accreditation. Practice nurses are also prominent in EPC and SIP activities where these are undertaken. Only GPs are involved in the Centrelink, DVA and PBS activities as might be expected.

3.3 Practice size

For practice-based compliance costs, the proportion of costs associated with GPs varied by practice size (Table 9). In the smaller practices (57.3%) of compliance costs were associated with GPs, for group practices, the proportion fell significantly to 11.7%, while for corporate practices it was only 2.5%. The case studies suggest that the larger the practice the more prominent non-GP time is associated with compliance requirements.

Table 9: Cost categories for practice-based costs

	Interview-ed GP	Other GP	Total GP	Practice Manager	Practice Nurse	Other Prof.	Admin	Ann. Expenses	Total
Small/ Solo	54.9%	2.4%	57.3%	12.2%	2.8%	0.0%	0.9%	26.8%	100%
Group	11.0%	0.7%	11.7%	15.6%	19.3%	0.0%	4.9%	48.6%	100%
Corporate	1.3%	1.2%	2.5%	21.9%	42.8%	4.4%	6.7%	21.5%	100%

For GP-related compliance costs, there was no difference in the proportion of GP-related costs by practice size. GP costs for small and solo practices, for group practices and for corporate practices were 86.7%, 87% and 83.7% respectively.

The non-labour costs did not demonstrate a trend, indicating that non-labour costs were driven by site-specific issues.

3.4 Cost category analysis

Compliance costs were identified across several cost categories including:

- The (interviewed) GP, who was also a proprietor of the practice in eleven of the twelve case studies;
- Other relevant GPs;
- Practice manager;
- Other professionals (eg. IT specialists);

- Other administrative and support staff; and
- Other (non-labour) expenses necessarily incurred in compliance.

There was considerable variation between the practice in the amount associated with each cost category, and in participation in activities by staff. This is summarised in Table 10, and Table 11 below.

Table 10: Total practice-based compliance costs by cost category for all practices

	Mean	Median	Minimum	Maximum	Range	Incurred
Interviewed GP	$2,947	$450	$11	$18,140	$18,129	11
Other GP	$715	$600	$535	$1,008	$473	3
Total GP	$3,142	$649	$11	$18,140	$18,129	11
P. Manager	$2,330	$1,550	$189	$8,973	$8,784	12
Nurse	$4,105	$4,474	$407	$13,625	$13,218	9
Other Prof.	$1,069	$1,069	$14	$2,123	$2,110	2
Admin	$678	$222	$16	$1,711	$1,695	11
Annualised Expenses	$4,994	$3,022	$300	$14,367	$14,067	12

Table 11: Total GP-related compliance cost by cost category

	Mean	Median	Minimum	Maximum	Range	Incurred
Interviewed GP	$20,129	$17,746	$5,822	$39,163	$33,341	12
Other GP	$286	$286	$264	$309	$45	2
Total GP	$20,177	$17,746	$5,822	$39,472	$33,650	12
P. Manager	$713	$491	$16	$2,583	$2,567	8
Nurse	$1,845	$2,443	$7	$3,458	$3,451	9
Other Prof.	-	-	-	-	-	-
Admin	$522	$226	$4	$1,742	$1,738	10
Annualised Expenses	$1,119	$1,000	$77	$2,000	$1,923	9

3.4.1 (Interviewed) General Practitioners

For practice-based compliance costs:

- Total reported interviewed GP costs for the twelve practices was $32,413, or 19.2%.
- The average cost for interviewed GPs was approximately $2,947 with a median cost estimated to be approximately $450.
- The range is again broad from a low of only $11 to a high of $18,140.

For GP-related compliance costs:

- Total reported interviewed GP costs for the twelve practices was $241,551, or 86.4%;
- The average costs for interviewed GPs was $20,129;
- The range is broad from a low of $5,822 to a high of $39,163

3.4.2 Other GPs

The total reported practice-based compliance cost attributed to other GPs is $2,144, or 1.3% of total practice-based compliance costs. Costs associated with "Other GPs" were costs that required another GP to contribute to compliance of the interviewed (prime) proprietor GP.

Only three of the practices reported costs in this category and all costs were associated with accreditation.

3.4.3 Practice manager

The reported cost of total compliance associated with practice-based activities attributed to practice managers is $27,963, or 16.5% of all practice-based compliance costs. Practice managers had some involvement in EPC and SIP, and PIP which tended to be concentrated in only two practices.

Practice manager costs ranged from a low of $189 to a high of $8,973. The average cost is $2,330 and the median cost is estimated to be approximately $1,550.

3.4.4 Practice nurse

The reported total practice-based compliance costs for practice nurses is $36,945, or 21.9% of total practice-based compliance costs. These costs tend to be focused on two programs:

- PIP (including accreditation): 88%; and
- SIP: 12%.

Practice nurse costs were reported across nine of the twelve practices. Three of the smallest practices reported not having practice nurses available.

While the average practice nurse practice-based compliance cost is $4,105, the median cost is estimated to be $4,474.

3.4.5 Other Professional support

There were few reported practice-based compliance costs associated with other professional staff. The costs reported are $2,137, or 1.3% and are entirely associated with PIP and accreditation. Two (corporate) practices reported practices-related compliance costs for other professionals. The professionals reported were mainly technical IT staff/contractors and some professionals experienced in accreditation and manual preparation.

3.4.6 Administrative support

Similarly, there were very few practice-based compliance costs reported for general administrative and support staff. Costs summed to $7,460 or 4.4% of total practice-based compliance costs. However, there was only one practice that reported no costs in this category.

3.4.7 Other costs

"Other costs" are the second most significant cost category. These costs are annualised estimates of non-labour costs and include, inter alia:

- Capital refurbishment and renovations;
- Information technology, information management and telecommunications;
- Travel and accommodation; and
- Equipment.

The reported practice-based compliance costs are $59,934, or 35.5% of all practice-based costs. Over 90% of the costs are associated with PIP and accreditation. EPC is the other two categories that has a small reported material costs of $360.

The proportion of costs between labour and non-labour costs varies across the programs as might be expected.

Table 12: Proportional costs for labour by program

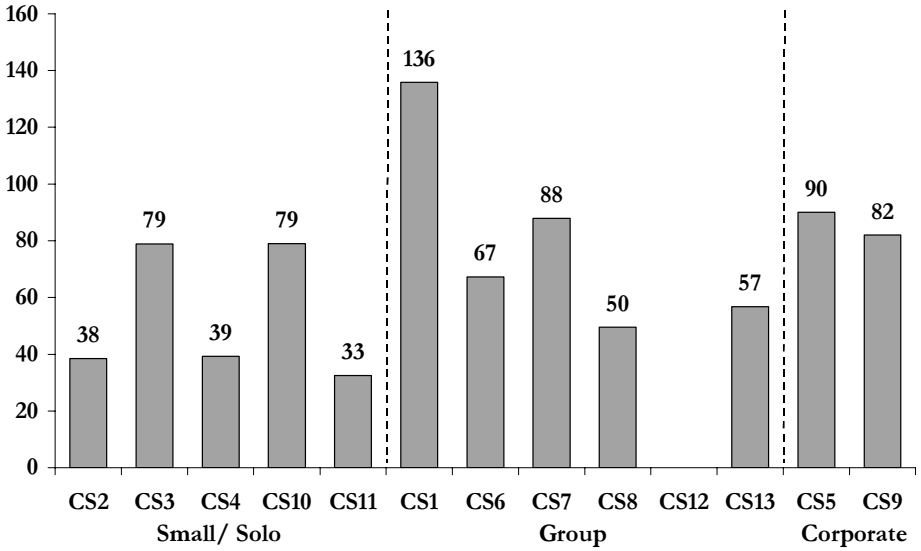
	GP-related cost	Practice–based cost
PIP	100%	63%
EPC	100%	94%
VR	98%	100%
SIP	90%	65%
Centrelink	100%	-
DVA	100%	-
PBS	100%	-

The PIP program has the largest proportion of "Other Costs" predominantly due to accreditation's requirement in relation to the practices' physical improvements.

3.4.8 Comparative hourly rates

A notable contributing factor to GP costs is the estimated hourly rates for GPs (Figure 19).

Figure 19: Interviewed GP hourly rates ($)

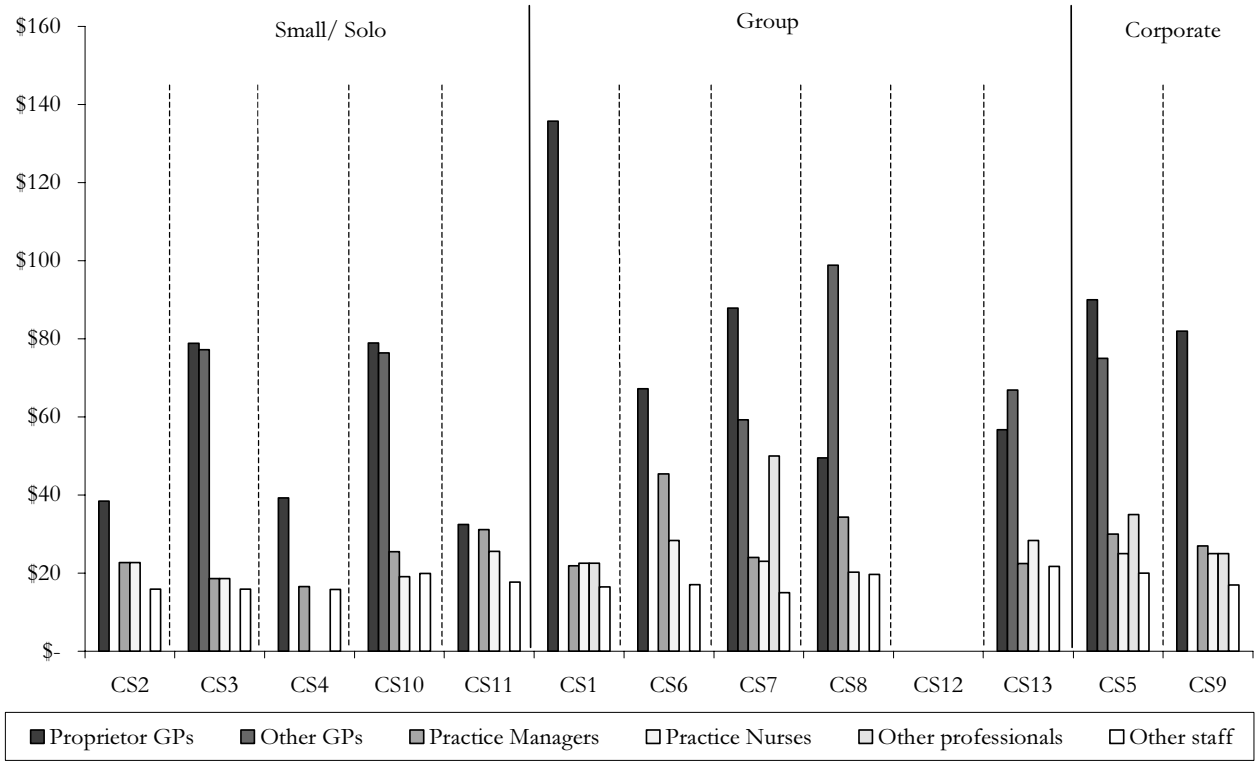


The hourly rates reported or derived for the GPs indicate significant variability. They range from a low of $32.50 per hour to $135.79 per hour; over $100 per hour difference. The median hourly rate is estimated to be $73 per hour across all case studies.

Interestingly, the three lowest hourly rate case studies are small/solo practices. This suggests that small practices are less able to generate returns to the proprietor practitioner. However, there is also a complicating factor where these practices also have spouses that manage the practice, which enhances the capacity for income splitting.

Figure 20 shows the hourly rates for each labour category across the twelve case studies.

Figure 20: Labour category relative cost differences (hourly rate)



The following analysis provides a comparative analysis of the rates between practices and across labour categories.

- The rates for GPs other than the interviewed GP had a median rate of $76.40, which is marginally higher than the $73 median rate for the interviewed GPs. This suggests that the interviewed GPs, who were proprietor GPs in all but one case, may not derive all of their income from the Medical Practice component of the business. CS8 is an illustration of this anomaly, where the proprietor GP is reported to have an hourly rate under $50 but the salaried GP has an hourly rate at almost $100.
- CS13 has costs for other GPs being higher than for the interviewed GP. The interviewed GP was not a proprietor of the practice.
- Hourly rates for practice managers and practice nurses were typically in the low $20s. There were two cases with rates around $30 and two cases with rates at $35 & $40.
- Administrative support staff in the $15-$20 range. One practice has administrative costs over $20 per hour.
- Rates for other professional staff vary depending on the nature of the professional.

3.5 Program cost analysis

There was considerable variation in the level of participation and costs incurred for both practice-based compliance costs (Table 13), and GP-related compliance costs (Table 14).

Table 13: Total practice-based compliance costs by program

	Mean	Median	Minimum	Maximum	Range	Incurred
PIP	$13,321	$13,205	$1,872	$30,665	$28,794	12
SIP	$1,029	$398	$37	$4,380	$4,344	6
EPC	$594	$423	$191	$1,078	$886	5

Table 14: Total GP-related compliance costs by program

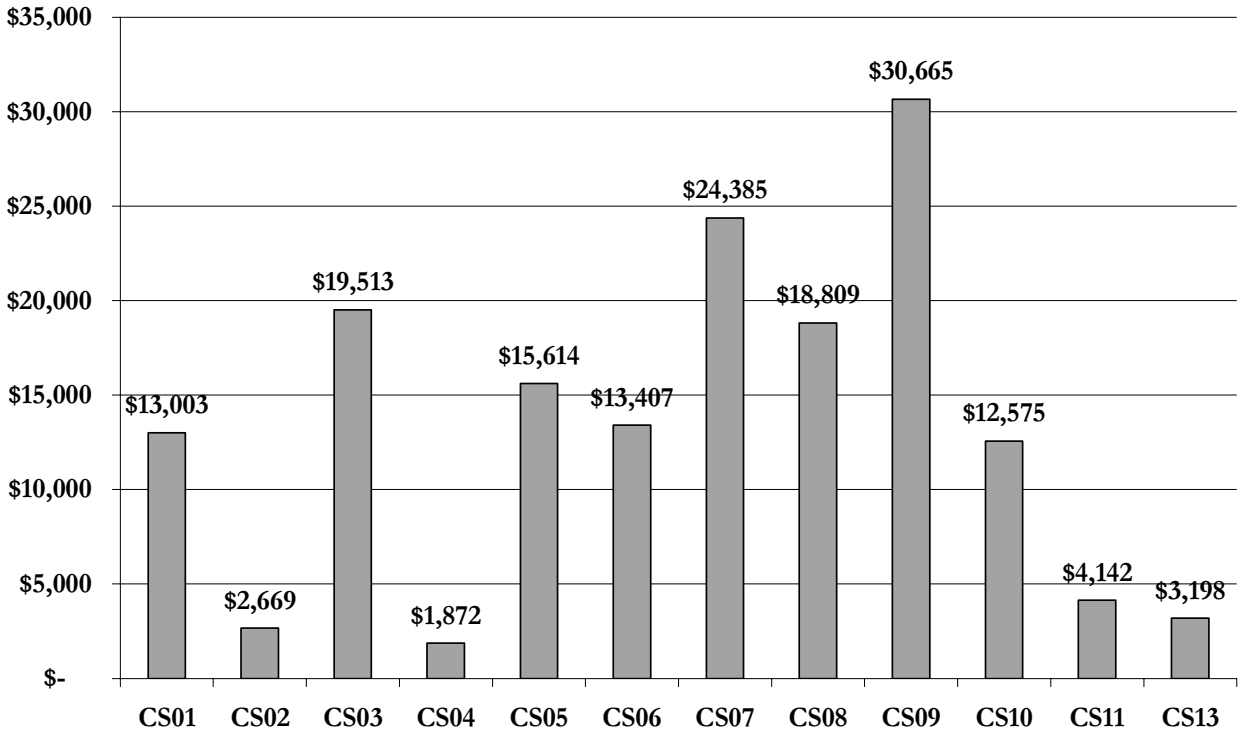
	Mean	Median	Minimum	Maximum	Range	Incurred
PIP	$2,033	$1,069	$309	$7,365	$7,056	9
SIP	$3,525	$1,796	$28	$12,316	$12,288	8
EPC	$9,449	$6,411	$813	$36,661	$35,848	8
VR	$7,395	$5,734	$762	$19,623	$18,861	12
Centrelink	$3,160	$2,582	$543	$8,340	$7,797	10
DVA	$648	$335	$25	$2,212	$2,187	10
PBS	$2,569	$1,938	$656	$5,950	$5,294	12
PIP	$2,033	$1,069	$309	$7,365	$7,056	9

3.5.1 PIP

The practice-based costs of PIP (including accreditation) ranged from a low of only $1,872 to a high of $30,665. Both the mean and median are approximately $13,000. Generally, PIP is the most significant single contributing program to practice-based costs.

The total annualised compliance costs directly attributable to accreditation preparation, accrediting activities and accreditation maintenance was estimated to be $59,537, or 38% of total reported practice-based PIP costs. The initial accreditation is the most costly process, requiring substantial time investment on behalf of the practice manager of the GP proprietor (where there is no practice manager). The re-accreditation is mainly an up-date of existing procedures. The maintenance of accreditation during the period in between accreditation (3 years) requires mainly nurse time.

Figure 21: Practice-based PIP costs



3.5.2 SIP

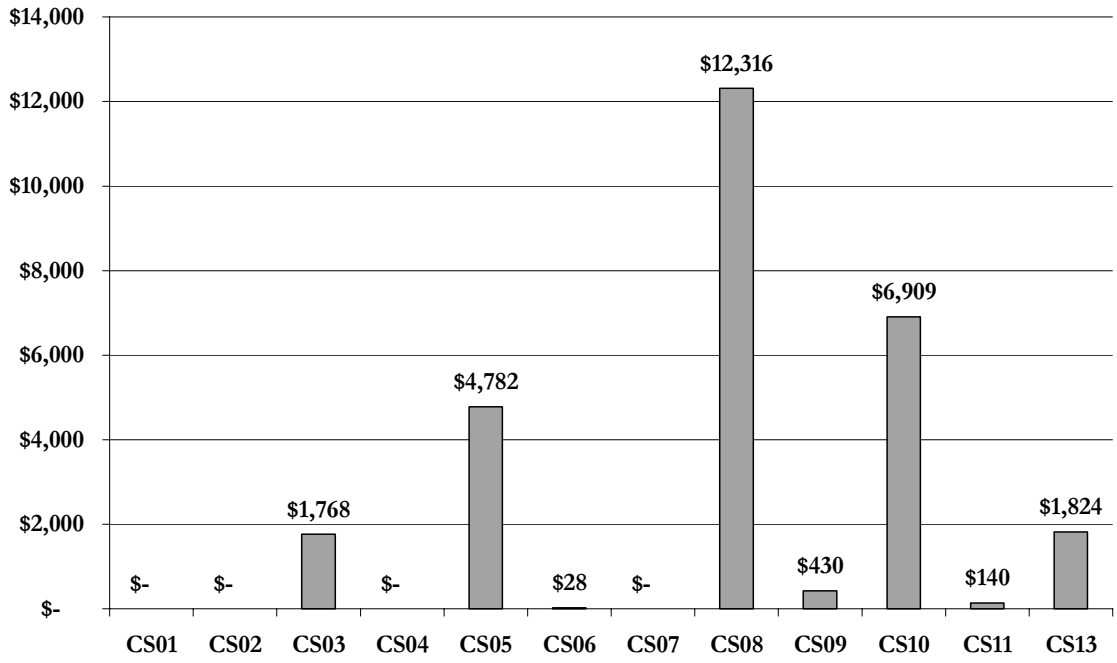
The overall reported practice-based compliance costs for SIP is $34,372. 82% of this cost is GP-related. The provision of GP-related SIP has also been variable across practices for reasons identified in Section 2.3. There are reported costs in eight of the twelve practices. Reported costs ranged from a low of $28 to a high of $12,316. The median cost is estimated to be approximately $1,796.

One practice alone reported total SIP costs of $17,000, which was 32% of the total practice costs. This one practice accounted for 50% of the total compliance costs reported for SIP across all practices.

SIP costs as a proportion of total compliance costs for practices ranged from a low of 0% to a high of 32%. The range of relative costs for SIP is more a reflection of the level of participation in the program rather than any indication of absolute compliance costs for SIP activities. SIP causes a number of concerns to GPs, which may to some extend explain the relatively low up-take of the program. Also SIP is a relatively new program (November 2001).

The overall GP–related compliance cost for SIP was $28.197, or 10.1% of al GP-related compliance costs.

Figure 22: GP-related SIP costs



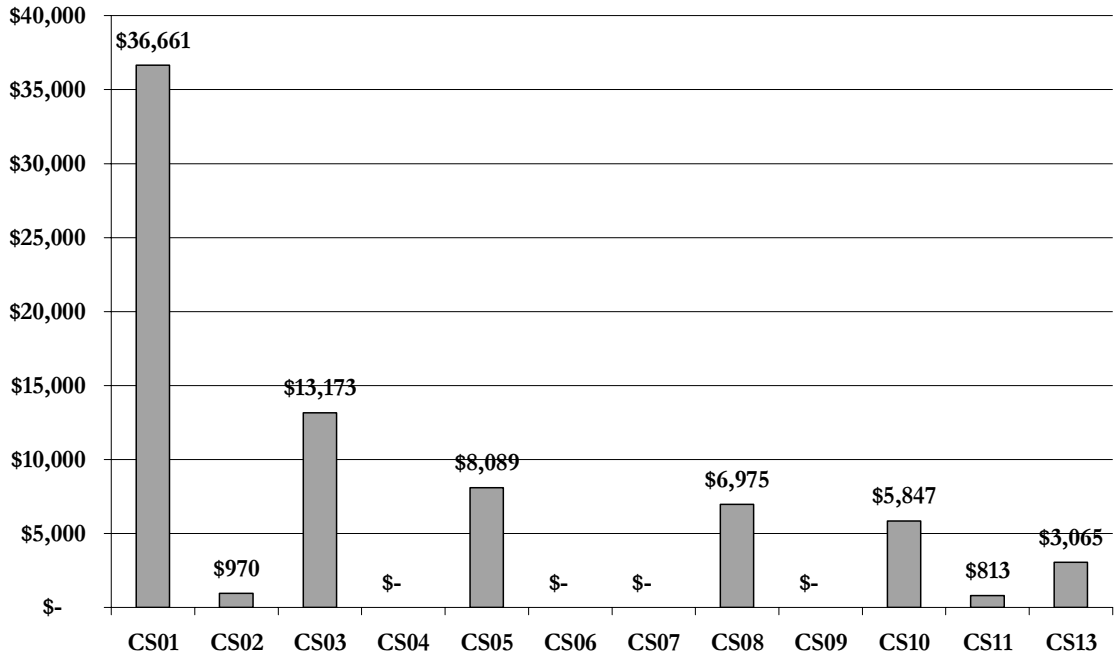
3.5.3 EPC

The cost of EPC also varies substantially, many of the case studies not being active in EPC. The most commonly used EPC items appeared to be Health Assessments and Care Plans. Five practices had reasonable involvement in the program.

GP-related EPC costs ranged from a low of $813 to a high of $36,661. The mean and the median cost was $9,449 and $6,411. The difference is attributed to one high outlier case study (Figure 23).

With the variable involvement of practices in EPC in the case study, and the variability of costs for those practices in the program, general estimates of costs for the program are problematic based on the sample size. The variable involvement of practices may be explained by the concerns expressed by GPs that the program raises such as complex implementation, not adapted to isolated practices, and inappropriate when there is a high load of acute care patients) (see detailed analysis in Section 2.4).

Figure 23: GP-related EPC costs



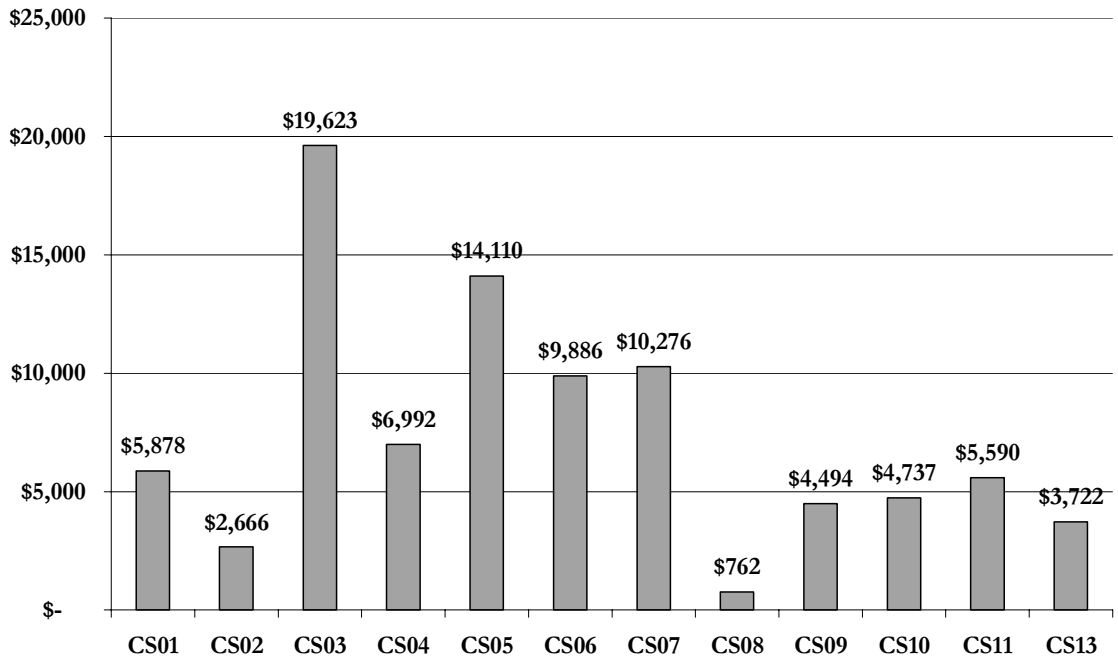
3.5.4 Vocational Registration

Vocational Registration was a notable contributor to costs in most practices. All reported costs were GP-related. The total reported cost across the 12 practices was $88,734. There was one practice that reported very little in the way of Vocational Registration costs ($762). At the other extreme, one practice reported Vocational Registration compliance costs were $19,623. The mean and median cost of all reported compliance for Vocational Registration is $7,395 and $5,734 respectively.

The wide range of variation in Vocational Registration costs is likely to be explained by a combination of factors, including:

- Some GPs undertake more activities than strictly required to received their Continuing Professional Development points (which allow them to maintain their Vocational Registration);
- CPD activities come at very different prices many being subsidised by pharmaceutical companies or representative bodies. Some GPs will try to chose activities that are "cost neutral", whereas other won't.

Figure 24: GP-related Vocational Registration costs

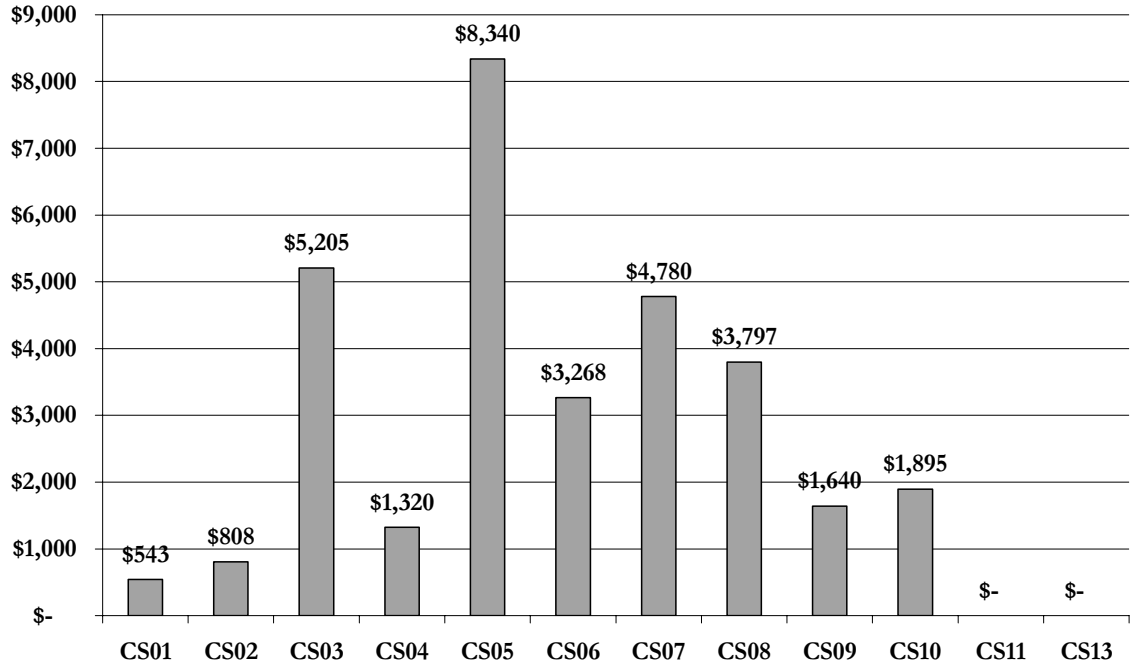


3.5.5 Centrelink

The reported compliance costs for Centrelink is $31,596. Almost all of these costs are attributable to GP time. All practices reported at least some Centrelink compliance costs (Figure 25). Again, they varied considerably from a low of $543 to a high of $8,340. The mean and median cost was estimated to be $3,160 and $2,582 respectively.

The variation in compliance costs is likely to be explained by the number of forms completed rather than the time spent completing each form.

Figure 25: GP-related Centrelink costs

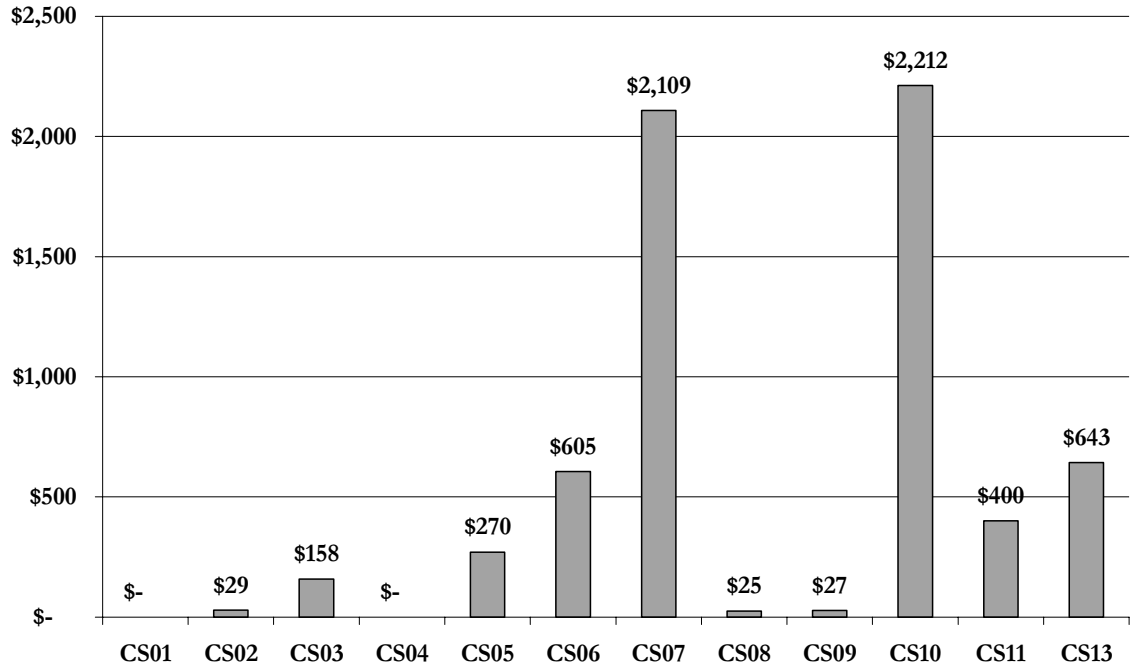


3.5.6 DVA

Reported DVA costs were relatively low at a total of $6,477 across all practices. Virtually all costs are attributed to the GP. There were only two practices that reported costs in excess of $2,000 per annum, no practices reported costs between $1,000 and $2,000, and eight practices reporting costs under $1,000. Two practices reported no costs (Figure 26). The mean and median costs were $648 and $335 respectively.

DVA costs were not identified as a concern for GP and most reported being appropriately recompensed for the time taken to comply with DVA reporting. As for Centrelink forms, the variation is likely to be due to the number of forms completed rather than the time required to complete each form.

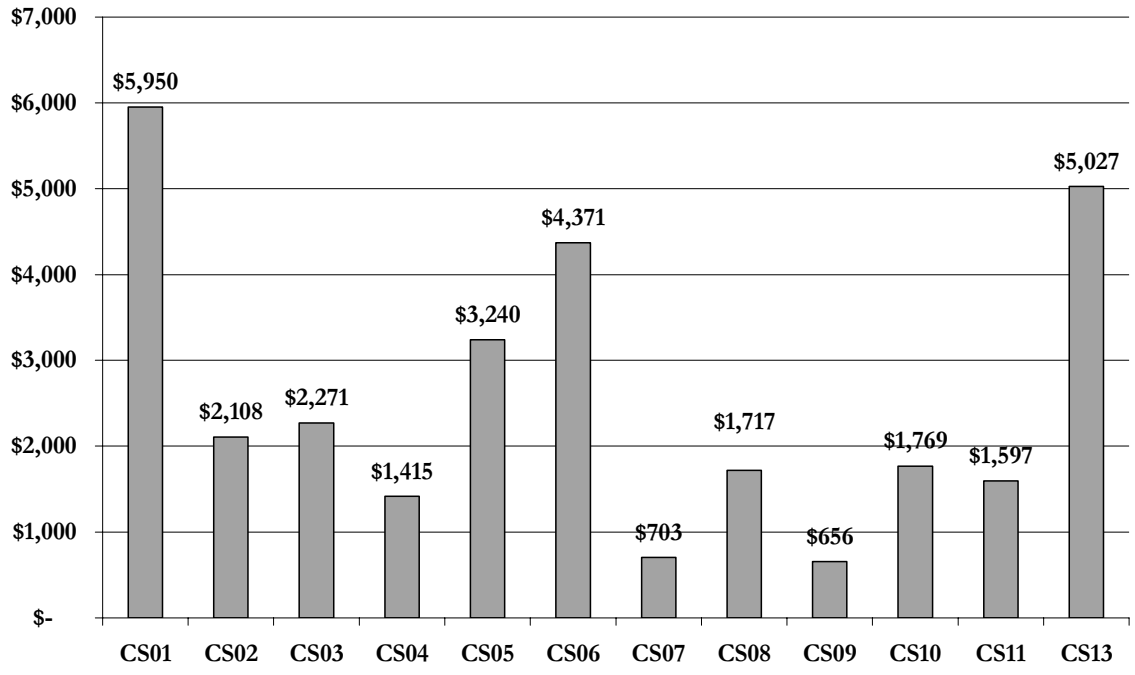
Figure 26: GP-related DVA costs



3.5.7 PBS

Phone authorisation of prescriptions from the PBS is a common cost across all practices, although written authorisation is seldom used. Overall reported costs were $30,825. The reported costs ranged from a low of $656 to a high of $5,950 (Figure 27). The average cost is $2,569 and the median cost is estimated to be approximately $1,938.

Figure 27: GP-related PBS costs



CAMPBELL RESEARCH & CONSULTING

General Practice Compliance Costs

Volume II
Case Studies

A report prepared for

Productivity Commission

28/35 Collins St
Melbourne
VIC 3000

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Background, Objectives and Methodology

On 5 July 2002, the Parliamentary Secretary to the Treasurer asked the Productivity Commission to undertake a research study examining the administrative and compliance costs associated with Commonwealth programs that impact on general practice. The aims of this research study are twofold:

- Provide an analysis of the nature and magnitude of the administrative and compliance costs resulting from Commonwealth policies and programs;
- Provide recommendation in relation to the amelioration of these administrative and compliance costs.

A broad range of consultations has already been undertaken by the Commission, including consultation of interested parties, a survey of GPs, some focus groups and an advisory committee.

As a major part of this research study, the Productivity Commission has commissioned a series of thirteen Case Studies to gain insights into the nature and the magnitude of the costs of complying with selective Commonwealth programs and policies. Campbell Research & Consulting (CR&C) was appointed to undertake the Case Study Compliance Cost Project.

The policies and programs that the Productivity Commission wished to examine are:

- The Practice Incentives program (PIP), including the cost of accreditation;
- Enhanced Primary Care (EPC), in particular Health Assessment and Care Planning;
- Requirements associated with GP Vocational Registration and the Royal Australian College of General Practitioners (RACGP) Fellowship;
- Centrelink – assessment for entitlement for disability, illness or injury payments; and
- Department of Veteran's Affairs (DVA) – assessments for entitlement for pension and allowances.
- Pharmaceutical Benefit Scheme (PBS) – phone and written authorisations.

1.1 Objectives

The overall objective of the Case Studies project was to provide specific, detailed information about the activities undertaken by GPs and other personnel working in general practices in order to comply with key policies and programs.

Specific objectives were to:

- Identify and describe the main activities and associated tasks undertaken; and
- Provide an estimate of the costs related to these activities and costs.

An important part of the project was to identify, understand and describe any additional factors impacting on the processes undertaken to comply with the programs and on the differences observed between practices.

1.2 Method

Two considerations were critical when designing the Case Studies method:

- The necessity to collect compliance costs data that are as accurate as possible;
- The importance of subjective factors in the GPs' appreciation of the administrative burden of the specific programs being examined.

To address these two considerations, CR&C developed a methodology combining several elements.

1.2.1 In-depth interviews

A series of in-depth interviews were conducted with several members of each practice participating in the project. Typically, the interviews included the practice principal and the practice manager. When appropriate, other relevant members of the practice were also interviewed (e.g. practice nurse, registrar, receptionist). In total, the interviews for each practice lasted up to four hours.

During these interviews, the activities deployed by each individual practice to comply with the programs and the practice members' perceptions of the programs were discussed in an in-depth manner. The discussion comprised three main components:

- Contextual information about the practice, including location and socio-economic profile of the patients seen by the practice;
- Level of participation in each program, description of the activities undertaken to take part in the programs, and estimation of time and other resources spent on the programs; and
- Overall issues relating to each of the programs. The GPs were asked to share their general perceptions and opinions of the various programs, and were invited to make suggestions for improvements to the programs.

All the interviews were conducted by CR&C executives, and were audio-recorded. They took place in November and early December 2003.

Despite the time allocated for the interviews and despite the full cooperation of the participating GPs and practice staff, not all programs could be explored with the same depth. Indeed some practices did not take part in some of the programs at all. However, the consultants conducting the interviews ensured that all programs were covered at least once across the thirteen case studies. Furthermore, in agreement with the Productivity Commission, priority was given to the PIP and the EPC programs, which were the most complex programs.

1.2.2 Financial information

Detailed financial and administrative information on the practice was collected. It included:

- The practice Income and Expenditure statement for 2001/2002
- The actual cost categories used by the practice to record expenditure (ie chart of accounts) and the expenditure against these cost categories for 2001/2002;
- The actual annual salaries/wages/remuneration levels/hourly rates for the personnel involved in the complying with the programs; and
- The EFT for each GP or member of staff.

Very stringent measures were taken so that the participating GPs could be confident that this information would be used with the utmost confidentiality. In particular, this information was not made available to the Productivity Commission, government or any other party. Reports provide summary information, and do not identify practices or employees.

1.2.3 Quality Assurance

Once completed, each Case Study report was forwarded to the individual practices. This allowed the participating GPs and practice managers to check that the:

- Information collected was accurate. Practices were invited to send their comments and amendments back to CR&C; and
- Reports had been comprehensively de-identified.

1.2.4 Logbook

Prior to the in-depth interview, a **logbook** was sent to the practices, so that GPs could record the activities, time and resources devoted to the programs during a three-day period.

An example page from the logbook is shown in Figure 1. For each program, the GP was asked to estimate:

- The number of times staff had engaged in activities associated with each program;
- The time taken to complete the activity;
- The personnel involved in completing the activity; and
- The resources (equipment, upgrading, training) required to complete the activity.

Figure 1: Example logbook page

Enhanced Primary Care	Task	Time spent (min) and Personnel involved		Other resources required
		GPs time	Other staff's time (specify)	Please describe
Health Assessment	EG. Home assessment	-	Practice nurse – 60 min	Car – petrol – medical consumable
	1			
	2			
	3			
	4			

The logbook was used mainly as a reminder to help GPs prepare the interview as most of the programs examined were complex, or not requiring action on a daily basis. . The data obtained from the logbook was used to complement the interview information.

1.3 Case Studies Stratification

The first ten case studies were recruited in Victoria and Western Australia (five in each state). The recruitment process focussed on the following characteristics:

- Practice size and type: small/solo (1-2 GPs), Group, and Corporate Practices;
- Practice location: inner metro, outer metro, rural/remote; and
- Practice accreditation status and participation to the PIP.

Three additional case studies were conducted in South Australia and focused on characteristics of GP practices that provided for a more representative sample including:

- Solo practices (GP);
- Female GP; and
- GPs currently undertaking their Vocational Registration.

The final distribution of the case studies gave a balance of regions and ownership structures (Table 3).

Table 1: Distribution of case studies				
	Small/Solo	**Group**	**Corporate**	**Total**
Inner Metro	CS4	CS8 CS12	CS5	**4**
Outer Metro	CS3	CS1 CS7	CS9	**4**
Rural and Remote	CS2 CS11 CS10	CS6 CS13	-	**5**
Total	**5**	**6**	**2**	**13**

1.4 Recruitment

Recruitment of practices was undertaken by telephone from the Campbell Research & Consulting offices in Melbourne. An information package including an introduction letter from the Productivity Commission and a project description was e-mailed or faxed after the initial contact was established.

The assistance and cooperation of Divisions of General Practice (at the national, state and local levels), of the RACGP and of GP Education Australia facilitated the recruitment process. However, despite this assistance, a $300 incentive and reassurance about the confidentiality of all information collected, the recruitment was a lengthy process in several cases.

In total, 40 practices were contacted before fourteen[1] were recruited for the case studies. Six Western Australian practices, 25 Victorian practices, and nine South Australian practices were contacted. A higher response rate was achieved in Western Australia (83%) compared with South Australia (34%) or Victoria (20%). An overall response rate of 35% was obtained[2].

The most commonly stated reason given by practices for refusing to participate were:

- Too busy *"snowed under already";*
- Too much work involved to participate *"onerous";*
- Concerns about the use of the financial information provided;
- Concerns that this would be *"another research project that does not change anything"*; and
- Not enough reimbursement for time involved to participate;

The number of calls and refusal rates for each state is detailed in Table 2.

[1] The fourteenth case study with a South Australian practice was cancelled because the project quota had been reached.

[2] This response rate is relatively high for a research project involving GPs and is explained by the support given by the peak body organisations' representative who sometimes participated actively to the recruitment process.

Table 2: Practices contacted & refusal rates				
	Practices Contacted	Practices Refused	Practices Recruited	Response Rate
WA	6	1	5	83%
VIC	25	20	5	20%
SA	9	6	3	33%
TOTAL	**40**	**26**	**14**	**35%**

1.5 Data analysis

The analysis of the findings integrated two distinct methodologies:

- Qualitative data analysis; and
- Compliance cost model analysis.

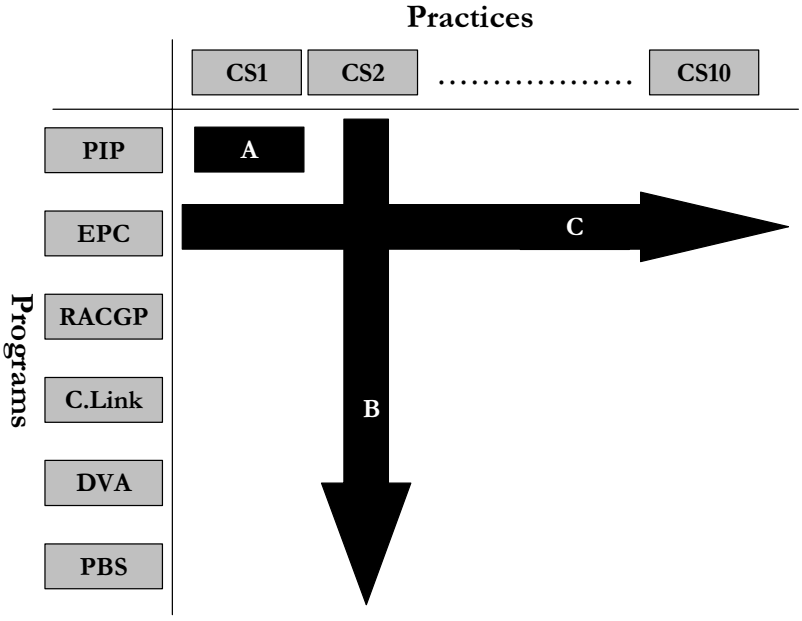
1.5.1 Qualitative data analysis

The qualitative information collected during the interviews was subjected to a thematic analysis and gives substance to the compliance cost analysis.

The data obtained in the interviews was analysed on three levels (Figure 2).

- Information and opinion regarding each program was examined for each practice (A).
- Overall issues regarding compliance for each practice were examined by collating information *across each program* (B); and
- Overall issues regarding compliance for each program were examined by collating information *across each practice* (C).

Figure 2: Levels of Analysis



For each case study, the activities developed by the practice in order to comply with each program were identified and described. Additionally, contextual information was collected to help identify any other factors likely to impact on the activities undertaken to comply with the programs.

An activity map was constructed for each program, whenever this was appropriate. Activity maps are a diagrammatic representation of the individual activities involved in a process. Essentially, activity maps summarise:

- Who undertakes each of the activities that make up the process;
- The order in which these activities take place;
- How long each of these activities take to complete; and
- Any other resources that might be required to complete the process.

Activity maps were constructed for each program for each practice (where the practice took part in the program and where a full account of that process was obtained). When the activities undertaken in order to comply with the programs were very straightforward and limited (eg. Centrelink form completion), an activity map was not deemed necessary.

For each program, one or several activity maps were constructed, drawing from the common activities and tasks developed by the individual practices. The program analysis also describes the differences observed for each program between practices, and the contextual factors that may contribute to explain these divergences.

1.5.2 Compliance cost model design and analysis

The cost model was designed around a few key principles, including:

- The model is **simple** and sufficiently **flexible** to be generally applicable to all GP practices;
- The cost model is transparent in its assumptions and methods;
- All material costs are captured;
- The costs captured relate only to the direct requirements of administration and compliance;
- The methodology enables comparative analysis.

The elements incorporated in the model conformed to the following principles

- Identification of the *elements* relating to compliance in each of the six programs. This was essentially an inventory of compliance requirements. (The cost analysis for the SIP program is reported separately, notwithstanding it formally being part of PIP.)
- Identification of all material *activities* that relate to each of the cost elements, being sure to adequately define the activities to avoid 'double counting' of activities (or costs) across different elements in the same program or with other programs.
- Identification of a common ledger of *cost categories* that adequately reflect the cost elements and costing activities.
- Mapping of the costing elements/activities to a common ledger of costs. Each activity was mapped to the most appropriate cost category item. The cost categories were divided between recurrent and capital cost items. The cost category items were sufficiently comprehensive to capture the activity costs in a meaningful manner.
- Identification of a consistent approach to the costing of the elements and activities.
- Identification of the relative costs of compliance compared to the total practice costs.

The general approach enabled a comparative analysis to be undertaken:

- across each of the programs;
- across different cost categories; and
- a comparison between different types and/or locations of GP practices.

The cost data available from GP practices was not uniform in its content. Practices had different accounting treatments and 'charts of accounts' from which the practice costs were derived. The model derived costs for hourly rates for all labour categories from information that was provided as total remuneration, salary, or hourly costs; with or without on-costs. The assumptions for cost derivation with respect to labour costs are identified in each case study.

Insufficient financial details were provided for one case study (Case Study 12). This prevented undertaking a cost analysis for this case study. It was only possible to determine the cost of the time provided by staff on the programs.

1.6 The team working on the project

To conduct this project successfully, Campbell Research and Consulting put together a team of experienced, senior consultants.

Stephen Campbell, Managing Director, who has undertaken a large number of projects with GPs, including the Benchmark study of Locum and Deputising services conducted while he was Project Director at RAMIS Corporation in 1994, and the National Profile of General Practices, conducted by CR&C in 1995. He was responsible for quality assurance, overseeing the project, drawing the strategic recommendations, and presenting the results. He also conducted some of the GP interviews.

Dr Isabelle Favre has over 15 years experience in conducting research in the health and social areas. Importantly for this project, she has managed the CR&C Business Models for General Practice project and has a broad expertise of general practice issues. She was the Project Director and was in charge with the overall management of the project, with conducting the interviews, with the reporting and with presenting the results and the strategic recommendations.

Peter Axten, Director of Axten Associates, has over 20 years experience in the health sector including over seven years as a consultant. Peter has been involved in numerous reviews and evaluations of health care programs and organisations preparing feasibility assessments, cost-benefit analysis, financial evaluations and regulatory impact statements, in addition to specific assignments that estimate the costs associated with agency compliance to government requirements. His role was critical in this project, and he was responsible for formulating the methodology, for managing the analysis of the results, and for reporting and presenting the cost information.

Aileen Loi has over six years consulting to the health sector. Aileen is an accountant who specialises in the health sector.

David Spicer was the research assistant for this project. He has provided support in all research tasks including recruitment, note taking, write-up of some case studies, and quality assurance of deliverables.

This team ensured that the maximum technical and field expertise were dedicated to the successful achievement of the project.

How to read this report

This report is Volume 2 of the draft final report for the Case Study Research Project. Volume 1 presents:

- The Executive Summary;
- The background and methodology developed to undertake this project;
- The qualitative analysis of each program, including activity maps where relevant; and
- The cost analysis for each program.

This volume (Volume 2) presents the qualitative analysis, the activity mapping and cost analysis for the case studies undertaken for the project.

The outcomes of this research project also include the cost model input sheets for each program and each case study.

Please note that no financial information could be obtained from Case Study 12. Therefore, the cost analysis could not be undertaken for this practice, and the comparative cost analysis undertaken for the other case studies used twelve (and not thirteen) case studies as the basis for comparison.

Case Study Profile

The case studies were conducted in three states (Victoria, South Australia and Western Australia) in Oct Nov 2002. The recruitment focused on practice size, location, and accreditation status.

The distribution of the practices in terms of size and location is described in Table 3.

Table 3: Distribution of case studies

	Small/Solo	Group	Corporate	Total
Inner Metro	CS4	CS8 CS12	CS5	**4**
Outer Metro	CS3	CS1 CS7	CS9	**4**
Rural and Remote	CS2 CS11 CS10	CS6 CS13	-	**5**
Total	**5**	**6**	**2**	**13**

Accreditation status

Typically, practices were within the first cycle of accreditation. There were three practices that were re-accredited or undertaking re-accreditation. The following table indicates whether case studies were in the initial accreditation phase or re-accreditation phase.

Table 4: Stage in accreditation cycle

Case Study	Case Studies in their initial accreditation Cycle	Case Studies in their re-accreditation Cycle
CS1		
CS2		
CS3		
CS4		
CS5		
CS6		
CS7		
CS8		
CS9		
CS10		
CS11		
CS12		
CS13		

Acronyms and abbreviations used in this report

Table 5: Acronyms and abbreviations used in this report

#	Number
~	About, approximately
ACIR	Australian Childhood Immunisation Register
AGPAL	Australian General Practice Accreditation Limited
ATSI	Aboriginal and Torres Strait Islanders
CPD	Continuing Professional Development (the most recent term for CME)
CME	Continuing Medical Education
CR&C	Campbell Research & Consulting

Table 5: Acronyms and abbreviations used in this report	
CS	Case Study
DMMR	Domiciliary Medication Management Review
DVA	Department of Veterans' Affairs
EFT	Equivalent Full Time
EPC	Enhanced Primary Care
GOC	Gross operating cost
GP	General Practitioner
GPEA	General Practice Education Australia
GPII	General Practitioner Immunisation Initiative
IM/ IT	Information Management & Information Technology
NPS	National Prescribing Service
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentive Payment
PM	Practice Manager
QPI	Quality Process Improvement
RACGP	Royal Australian College of General Practitioners
RRMA	Rural, Remote and Metropolitan Areas Classification
SA	South Australia
SES	Socio Economic Status
SIP	Service Incentive Program
TDR	Treating Doctor's Report
Vic	Victoria
WA	Western Australia

Key assumptions for cost estimates

The main assumption has been that only costs assessed to be directly associated with actual compliance requirements have been included in the analysis. Other key assumptions include:

- Labour costs associated with accreditation preparation and surveys that were borne within the practices' current accreditation cycle were included in the costs. The identified costs were then annualised over three years, being the duration of accreditation. These costs were not amortised to reflect present day costs of prior year expenditure as the amounts are deemed to be immaterial.
- Technology costs, whether part of accreditation or not, were annualised over three years to reflect the likely life of the asset, unless the costs were specifically identified as annual costs.
- Major capital improvement were annualised over a two year period. Minor capital improvements, refurbishment and equipment costs were annualised over five years being the likely life of assets in the sector.

- Vocational registration (Vocational Registration) of general practitioners requires a specified number of 'points' over a three year cycle to retain registration, GP costs associated with Vocational Registration were almost universally identified by practices for the last twelve month period. Therefore, the identified costs did not need to be annualised over the Vocational Registration cycle. One case study only effectively completed the three years points within the past year. These costs were not annualised in order to maintain a consistent treatment of costs across the case studies and to reflect the costs associated with sitting the RACGP fellowship examination. There is a related issue that several GPs reported time/costs for Vocational Registration in excess of the minimum number of points necessary to maintain Vocational Registration. The study reported all legitimate Vocational Registration costs. This approach was preferable to selectively omitting the costs of some Vocational Registration activities. However, it would suggest that the report has the tendency to over-estimate Vocational Registration costs to meet minimum compliance.
- Labour costs were identified as, or converted into, hourly costs by the practice based on the remuneration/salary. Where practices advised of annual salary or remuneration, the derivation of hourly rates have been determined by assuming 260 working days per annum and eight-hour days for all GPs and support staff. The hourly rates include all on-costs. Where practices did not include on-costs in the salary data, and where on-costs could not be directly determined from the *Income & Expenditure* statements for each staff member, an on-cost of 13.5% has been applied to the hourly rate for compulsory superannuation, payroll tax and workers' compensation).
- The reported level of remuneration/salary by practices for GPs may not reflect the total incomes for the GPs in question. The GP income is a function of the remuneration derived from the medical services provided directly by the practitioner (which is captured in all cases), income from the business of the medical practice (which is included to the extent known), income from other professional services and land holdings (not included in the estimate of rates), and distributions from Trusts (which are unknown in all cases). The extent to which GPs choose to split the income from these sources is variable and makes comparative analysis problematic.
- The gross operating cost is the identified recurrent expenditure from the Income & Expenditure Statement for 2001/02 for all practices. Some more detailed expenditure information has been provided directly by the practices on request. Additional information was derived from the Payroll Activity Summary report for 2001/02 for two practices.
- One practice did not provide the minimum income and expenditure information necessary to undertake meaningful (comparative) analysis of the practice. This case study has been excluded from the analysis.

Disclaimer

Please note that, in accordance with our Company's policy, we are obliged to advise that neither the Company nor any member nor employee undertakes responsibility in any way whatsoever to any person or organisation (other than the Productivity Commission) in respect of information set out in this report, including any errors or omissions therein, arising through negligence or otherwise however caused.

Case Study 1:
Outer Metro Group Practice

1. Contextual information

1.1 Practice profile

CS1 is a group practice located 22 kilometres from the capital city centre, in a middle-to-lower class suburb. The practice counts a large number of pensioners and health cards holders among their patients, and the practice manager estimates that the average wage in the suburb is between $25,000 and $30,000 per year. The practice does not bulk bill.

The practice was accredited in 2001, and is due for re-accreditation in April 2004. It receives PIP payments for most of the PIP programs.

1.2 Practice size, number of EFT GPs and other staff

The practice employs seven GPs. Six of them work 0.9 EFT, and one works 0.4 EFT. The practice also employs:

- A full time practice manager,
- Four casual practice nurses (0.4 EFT each);
- 2 full time receptionists; and
- 8 part time receptionists (0.8 EFT each).

The interview was conducted with one of the practice principals and with the practice manager.

1.3 Participating GP

Dr CS1 became a Fellow of the RACGP in 1982, after 4 years in pre-fellowship. He works mostly in the group practice, but also does consulting work at a state government program providing home nursing services (about 15 hours a week, on evenings).

1.4 Observation period

1.4.1 Number of patients seen per session by participating GP

Dr CS1 saw 60 patients during the observation period (six sessions). He worked a total of 28 hours, or 4.5 hours per session on average.

1.4.2 Log book completion

Very few sections of the logbook were completed during the observation period. The only activities that were encountered during the observation period were:

- PIP: Accreditation (maintenance), IM/IT (maintenance);
- EPC: Health Assessment;
- Centrelink: Disability allowance; and
- PBS: Phone authorisation.

2. Overall issues relating to program compliance

2.1 General attitude

Dr CS1 does not encounter major difficulties when complying with the programs. This is because he is able to rely on systems and procedures developed by the practice administrative staff and because the practice employs several nurses who play an important role in the PIP and EPC programs. The partners decide which programs to participate in, and develop systems and procedures for use in those programs.

His opinion about the programs is that they are good ideas, but are often difficult to implement, as doctors are in short demand and busy providing acute care. Therefore, there is always a tension between provision of acute care and participation in preventative care programs.

2.2 Program periodicity and burden

Periodicity was not a major factor when undertaking the programs. To some extent some programs are periodic:

- The immunisation incentive program reports have to be dealt with every quarter by the nurse and/or administrative staff;
- A higher number of SIP asthma assessments are likely to be undertaken during the months when the illness is more prevalent.

The initial accreditation process was perceived as a major disruption to the usual work in the practice, because at least one staff member (often the practice manager) had to dedicate several months work to achieve the required standards.

The initial establishment of systems and procedures for PIP and EPC participation was also reported to be very demanding in administrative time.

Consequently, when no or little administrative support is available in the practice, the take up of the programs is likely to be delayed or even prevented.

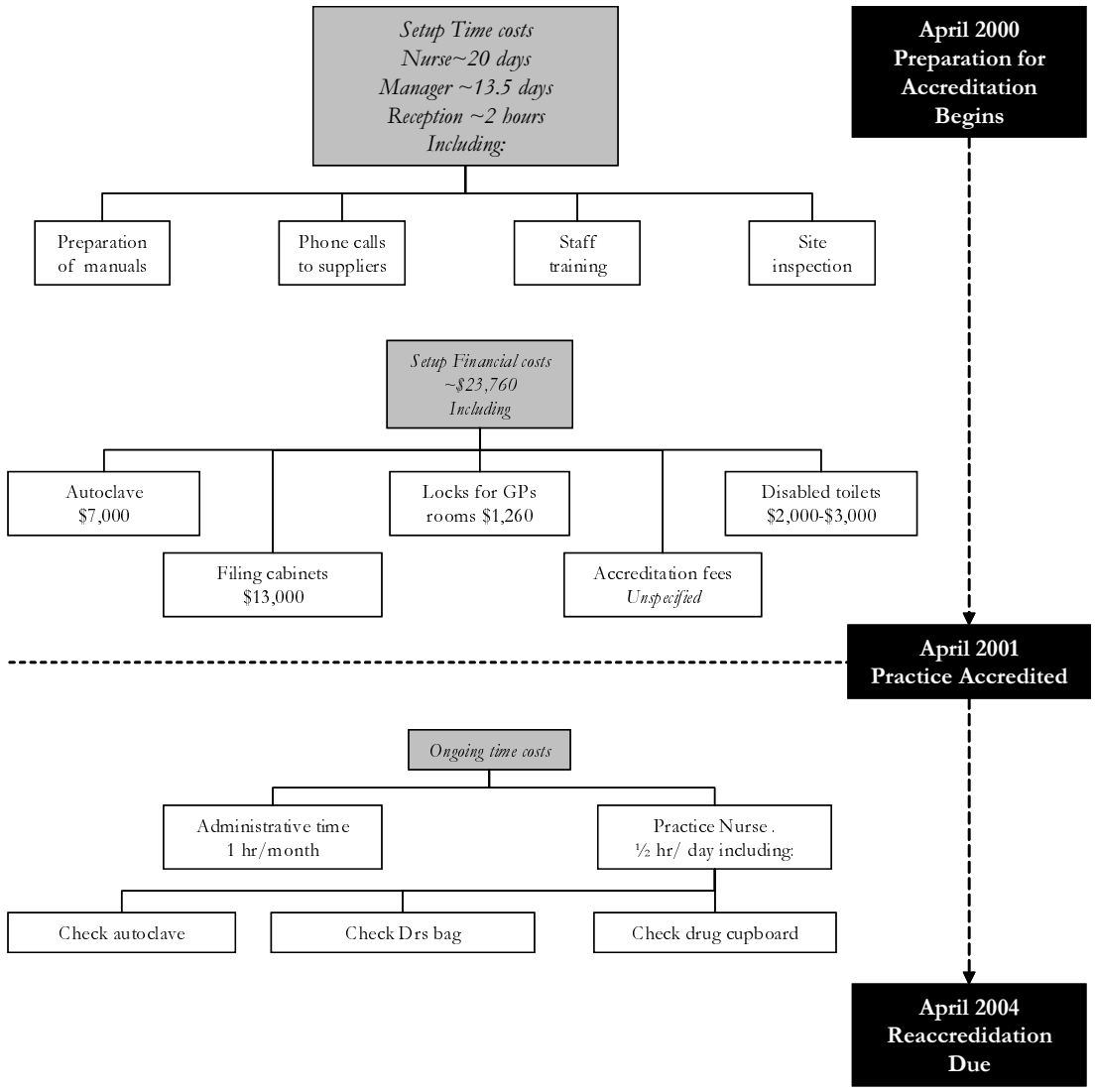
3. PIP Program

3.1 Accreditation

The practice received its accreditation for the first time in April 2001. Re-accreditation is due in April 2004.

The accreditation process started in April 2000, with most of the work done by a practice nurse. The nurse left five months later, and the practice manager took over the accreditation preparation work.

Figure 3: Accreditation activity map



The costs incurred to prepare for accreditation included:

- One day's work per week for approximately 4 months to develop the procedure manuals (nurse time), including 3 or 4 conferences in the capital city (no fee but travel expenses estimated at $700);
- One day's work per week for 3 months for continuing the accreditation preparation work (PM time);
- A large number of telephone calls (ordering, contracting, getting quotes…) estimated to be approximately $150;
- Purchasing and installing a new autoclave ($7,000);
- Purchasing and installing locks for all GP's rooms (12 x $100) and half a day work for handyman ($15 per hour);
- Improvement to the filing system (building of new cabinet) $13,000
- Purchasing and installing a disabled toilet (included in new extension work, estimated at $2,000 to $3,000);
- The training of staff: 2 hour meeting for administrative staff;
- Paying accreditation fees to AGPAL.

The costs involved in the inspection included:

- A one-day surveyor's visit, during which all administrative staff had a 15 minute interview.

The time and costs involved in maintaining the accreditation are:

- 1 hour PM time per month; and
- ½ hour nurse time per day to:
  - check autoclave;
  - check doctors bag; and
  - check drug cupboard.

3.2 IM/IT

The electronic data transfer system has been established since about February 2001. The practice has been in Tier 3 since then. *(DN: No cost identified at this time)*

3.3 After Hours Care

The practice runs a weekly roster listing which Doctors are available for after-hours telephone consultation. Additionally, after-hours calls are transferred to a night clinic. This was done before the PIP, therefore from Dr CS1's perspective, complying with this activity has not created any extra cost. *"It was just a matter of "ticking the box".* The practice is in Tier 3.

3.4 Teaching

Dr CS1 has three students following one of his sessions three times a month. He receives $50 per session per student for this teaching. Dr CS1 reported that the teaching remuneration does not cover the real costs of taking on students:

- Dr CS1 must reduce the number of patients he sees when he has students to allow for discussions before, during and after each consultation.
- The direct compliance cost of the teaching including paperwork etc. is the loss of revenue per teaching session (estimated to be $250 based on one hour, offset by $50 per session.

However he is committed to teaching because:

- "*We like doing it"*
- *"We feel we had good teachers ourselves and we want to reciprocate"*
- *"We hope that one of the students will like the practice and will come back to ask for a job, which at my age is something I consider".*

Consequently, he would still undertake teaching even if there were no $50 remuneration.

Other resources involve are:

- PM time to communicate with the students and the university before and after teaching: ½ hour once a month

3.5 NPS program

3.5.1 Case studies

Dr CS1 has not participated in Case Studies recently. He describes past Case Studies as a small group workshop with practice GPs and a facilitator employed by the Division, taking place over lunchtime for 1 hour. The only cost involved is the lost income, as lunch is provided.

3.5.2 Practice visit

No participation.

3.5.3 Clinical audit

Clinical Audits are associated with vocational registration requirement if they are undertaken as part of vocational registration or of PIP. One clinical audit is required in a three-year period.

3.6 Rural Loading

Not Applicable.

3.7 Immunisation Incentive

Approximately 15-20 immunisations are undertaken per week. According to the GP, the costs are negligible, and only require 15 seconds to fill in the form.

Additionally, the nursing department will spend:

- 5 minutes per patient to check and fill the forms out; and
- 2.5 hours per month checking the immunisation register report.

3.8 SIP

No participation:

"It's too hard to organise, we need to line up 3 consultations, with the last one being claimed on a different item number. We just consult with our patients."

Dr CS1 suggests that:

"It would be better to audit the practices like is done with prescribing, which is a positive and helpful approach. Reward practices that do things right, and develop recommendation for those who don't."

4. EPC

Familiarisation with EPC was done during a 2-3 hour meeting of all partners, during which information on the program was discussed and the decision to implement health assessments was made. There were no other set-up costs for the GP's.

Case Conference and care planning were judged to be too complicated and prescriptive in nature, incurring more costs than benefits for both patients and the practice. For instance, if one requirement of case conference is missed or incorrectly reported, payments are delayed or missed altogether.

CS1 undertakes care plans as part of his work as a consultant in palliative care for the government program. Other GPs in the practice do about 10-15 care plans per year. The practice undertakes about 10 to 15 care plans in total, (however, Dr CS1 does not do any). Dr CS1 undertakes care plans in his own time while working a consultant in palliative care.

4.1 Health Assessment

The nurse spent 2 hours developing a form to enter health assessment summary notes.

About 20 health assessments are undertaken per year. The only "other" resources required are computer use, stationary. No consumable is needed. A practice nurse supports the GP.

The process involves:

1. Nurse does a computer search for eligible patients (5 hours annually, to select all patients eligible for the practice);
2. Nurse discusses the list with GP (5 minutes of GP time);
3. Nurse makes appointment with selected patients (5 minutes per patient);
4. Nurse does a home assessment and makes an appointment time for the health assessment consultation with the GP. Costs: 1.5 hour of nurse time including travel (30 minutes), for which the nurse is paid $40 per patient (including expenses);
5. Nurse enters the data from health assessment (15 minutes);
6. Nurse calls to confirm appointment (2 minutes); and
7. Health assessment with GP (30 minutes).

4.2 Care Plan

Dr CS1 is undertaking 2-3 care plans per week for palliative patients.

Upon referral, Dr CS1 makes appointment to do a home visit. He uses his own car and spends about 30 minutes for the return travel to the patient's home. The assessment as such takes 90 minutes, including the handwriting of the report. The report is then photocopied and sent to other care providers (about 2-3). This takes approximately 15 minutes of administrative staff time (plus stationery).

A follow up consultation is done 7 to 10 days later, this is charged as a normal home consultation (not an EPC item).

There are no three-month care plan reviews because patients are usually deceased.

Figure 4: EPC setup activity map

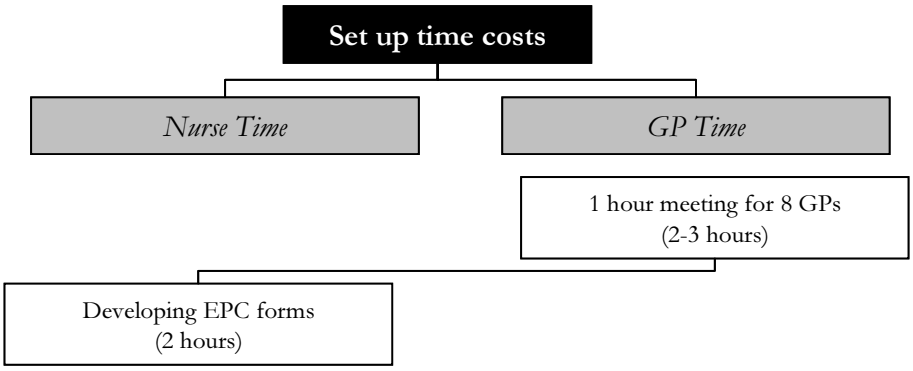


Figure 5: Health Assessment activity map

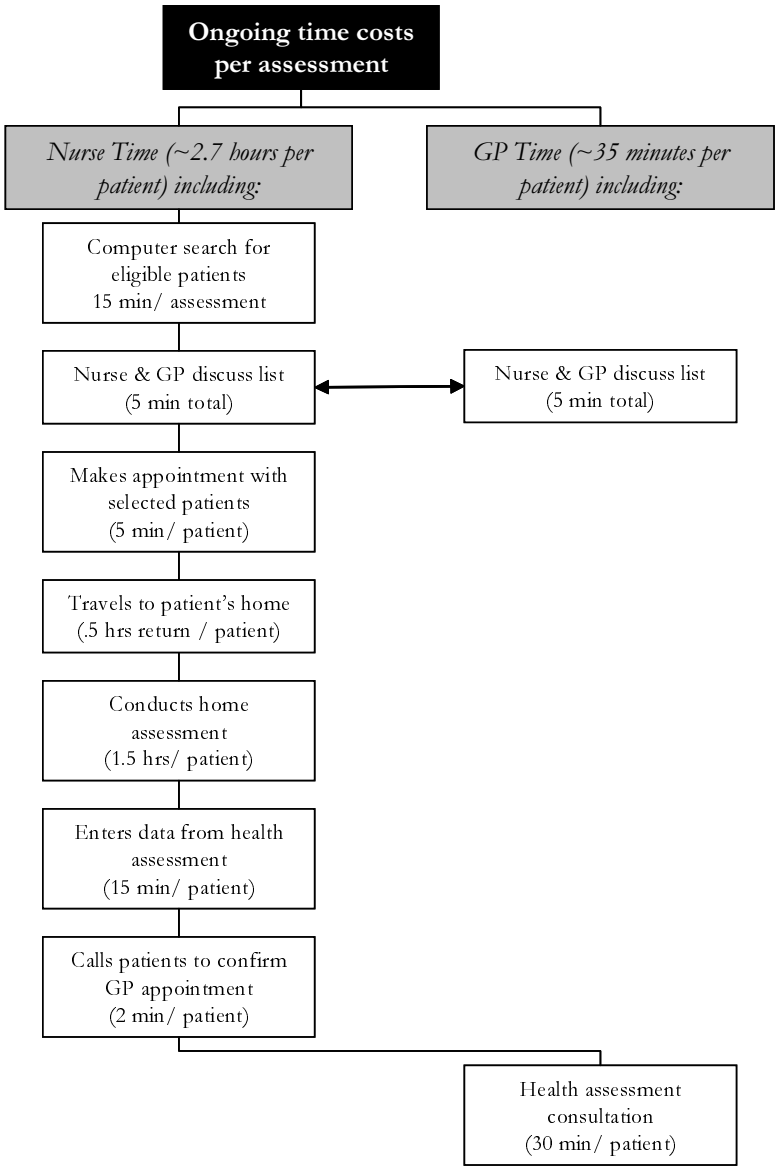
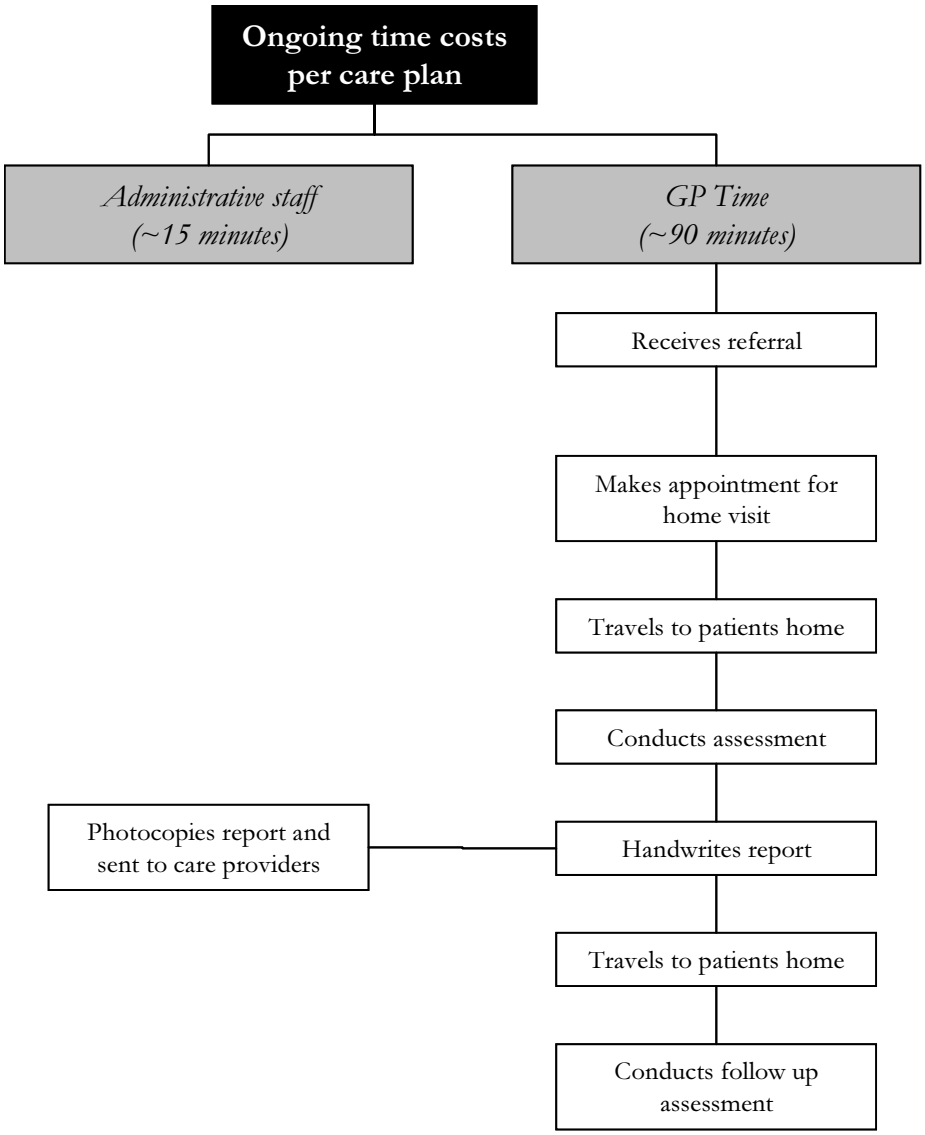


Figure 6: Care Planning activity map



4.3 Case Conference

No participation, case conference requirements are considered to be too draconian for Dr CS1 to be involved formally. Specific people have to meet, including pharmacist, nurse, which is *"impractical and artificial"*.

"The organisation is too onerous and we can reach the same results without being so formal, such as meeting with the hospital nurse. We could hold weekly meeting to discuss palliatives care patients with other carers, during which we discuss several patients, without recording how much time we spend on each, this may be 5 or 15 minutes, as is required."

Remuneration for these meetings is done using a normal consultation *item "because it is part of patient care"*.

5. Vocational Registration & RACGP Fellowship

5.1 Pre-fellowship

Dr CS1 undertook his pre-fellowship in 1978 by examination.

5.2 Fellowship

Dr CS1 undertook his fellowship in 1982 by examination.

5.3 Vocational registration, including

5.3.1 Professional Education

Each point is supposed to represent one hour of GP time. However it would be more accurate to say that each point represents 1.5 hours of GP time (including travel to and from the venue, lunch, preparation etc). Therefore it would be more accurate to say that a total of 205 GP hours are required every three years to complete the CME requirements and not 130 hours).

In addition to the direct CME costs, one should mention the revenue loss. *"But there are some remuneration in kind (meals or accommodation) which should not be considered to be perks".*

"But most of us would not find this onerous because it's important for us to keep up to speed. I don't see why other GPs complain about that".

CME costs included:

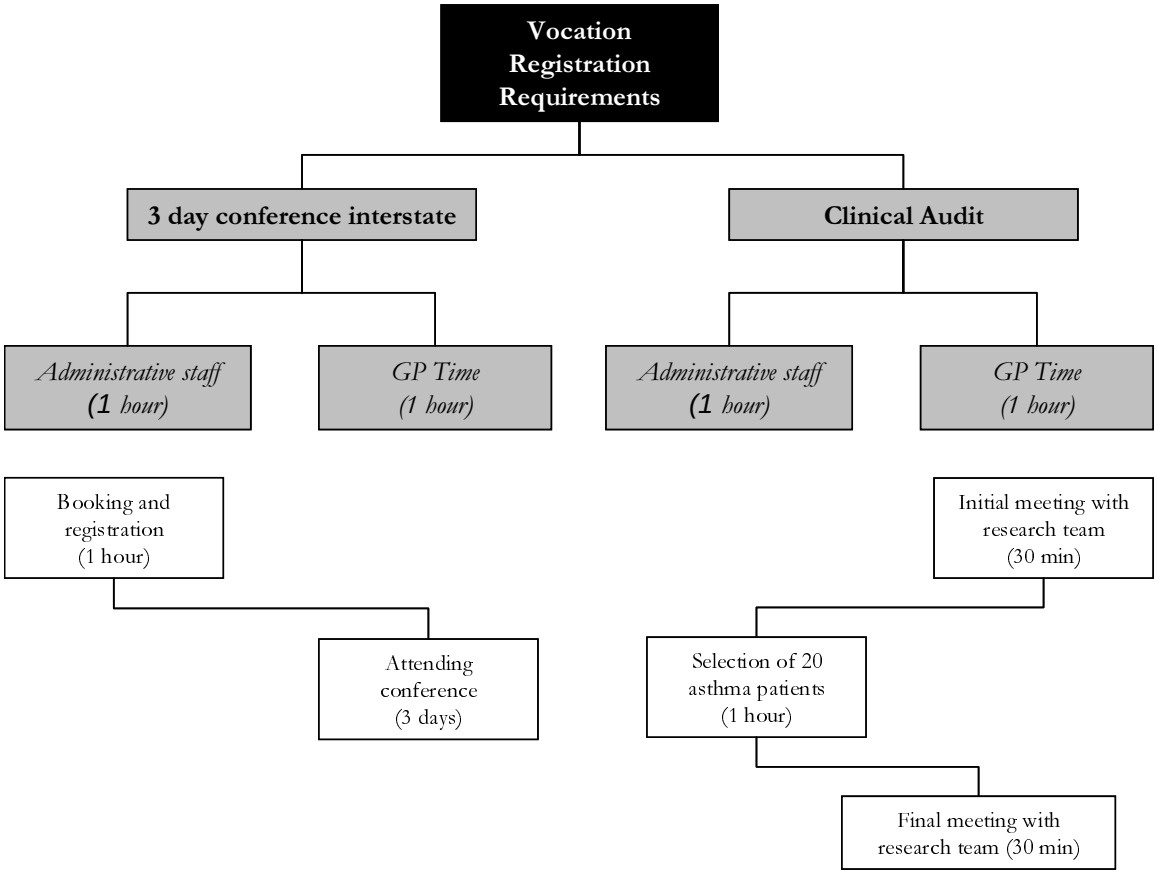
- 3-day annual conference in Sydney 2001 (40 points):
- $600 registration fees;
- Return ticket ($850);
- Accommodation ($120) & meals ($60);
- Loss of income for three days;
- $100 taxi fares; and
- 1 hour administration time (for bookings etc).

5.3.2 Clinical Audit

Dr CS1 reported that a Clinical Audit entails *"an independent assessment of your practice".* Some agencies are coming into the practice to look at how a group of patients with a specific illness is managed.

- Initial meeting with research team: 30 minutes of GPs time;
- Selection of 20 asthma patients: 60 minutes of administrative staff time; and
- Final meeting with research team: 30 minutes.

Figure 7: Vocational registration process map



6. Centrelink

Centrelink forms are all fairly similar in nature, and therefore fairly fast to fill out, especially when doctors know their patients. Furthermore, forms are filled out during the consultation, therefore there is a payment for filling out the forms.

Dr CS1 reported that filling out the Centrelink forms is a normal process of accountability for taxpayer money. It is normal and important that GPs keep on filling out these forms.

Dr CS1 reported that Treating Doctor Report (for disability pension) requires useless information. Eg ability to comprehend, which has nothing to do with disability itself, which may be back pain.

Only GP time is involved in complying with the Centrelink programs.

- Disability allowance: 5 minutes of GP time, 1 x month;
- Sickness allowance: 5 minutes of GP time, 1 x month;
- New Start/Youth allowance: 5 minutes of GP time, 1 x month;
- Carer payment/allowance: 5 minutes of GP time, 1 x month; and
- Mobility allowance: unknown by GP.

7. DVA

DR CS1 hardly ever does DVA assessments. Maybe one in the last ten years.

8. PBS

8.1 Phone authorisation

Very quick on the phone, hardly any wait. And part of the consultation for which the GP is being paid. In total: 1 minute. GP time. Estimated to be 50 per week across the practice.

8.2 Written authorisation

Negligible time taken thanks to electronic prescribing. But often time is wasted if prescription is sent back. 30 sec of GP time, 30 sec of administrative staff time, envelope + stamp. Estimated to be one per week across the practice.

9. Cost Estimates

The cost estimates of compliance for CS1 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and after hours services.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, and PBS where the costs are GP based. Some PIP costs (including NPS), and EPC are based on the GP.

The practice-based costs for CS1 were $13,003 and represents 1.3% of the gross operating cost (GOC) of the practice. This was entirely attributed to PIP with no practice-based costs for SIP and EPC. The bulk of these costs were attributed to annualised expenses associated with accreditation. The remainder were primarily associated with nursing staff costs.

Table 6: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	-	-	$961	$4,506	-	$49	$7,487	$13,003	100.0%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	-	-	$961	$4,506	-	$49	$7,487	$13,003	100.0%

% of Compliance Costs	0.0%	0.0%	7.4%	34.7%	0.0%	0.4%	57.6%	100.0%

The total GP related compliance costs for the GP interviewed was $56,397 (Table 2). Two thirds (65.0%) these were attributed to EPC with Dr CS1 having a practice heavily oriented to palliative care which relied on EPC funding. The remainder were equally distributed between PIP, VR and PBS.

GP compliance costs were primarily due to the GP's time with 88.1% being associated with the principal GP.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 33.5% of a single GP's 'share' of the practice GOC[3].

Table 7: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$5,432	-	$131	$1,802	-	-	-	$7,365	13.1%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	$34,366	-	-	$1,001	-	$494	$800	$36,661	65.0%
VR	$3,395	-	-	-	-	$33	$2,450	$5,878	10.4%
Centrelink	$543	-	-	-	-	-	-	$543	1.0%
DVA	-	-	-	-	-	-	-	-	0.0%
PBS	$5,943	-	-	-	-	$7	-	$5,950	10.6%
Total	$49,679	-	$131	$2,803	-	$534	$3,250	$56,397	100.0%
% of Compliance Costs	88.1%	0.0%	0.2%	5.0%	0.0%	0.9%	5.8%	100.0%	

[3] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 2:
Solo Rural Practice

1. Contextual Information

1.1 Practice Profile

CS2 is a solo GP practice located two and a half hours from the capital city, in a small, rural village. Being the only GP in a 50 kilometre radius, the practice patients include a wide range of profiles and SES, from young families to elderly people and from health care card holders to wealthy land owners.

There is a hospital in the village, but he is the only doctor working there. He is also licensed to dispense medicines and has a range of pharmaceutical products stocked at the practice. His wife is the practice manager and a certified nurse. The practice employs two part time receptionists and has a patient base of about 1,500 patients. They have been in the small town for six and a half years and enjoy being there. They had initially come for two years, and have extended they stay since then.

The practice was accredited in May 2000, and re-accreditation is presently in process. The practice receives some of the PIP payments. However, the GP mentioned that several of these programs are not designed for solo, rural practices. They do not take into account, for instance, the fact that other care providers (eg. dieticians, pharmacists accredited to undertake DMMR) are not accessible in isolated areas.

1.2 Staff

DR CS2 and his wife run three businesses:

- Clinic;
- Service trust (leasing of secretarial services); and
- Dispensary.

The staff includes:

- 1 GP: 1 FTE;
- 1 Nurse/practice manager (GP's wife): 0.5 FTE; and
- 2 Receptionists: 0.8 EFT and 0.6 EFT.

The GP to administrative staff ratio is therefore 1 to 1.9.

2. Overall issues

- DR CS2 considered that the PIP and EPC program are designed for city GPs and/ or group practices. Rural, solo GPs are discriminated against. *"PIP and EPC unfairly give preference to city doctors"*. Dr CS2 reports that the following programs are not possible in rural areas:
  - Tier 3 after hours coverage, as there are no doctors available:
  - DMMRs, as there are no accredited pharmacists in area;
  - Case conferences and care plans, as there are no specialists available in area, and it is impossible to get everyone together;
- Teaching of overseas trained doctors not recognised by the PIP whereas more and more overseas trained doctors are working in rural Australia;
- PIP, SIP and EPC are suited for corporate, city doctors who have secretarial support and can rely on other GPs to treat acute patients;

- PIP financial benefits are necessary for the practice to remain viable, so the practice has to comply with requirements. However, it is not considered to be a good program for rural doctors. It is considered to create a disincentive to go to a rural practice;
  - The GP has agreed to do two sessions per week in a nearby town that did not have a GP. He will have substantial costs to travel to the town and rent a house, but will not receive any the PIP payment because the practice will need to be accredited first and wait for a year before joining the PIP.
- The six programs constitute only a fraction of the paperwork involved when running a practice. HIC and federal paperwork (estimated by Dr CS2 to be around 40% of all paperwork) needs to be added to:
  - all the State documentation (around 40% of all paperwork), which is particularly burdensome for rural doctors also working in hospitals and including:
    - Travel forms; and
    - Immunisation for ATSI patients.
  - the 'private' paperwork (around 20% of all paperwork), including:
    - referrals;
    - lab forms;
    - X-Rays, Dr CS2 stated that they are *"an organisational nightmare in rural areas, it takes 15 minutes to organise an appointment in the capital city, this is unpaid and unrecognised for rural doctors."*

The most burdensome federal programs are:

- WorkCover, Dr CS2 reported that GPs are *"not remunerated for many months afterwards, and only if the claim is accepted by insurer"*. Forms take 5 minutes in addition to normal consultation, with 2 to 3 cases per day (Dr CS2 practices in an area with a high number of work accidents area associated with of farm work);
- DVA pension claims; and
- Authority prescription for restricted drugs.

3. PIP Program

PIP and accreditation require a large amount of PM time. In this practice, the PIP up-take was slowed down by the amount of time required to establish procedures necessary to participate in the PIP activities. The PM has not reportedly been able to dedicate the time required, as she only works part time. The PM is also a RN. However, having to dedicate time to accreditation and the PIP related paperwork has prevented her from working as a nurse, eg on health assessments.

3.1 Accreditation

3.1.1 Initial accreditation

The practice was first accredited in 2000. They are presently working through the re-accreditation process, to be finalised in March 2003.

Becoming accredited is perceived mainly as a bureaucratic requirement, because the PM believes the practice already had high standards. Therefore, *"the amount of changes required were minimal, but the work involved in getting the accreditation paperwork done was huge"*.

3.1.2 Re-accreditation

Re-accreditation started in September 2002, and mainly involved the practice manager.

Preparation for re-accreditation included:

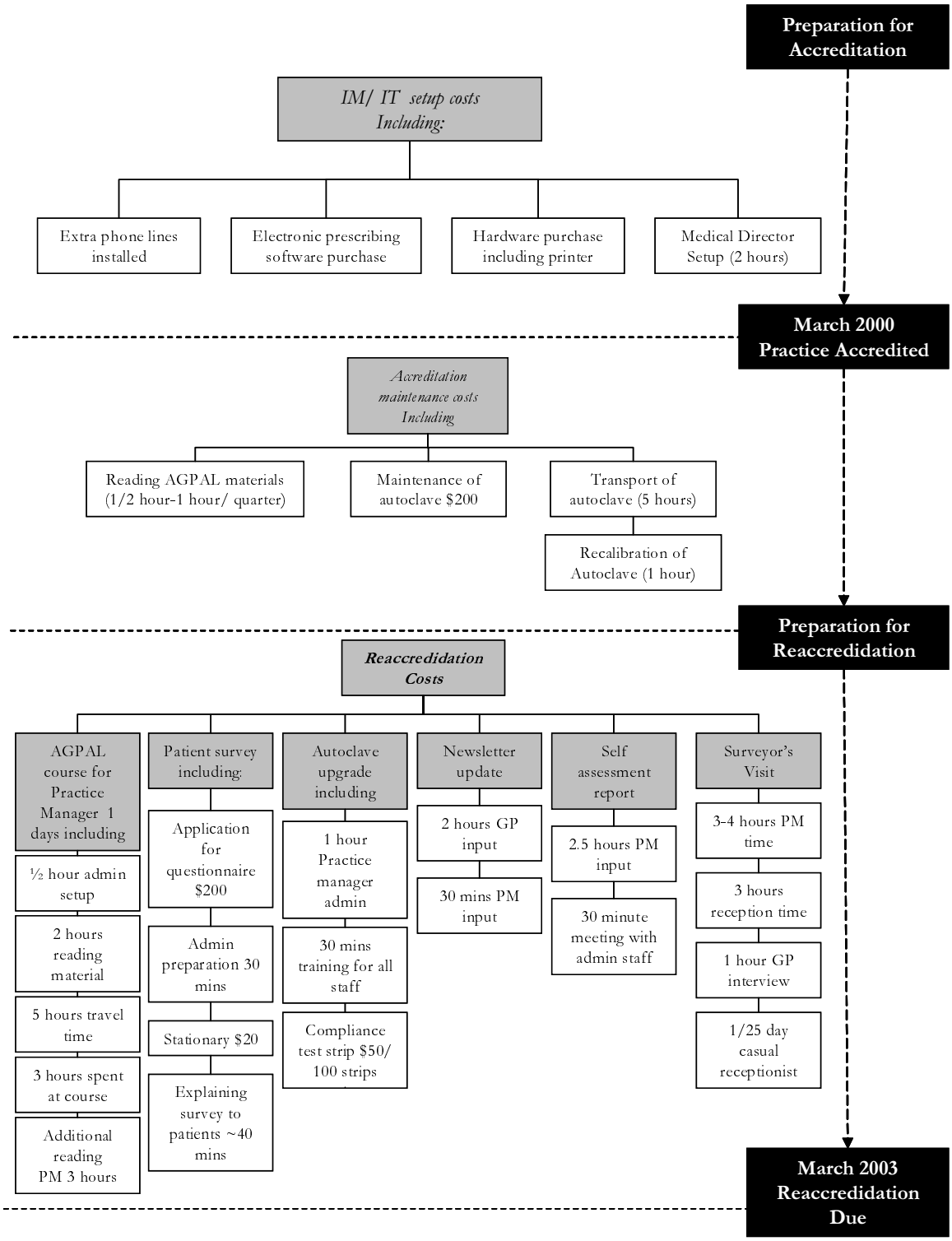
- An AGPAL Course: 1 day + PM time in total:
  - Driving: 5 hours return plus petrol and parking costs;
  - Course: 3 hours; and
  - Reading for course preparation: 2 hours.
- Reading of manual:
  - 3 hours PM time.
- Patient survey (75 patients survey):
  - Application to RACGP for the questionnaire $200;
  - Administrative preparation (including communication with RACGP, design of box for confidential collection) 30 minutes PM time;
  - Stationery: Clip boards 4 x $5; and
  - Explaining survey to patients: 75 x 30 seconds receptionist time.
- Autoclave upgrade:
  - 1 hour PM time;
  - 30 minutes training of staff (receptionist x2); and
  - New 'Compliance test strip' $50 per 100.
- Update of the newsletter:
  - 2 hours GP time; and
  - 30 minutes PM time.
- Self assessment report:
  - 2.5 hours PM time; and
  - Meeting with admin staff: 30 minutes (2 receptionists + PM).
- Re-accreditation fee of $1200;
- Surveyor visit:
  - 3 to 4 hours PM time;
  - 3 hours 1 receptionist time;
  - GP interview 30 min; and
  - Extra staff for half a day (receptionist).

3.1.3 Accreditation maintenance

Dr CS2 reported that little needs to be done once accreditation is obtained. Maintenance of accreditation includes

- Reading AGPAL material and other administrative tasks:
  - 30 minutes to 60 minutes quarterly.
- Autoclave maintenance (annual) "but that should be done anyway"
  - Service: $200;
  - Bringing the autoclave to capital city (5 hours drive, not undertaken exclusively for the autoclave); and
  - 1 hour PM time to recalibrate autoclave upon return.

Figure 8: Accreditation Process Map



3.2 IM/IT

IM/IT equipment was first installed in 1999 using the PIP incentives. All IM/IT costs add to $1000 per year approximately, including:

- extra phone line for downloading pathology results:
  - $200 one-off; and
  - $25 a month line rental.
- Electronic prescribing:
  - Initial purchase of Medical Director software, and subsequent subscription.
- Hardware:
  - Computer and printer in GP room up-graded every two years because of technology changes.
- IT Maintenance; and
- Time spent by GP to set up advanced the Medical Director functions (email and data management), including a 2 hour observation period.

IM/IT equipment is seen as a requirement because of the practice isolation and because of general practice evolution. Costs would have been met *"by now, even without subsidies"*. The PIP incentives helped the practice to get computerised earlier and faster than they would have otherwise. Some IT support is given by the Division.

3.3 After Hours care

All after hours calls are received and triaged by the hospital nurse. There is also a roster system organised with 5 other regional GPs to cover after hours calls and GP leave. This roster was in place before the PIP was established. Therefore, complying with the Tier 2 After Hours Care program was only a matter of documenting the existing practice arrangement to the HIC.

Tier 3 is not accessible to this practice because it would require 24 hour, 7 day medical coverage, *"which is impossible to achieve for county doctors"*. This is seen as a disadvantage for, and a discrimination against rural doctors.

3.4 Teaching

Dr CS2 does no teaching as part of the PIP.

Dr CS2 does teach overseas trained doctors (which is not part of the PIP), once or twice a week during one session plus time for briefing. *"This is unfair to country doctors where there are more overseas trained doctors"*.

3.5 NPS program

3.5.1 Clinical audit

Dr CS2 takes part in Clinical Audits, and reported that they involve:

- Selecting 10 depression patients;
- Writing 2-3 pages of notes per patient;
- 4-5 hours spent undertaking the audit for the ten patients (non-consultation time); and
- 30 minutes administrative time;

Dr CS2 does one Clinical Audit 1 every three years.

3.5.2 Case studies ("magazine questionnaire")

Dr CS2 spends 10 minutes completing each questionnaire (in non consultation time); and receives good feedback from NPS.

3.5.3 Practice visits

Dr CS2 does not take part in Practice Visits as there are no pharmacists available in the country at this time. However, a Practice Visit is scheduled for November 2002; and Dr CS2 anticipated that it will last 30 to 60 minute (plus loss of income).

3.6 Rural Loading Payment

Dr CS2 reported that there are no administrative costs associated with the Rural Loading Payments. He reported that there was an issue with GST, as he did not know whether the tax applied to the payment or not. Dr CS2 reported that the Rural Loading Program provided unclear instructions. Dr CS2 reported that the administrative work associated with the Rural Loading Payments required:

- 15 minutes accountant time;
- 15 minutes PM time; and

Dr CS2 raised questions about classifications that do not take all local criteria into account (a town closer to capital city than the GP's town gets a better rating and therefore, higher and faster payment). He stated that *"classification is arbitrary and unfair, formula doesn't pertain well to rural Australia"*.

3.7 Immunisation Incentive

The GP performs about 15-20 immunisations per month. These involve:

- GP to fill in immunisation forms: 30 seconds per patient;
- Administrative staff to send of immunisation forms: 20 minutes per month;
- Quarterly report: in total 3 to 4 hours PM time, including:
  - check report against patient files;
  - send letters to patients or call patients;
  - make appointments; and
  - ring and/or fax back immunisation register to correct details.

3.8 SIP

Dr CS2 reported that he had very little to do with SIPs. He questions the choice of the diseases targeted by SIP, in particular, he does not know why osteoporosis is excluded from the program. He sees this as an arbitrary choice by the SIP administrators. Dr CS2 also believes that some SIPs reward bad practice. For example, pap smears provide *"incentives for GPs who are not monitoring their patients, as they should"*.

The CS2 practice does not qualify for the program because for the last three years they have brought a female GP from the capital city to consult with patients who want to be seen by a female GP. At the time of the interview, all their female patients are up to date.

Dr CS2 has claimed only one SIP over the last 12 months, which took a lot of time because of lack of established, routine procedure: 10 minutes consult time; 10 minutes admin time to fill forms and find proper item to claim.

Dr CS2 reported that the Asthma 3+ *"are a waste of time because if you cannot sort out a patient in two visits then you should send them to a specialist. I did one and I felt guilty to ask the patient to come back three times, I felt I was over-servicing, that it was not very ethical."*

- Dr CS2 has organised a diabetic clinic, which he stated was *"not technically part of SIP but indispensable to be able to organise Diabetes 3+ and care plans. And you would do it anyway, it's part of running a practice"*. This took about one hour PM time for each clinic.

3.9 PIP Administration

Dr CS2 reported that most forms to apply for the PIP were filled out three years ago when the practice first joined in the program, apart from:

- Initial application to be part of SIP: 10 minutes PM time; and
- Application for incentive to employ a practice nurse: 30 minutes PM time.

Dr CS2 reported that there are no ongoing administration costs for the PIP. He stated that *"every quarter I receive a the PIP payment sheet. I don't have to do anything to get it, the HIC send it. There are no errors, I just spend 5 minutes checking it"*.

4. EPC

Dr CS2 reported that most EPC items are not suitable to country practice. He stated that it took administrative staff 45 minutes to start procedures during observation period.

4.1 Health Assessments

Dr CS2 believed that Health Assessments could be beneficial but require too much preparation, as the practice did not yet employ a practice nurse. Instead of health assessments DR CS2 does an 'item 700'. He stated that "*Too many patients are waiting to be seen. It's easier to do an item 700. Health assessments are beneficial to corporate GPs who have support, and to GPs who don't mind leaving acute patients waiting for care. I would make more money if I didn't have so many patients waiting to see me"*. An item 700 requires either 20 to 30 minutes to make the appointment when patients are known to GP, or 40-45 minutes when patients are not known to GP.

4.2 Care Planning

Care plans require two or three other care providers, which is very hard to organise in rural locations. Dr CS2 has tried to organise a few care plans, but found that it was *"too hard"*. A diabetic educator consults regularly in the area, so the care plans are organised around one of her visits. In October a diabetic clinic was organised during which 8 care plans were implemented. On a regular basis, Dr CS2 undertakes approximately 1 care plan per week. Care Plans involve:

- Identify eligible diabetic patients: 2 minutes consult time;
- Consent form and management goals: 1 min;
- Involve dietician and diabetic educator: 10-20 min;
- Subsequent appointment: 10-15 min; and
- Administrative support: 2-3 minutes per patient.

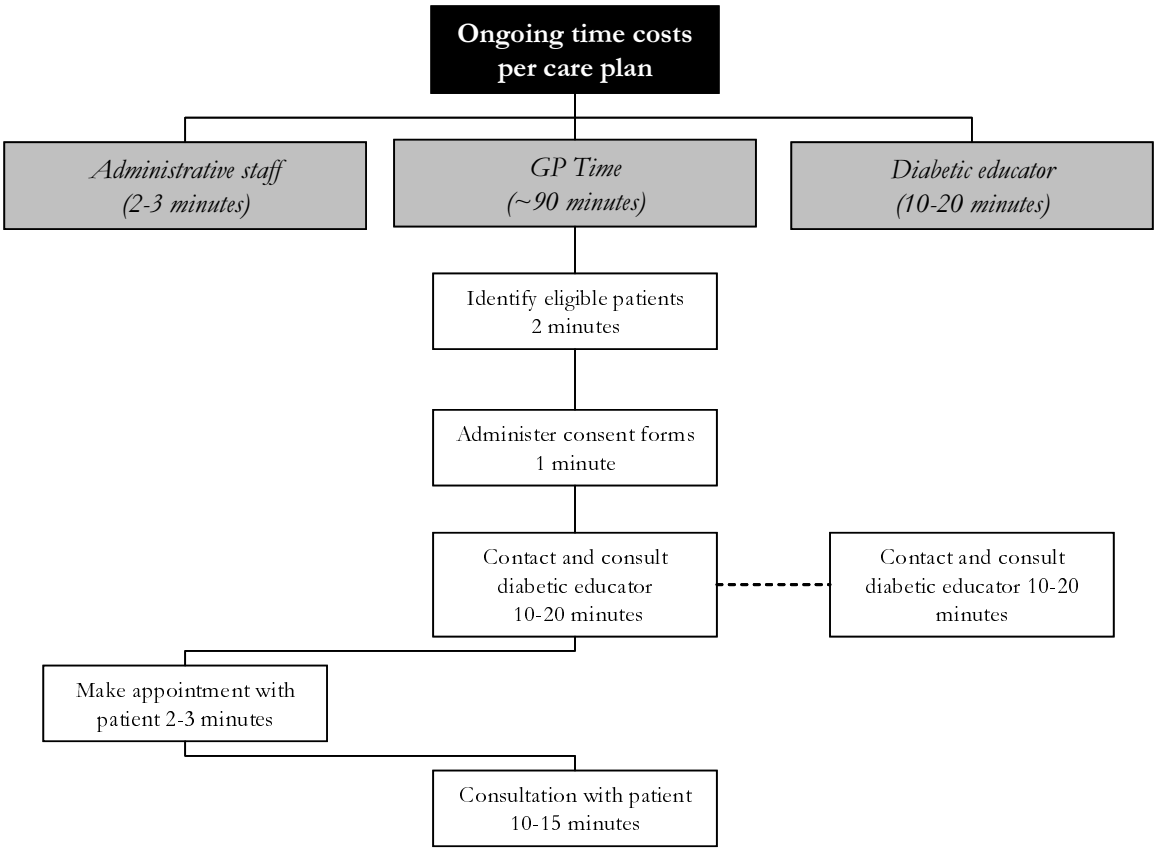
4.3 Case Conferences

Dr CS2 reported that Case Conferences are *"…physically impossible to organise in rural areas, where there are no specialists available and where it is impossible to get everyone together"*

4.4 DMMR

Dr CS2 reported that DMMR are *"unworkable and pointless in country Australia"* because there are no pharmacists in the area. However, he reported that work is being done with the Division to have a pharmacist available for DMMR.

Figure 9: Process Map for Care Plans



5. Vocational Registration and RACGP Fellowship

5.1 Vocational registration

Dr CS2 reported that country GPs are disadvantaged because no drug company will subsidise programs for Continuing Medical Education in rural areas. Dr CS2 reported that registration involved:

- RACGP Administration fee: $250;
- Seminar in 2001/02;
- Fee: $800;
- Accommodation and travel: nil because subsidised by Division and GP has a house in capital city which he used for accommodation; and
- Time: 4 days (2 week ends of two days each).

5.2 RACGP Fellowship

Dr CS2 entered the pre fellowship program in 1991, and completed fellowship by training pathway in 1994. He is not presently a member because he became annoyed with the administrative time that RACGP took to process his fellowship, which meant he couldn't claim any rebate for three months.

6. Centrelink

Dr CS2 reported that all forms are photocopied and kept in the patient records. He considered the forms to be unnecessarily long-winded and repetitive, because Centrelink did not keep illness history. As such, the same forms to be completed every 2 years for conditions that do not change.

6.1 Disability allowance

Dr CS2 stated that "*…the form has been reviewed but there is still at least one page of irrelevant questions because Centrelink want to have one form fits all.*" Dr CS2 reported that A TDR involves:

- 15 minutes of consultation time; and
- A review five minutes consultation time.

Dr CS2 does about one TDR per week.

6.2 Sickness allowance

Dr CS2 reported that a Sickness Allowance form takes about five minutes or less of consultation time; and would do about three forms per week.

6.3 New Start/Youth allowance

Dr CS2 does not deal with New Start Allowance forms.

6.4 Mobility allowance

Dr CS2 does not deal with New Start Allowance forms.

6.5 Carer payment / allowance

Dr CS2 perceived no difference between allowance and payment forms. He stated that, as per Disability forms, a Carer Payment form involves:

- 5 minutes for review; and
- 15 minutes for new.

Dr CS2 reported that he would do about one Carer Payment form per month.

7. DVA

Dr CS2 reported that DVA forms are rare. He would complete two to three DVA forms per year. He reported that the DVA forms involve a Medical Impairment Assessment, which takes 15 minutes per patient. He stated that although the forms are very repetitive, the GPs are paid well for their time. The DVA forms are completed as part of a regular consultation.

8. PBS

8.1 Phone authorisation

Dr CS2 reported that a PBS Phone Authorisation takes about 2 minutes including the call itself, waiting time, writing the number on prescription. Dr CS2 would do about 20 to 30 phone authorisations per week.

8.2 Written authorisation

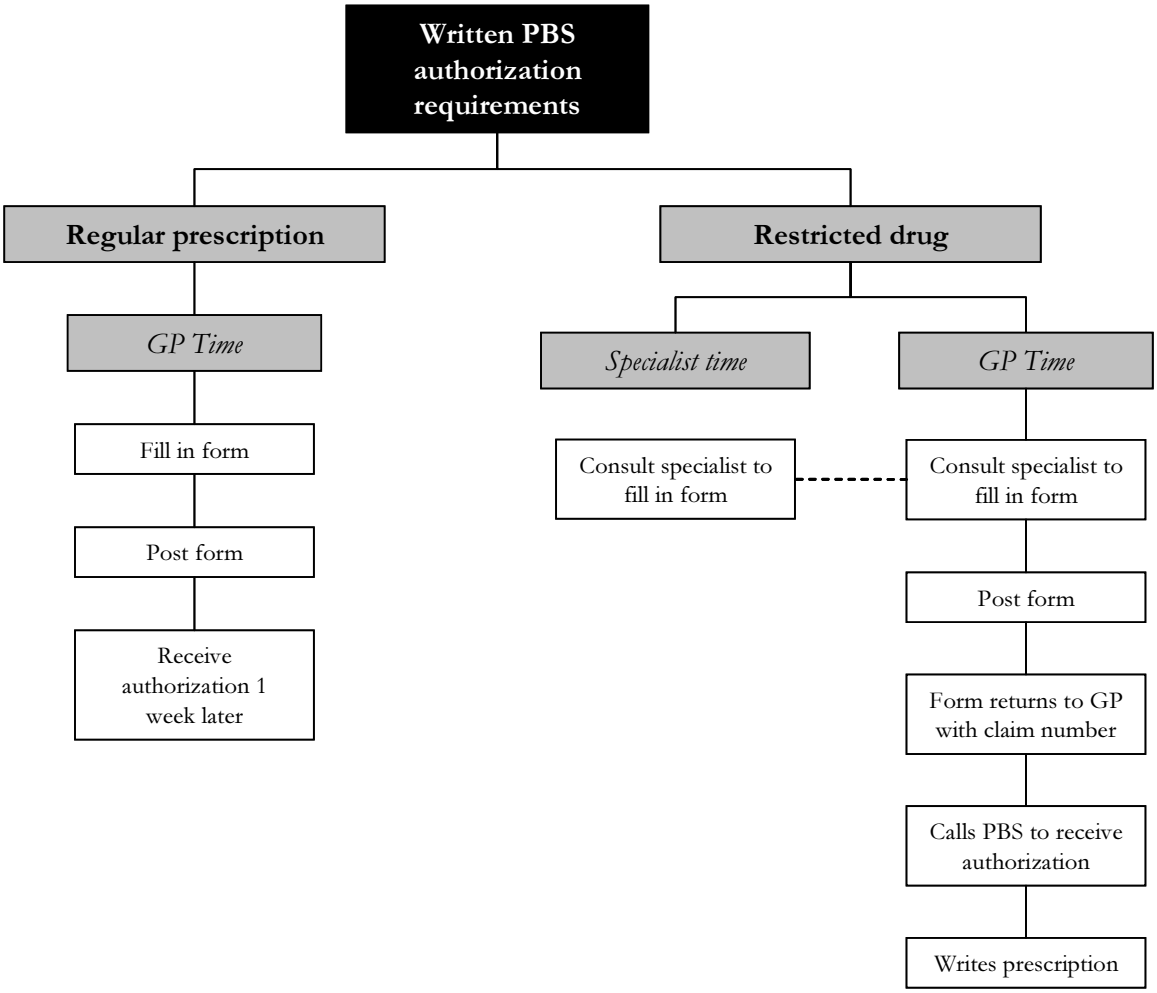
Dr CS2 regarded Written PBS Authorisations as a convoluted process, which is a problem because patients do not realise they will have to wait to get their prescription drug. Dr CS2 does about one or two written authorisations every week. They are undertaken when the line is busy for a phone authorisation and/or when the patients can wait for their prescription. The process of a Written PBS Authorisation includes:

1. Fill in state government form (1 min);
2. Send it;
3. Wait for a week;
4. Receive authorisation.

Restricted drugs (eg amphetamine for ADHD) take 15 to 20 minutes process over 7 to 10 days. The process includes:

1. Call to a specialist and get him to fill in the form (1-2 STD calls, 10 min)
2. Form is sent;
3. Comes back to GP with a claim number;
4. GP rings up PBS and receives an authorisation number;
5. GP writes prescription manually.

Figure 10: Process Map for Written PBS Phone Authorisations



9. Cost Estimates

The cost estimates of compliance for CS2 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs were all associated with PIP [including accreditation], and IM/IT strategies.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), and EPC are based on the GP.

The practice based costs for CS2 was $2,699 and represents 2.2% of the gross operating cost (GOC) of the practice. This was entirely attributed to PIP with no practice-based costs for SIP and EPC. The bulk of these costs were attributed to annualised expenses associated with PIP (69.8%).

Table 8: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$237	-	$509	-	$14	$46	$1,863	$2,669	100.0%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	$237	-	$509	-	$14	$46	$1,863	$2,669	100.0%
% of Compliance Costs	8.9%	0.0%	19.1%	0.0%	0.5%	1.7%	69.8%	100.0%	

The total GP related compliance costs for the GP interviewed was $6,976 (Table 2). The bulk of these costs were distributed between PBS (30.2%) and vocational registration (38.2%). EPC and Centrelink programs each accounted for close to one tenth of the GP's compliance cost. There were few costs associated with the other programs.

GP compliance costs were primarily due to the GP's time with 83.5% being associated by the principal GP. The remainder were primarily non-labour costs.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 5.7% of a single GP's 'share' of the practice GOC[4].

[4] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Table 9: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$324	-	-	-	-	$72	-	$395	5.7%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	$939	-	-	-	-	$32	-	$970	13.9%
VR	$1,616	-	-	-	-	-	$1,050	$2,666	38.2%
Centrelink	$808	-	-	-	-	-	-	$808	11.6%
DVA	$29	-	-	-	-	-	-	$29	0.4%
PBS	$2,108	-	-	-	-	-	-	$2,108	30.2%
Total	$5,822	-	-	-	-	$103	$1,050	$6,976	100.0%
% of Compliance Costs	83.5%	0.0%	0.0%	0.0%	0.0%	1.5%	15.1%	100.0%	

Case Study 3:
Small Outer Metropolitan Practice

1. Contextual Information

1.1 Practice Profile

CS3 is a 2 EFT GP practice located 35 kilometres away from the CBD, in a semi-rural, middle class area. The practice is owned by a family trust and charges management fees to the GPs working in the practice.

1.1.1 Patient base – practice specialty

The CS3 practice offers a range of services to elderly and diabetic patients, in addition to the general practice.

1.1.2 Practice size, number of EFT GPs and other staff

The wife of the practice principal works part time as a practice manager and a nurse. Additionally, a casual nurse and three part-time receptionists are working in the practice, as follows:

- PM / nurse: 2 mornings per weeks;
- Receptionist 1: 34 h/w;
- Receptionist 2: 24 h/w;
- Receptionist 3: 30 h/w; and
- Nurse 2: 6 h/w.

The ration of GP's to administrative staff at the practice is 1 to 1.65. The practice was accredited in 1999. They take part in most elements of the PIP and EPC program.

1.1.3 Number of patients seen per session by participating GP

Dr CS3 worked 71 hours over the observation period, and saw 251 patients in this time.

2. Overall issues relating to Program Compliance

2.1 General attitude

Dr CS3 reported that the most burdensome administrative tasks involve keeping his practice up to date with accreditation requirements. He is critical of the amount of information that he is required to read to comply with the various programs, stating that GPs are "*punch drunk with information*".

2.2 Program participation

Dr CS3 takes part in the following programs:

- After hours care;
- Teaching;
- Case studies;
- Diabetic SIPs
- Health assessments;
- DMMRs; and
- Care plans.

3. PIP Program

3.1 Accreditation

3.1.1 Set up costs

The practice was first accredited in 2000, and is due for re-accreditation next year. The major cost associated with accreditation was constructing the practice manual. Dr CS3 reported that the practice manager spent one month full time constructing the practice manual, which was required for accreditation.

A major financial cost associated with setting up for accreditation was the $300 spent on a 'double-locked safe'. Dr CS3 installed it himself, which took half a day. Other financial costs included a shredder, and special handles for the toilet doors.

3.1.2 Ongoing costs

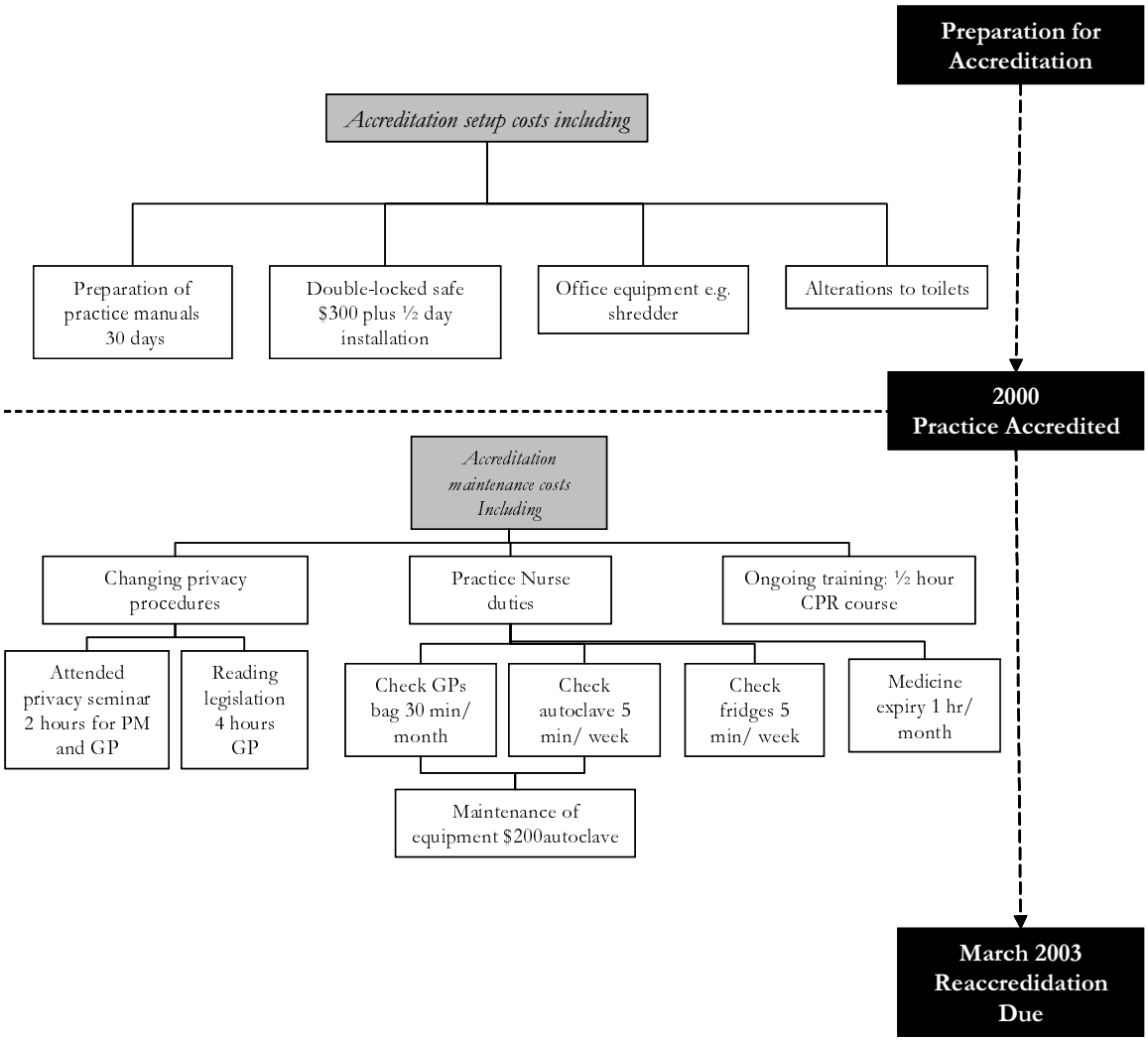
A major task associated with maintaining accreditation standards involved changes in patient privacy legislation. Dr CS3 and the practice manager attended a lecture on privacy, to keep up to date with the privacy requirements. The lecture lasted one hour, plus about an hours worth of travel. In addition, Dr CS3 spent four hours reading information about the new privacy laws, and the practice manager spent two hours writing a new practice manual incorporating the new privacy principals.

To maintain accreditation standards, the practice nurse needs to:

- Check and update the Doctor's bag. This would take about half an hour every month.
- Check the autoclave and ultrasonic cleaner, which takes about five minutes each per week.
- Check the fridge temperatures twice a week.
- Arrange for servicing of the above equipment, which takes about ten minutes per year. The servicing itself costs about $200.
- Check that medicines have not expired, which takes about one hour per month.
- Staff need to attend a set number of ongoing training sessions. The staff recently attended a CPR training session, which took about one hour.

Dr CS3 reported that the practice would undertake these tasks even if they were not required for accreditation.

Figure 11: Accreditation Process Map



3.2 After Hours Care

Dr CS3 does his own After-Hours Care, doing call-outs on the weekend. He estimates that he would spend between three and six hours on call-outs each weekend.

3.3 Rural Loading

Rural Loading is not applicable to this practice.

3.4 Teaching

Dr CS3 currently supervises a senior registrar. The registrar stays with the practice for six months. During this time, the GP spends his lunch times with the registrar either looking at case reviews, or discussing other medical issues. The registrar can also call the GP should any issues arise at the practice.

Dr CS3 estimated that he would spend about three hours per week in medical consultation with the registrar, and another two hours per week engaged in other informal discussion. The presence of the Registrar presents extra value to Dr CS3, as he finds it difficult to attract GPs to the practice. Dr CS3 receives about $200 per week for a basic registrar. This amount decreases as the Registrar becomes more experienced.

3.5 NPS program

3.5.1 Case studies

Dr CS3 would take part in four Case Studies per year. Each Case Study take about an hour, and are conducted over lunch.

3.5.2 Practice visit

Dr CS3 does not take part in practice visits.

3.5.3 Clinical audit

Dr CS3 has not taken part in a clinical audit.

3.6 SIP

As a male, Dr CS3 rarely does cervical screens. He no longer does asthma screening because people don't come back for the required follow-up consultations, and so he does not receive the payment (three visits are required to receive the incentive).

Dr CS3 reported that he does receive SIP payments for his diabetes patients. He stated that it is easier to follow up the diabetes consultations, as diabetics recognise that they have a chronic condition, which needs to be kept under control. He estimated that a diabetic SIP consultation takes between 20 and 30 minutes.

Dr CS3 does about one diabetic SIP consultation per week. He reported that he personally does no paperwork for the program, but has to tell the administrative staff which item number corresponds to the current consultation. He is critical of the new item number system, stating that it is needlessly complex, and detailed.

Dr CS3 considered that he would receive about one quarter of the SIP payments to which he is entitled.

4. EPC

4.1 Health Assessment

4.1.1 Set up costs

Dr CS3 estimated that it took the practice manager about 24 working hours to prepare the forms and other documentation that are required to undertake Health Assessments. He and the practice manager produced 'form templates', which are stored on the computer. He reported that there are some forms, or templates provided by the Divisions, but that he does not use them, as they are "*too medical*".

Dr CS3 has done about 50 Health Assessments. However, Dr CS3 has not done any Health assessments recently, as he has already completed assessments for most of the eligible patients on his files.

4.1.2 Process

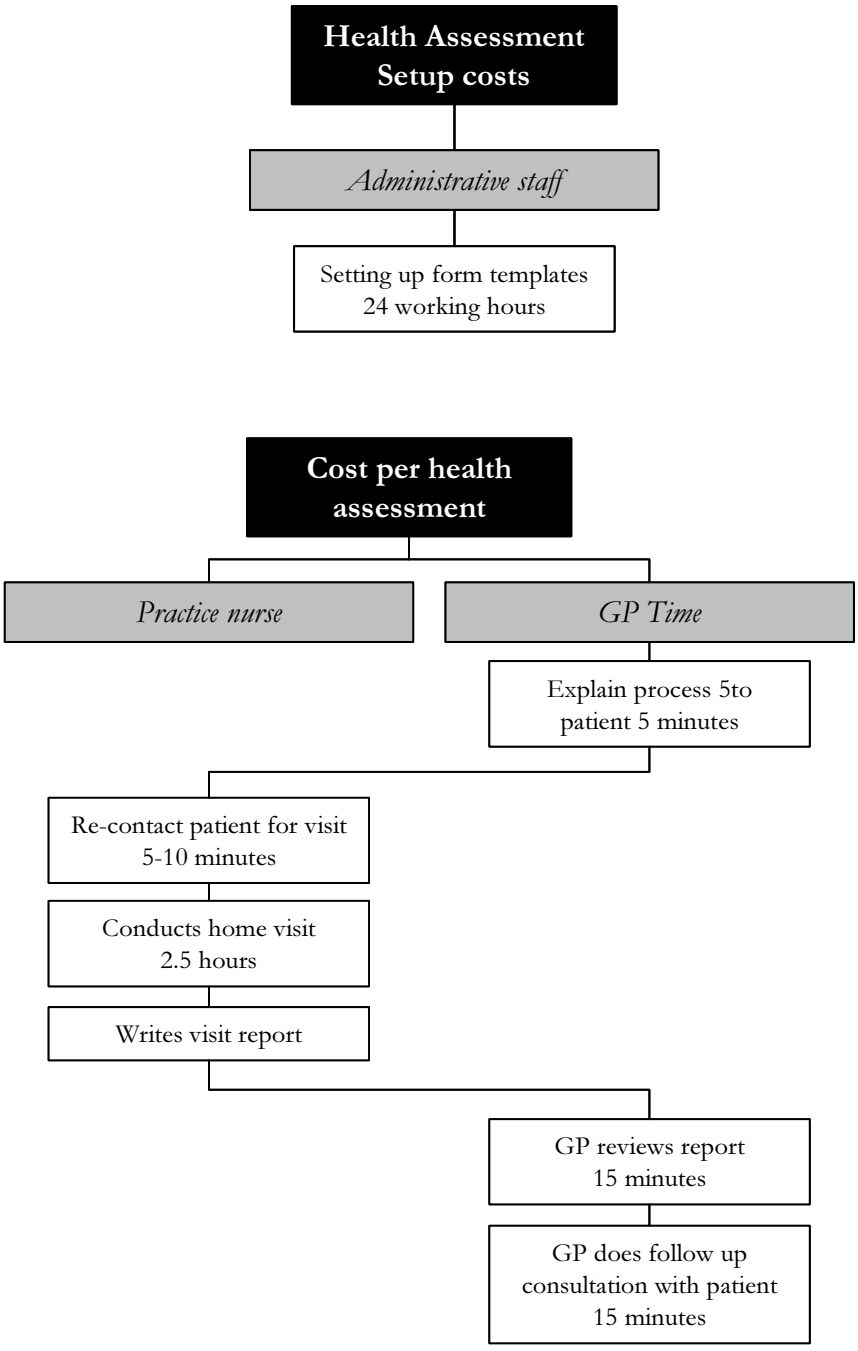
A Health Assessment involves a visit to an elderly patient's home by a nurse. The assessment examines general medical condition, medication, and environmental factors that might impact on a patient's health. When Dr CS3 was undertaking Health Assessments, the process included:

1. Dr CS3 would explain the Health Assessment process to the patient during a regular consultation. This would take about five minutes;
2. The practice nurse would re-contact the patient to make an appointment for the Health assessment. This would take about five to ten minutes;
3. The nurse would then visit the patient's home for the health assessment. This would take about two hours, plus travel time of about half an hour;
4. The nurse would write a report based on the visit;
5. The GP would review the report outside of consultation time. This would take about 15 minutes; and
6. The GP would then have a second consultation with the patient to discuss the recommendations made in the Nurse's report. This second consultation usually lasts between 20 and 30 minutes.

Dr CS3 stated that it could be quite difficult to persuade the patient to follow through with the recommendations in the report, as many of the recommendations require financial outlay. For example:

- Fitting of deadlocks and smoke detectors at the patient's home;
- Installation of a ramp for the door of the house; and
- Installation of a circuit breaker for electrical safety.

Figure 12: Process map for Health Assessment Set-up and Ongoing Costs

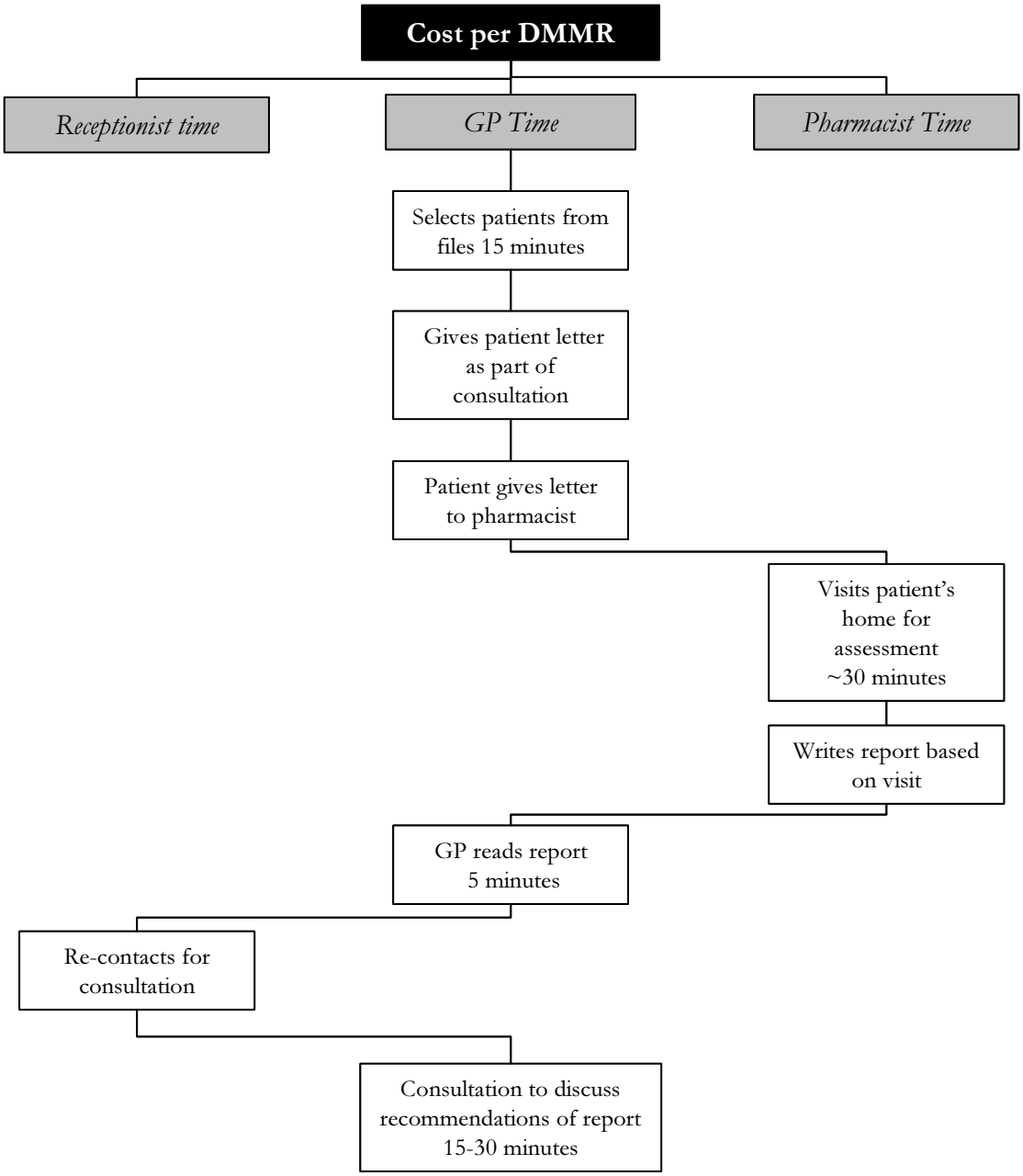


4.2 DMMR

A DMMR entails a review of the medications taken by an elderly patient with complicated medical problems. This patient typically takes a range of different medications, thus increasing the risk of interaction effects. The DMMR involves the GP, a pharmacist, and the patient.

1. The GP either selects a patient from his records, or recommends a patient for DMMR after a regular consultation (usually about 15 minutes);
2. The GP gives a letter to the patient to pass on to their pharmacist. The letter invites the pharmacist to take part in a DMMR, (not all pharmacists agree take part at this point);
3. The pharmacist visits the patient at home for about half an hour to review all medications currently taken by the patient (including non-prescription and alternative medicines);
4. The pharmacist writes a report on these medicines based on the home visit with recommendations for further medical action. The report is sent to the GP;
5. The GP then reads the report. This would take about five minutes, and usually takes place after-hours;
6. The receptionist then recontacts the patient, to invite them back for a third consultation (this would take no longer than five minutes); and
7. The patient and the GP then discuss the changes that will need to be made to the patient's treatment (this usually takes 15 to 30 minutes).

Figure 13: DMMR Process Map



Dr CS3 reported that a DMMR takes more of the pharmacist's time than the GP's time. Dr CS3 has undertaken two DMMRs since the program started, and reported that it took about 30-45 minutes in total.

4.3 Care Plan

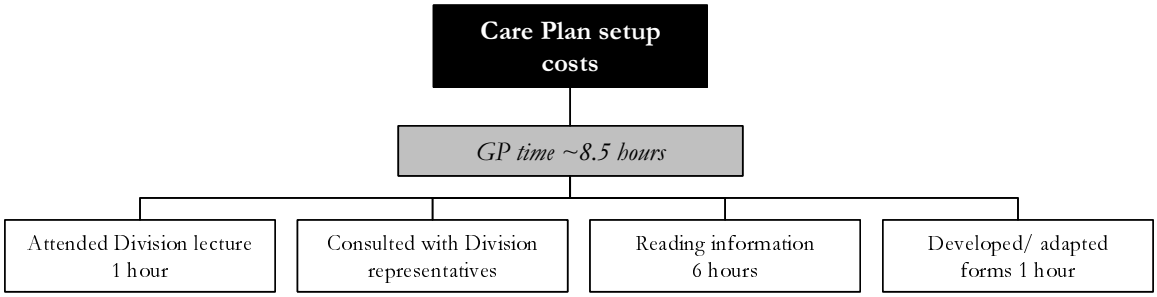
4.3.1 Set up costs

To prepare for the EPC Care Plans, Dr CS3:

- Attended an information session at the Division, which took about an hour;
- Spoke with some representatives from the Division, who came to his practice to "*sell the programs"* over lunch;

- Spent about six hours reading information about the programs; and
- Developed forms for the programs, which were adapted from photocopies provided by another clinic. This took about an hour.

Figure 14: Care Plan Set-up Costs Process Map



4.3.2 Process

Dr CS3 takes part in about one diabetic Care Plan per week. He estimated that the whole process would take about an hour of his time.

The process for a diabetic Care Plan begins with a consultation between the diabetic patient and the GP. This typically happens as part of a diabetic's yearly check-up (Dr CS3 will often refuse to write a script for a diabetic patient unless they come to the clinic for a consultation). This consultation involves a basic examination, and a series of blood tests. The initial consultation takes about 20-30 minutes.

From this initial consultation, a GP can usually assess the patient's overall health, and whether the diabetic patient requires a Care Plan (not all patients require a care plan, only those whom the GP feels might be at risk). If the GP decides to go ahead with the Care Plan, the patient is re-contacted, and invited back to the clinic for a more lengthy consultation (the patient is not charged for this second consultation).

This second consultation involves inviting other health professionals to assist in the Care Plan in consultation with the patient. For example, a letter detailing the Care Plan could be sent to:

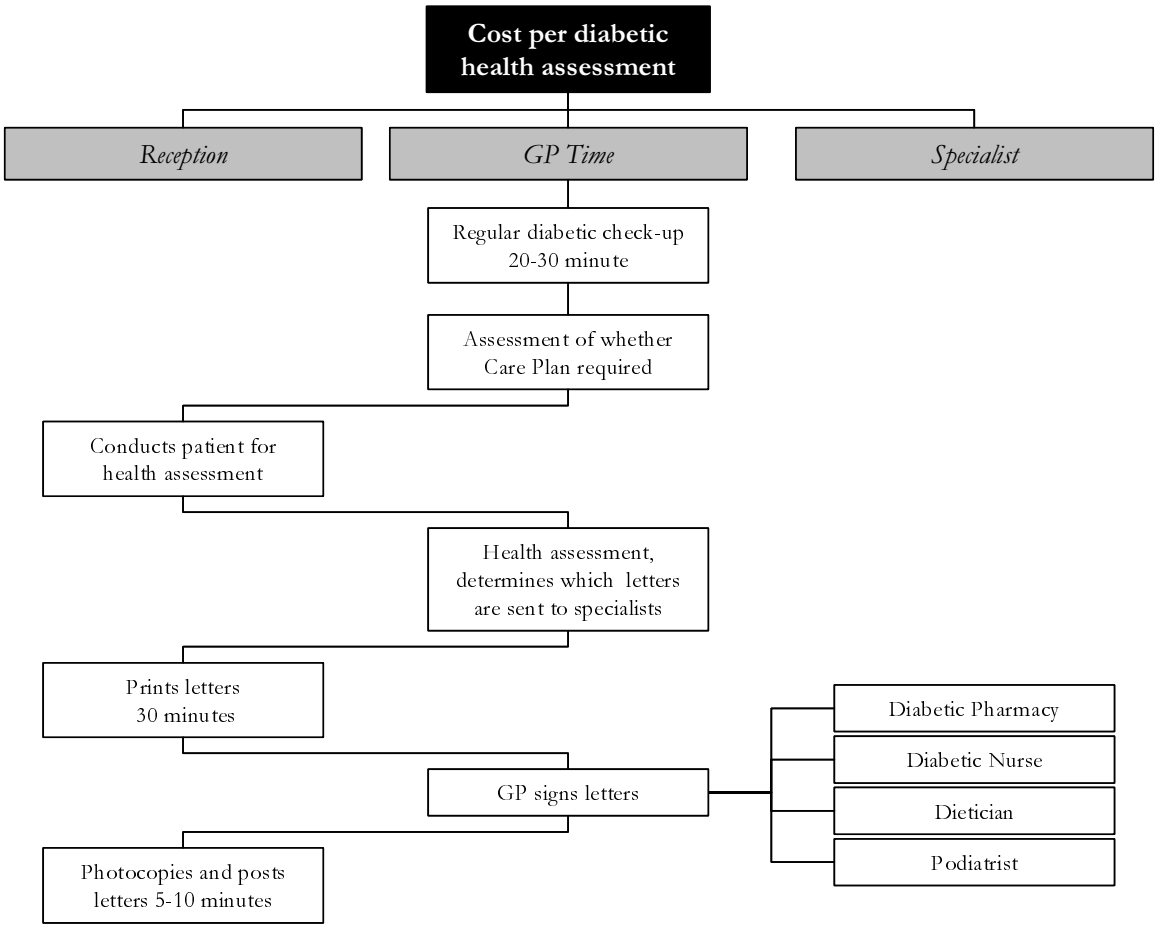
- The diabetic pharmacy requesting needles, test strips and other requirements;
- A diabetic nurse or educator requesting that they consult with the diabetic patient;
- A dietician requesting dietary guidance and materials; and
- A podiatrist to advise on circulation.

Dr CS3 estimated that these letters are based on a standard template, and take about 30 minutes to write. These letters need to be signed by each health professional.

The administrative staff would spend five to ten minutes faxing and copying the documentation required to complete the Care Plan in addition to the GP's time

Dr CS3 tries to charge the HIC for the Care Plan straight away rather than waiting for the documentation from all of the other health professionals involved. He is aware that this may not be the officially recognised method of payment, but he reported that Care Planning payments can sometimes be *"overlooked"* or missed by the HIC if they are left too long. The practice manager reported that she refused to chase up all of the health professionals from the care plans, as she did not have time.

Figure 15: Health Assessments process map



4.4 Case Conference

Dr CS3 does not take part in Case Conferences, as he does not have time.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

Dr CS3 undertook his RACGP fellowship in 1998-99. He went through the training program but he can not remember the exact costs in terms of time or money.

5.2 Vocational registration

Dr CS3 estimated that he would spend about $300 each year to undertake the programs required for vocational registration.

5.2.1 Professional Education

Dr CS3 reported that a typical seminar is about four hours long, and involves half an hour's travel each way (total five hours). Dr CS3 tries to attend about one seminar or meeting per week.

5.2.2 Clinical Audit

Dr CS3 estimated that a clinical audit takes about five hours in total. This includes:

- one hour to read the required information; and
- four hours to select the patients and complete the case study.

Dr CS3 reported that this audit was a 'once-off', which happened to occur during the observation period.

6. Centrelink

6.1 Key Issues

Dr CS3 reported that Centrelink sends so many forms for the same patient, that he "*just switches off*". He reported that he often receives six Centrelink forms per year for the same patient, that all ask for the same information. He is sceptical about the way in which Centrelink uses these forms, suggesting that the forms are "*looked at once, then filed…they aren't even put on the computer…they collect information for the sake of collecting information, I have seen no evidence that they use the information*".

Dr CS3 reported a particular issue with the disability allowance and sickness allowance forms, which Dr CS3 perceived as almost identical. He reported that some of his patients "*juggle between sickness and disability allowances*", which requires him to fill out both forms for the same patient. This involves a lot of repetition, and extra paperwork.

6.2 Sickness & Disability Allowance

Dr CS3 reported that he would have to fill out between two and three sickness or disability allowance forms per week, which takes about 15 minutes per form.

He reported that the form usually takes up the entire consultation, with no extra time for other medical matters

6.3 New Start/Youth Allowance

Dr CS3 would fill out a New Start Allowance form about once per month. This would take about ten minutes.

6.4 Mobility Allowance

Dr CS3 has never seen a Mobility Allowance Form, but has undertaken assessments of mobility for older patients.

6.5 Carer Payment/Allowance:

Dr CS3 would fill out a Carer Payment/ Allowance form about twice per month. These forms take about ten minutes to fill out.

7. DVA

Dr CS3 does some DVA assessments, but quite infrequently. He reported that a single DVA consultation can take up to half an hour to complete all of the paperwork. The paperwork must be filled out by a GP, as administrative staff do not understand the requirements of the forms. He reported that the payment for completing DVA forms is fair, as the GP is paid per sheet.

He reported that the patients who present with the DVA forms have no idea how long it will take to complete the paperwork.

Dr CS3 reported an issue with the specific treatment entitlement form (used for referring to specialists). He is critical of the fact that a letter to the specialist is required in addition to the form, which Dr CS3 sees as repetitive and "*superfluous and unnecessary paperwork*".

8. PBS

8.1 Phone authorisation

Dr CS3 reported that he typically does 12 PBS phone authorisations per week, each of which take about three minutes (36 minutes total time per week).

8.2 Written authorisation

Dr CS3 does not do written PBS authorisations because he stated that they are too time-consuming.

9. Cost Estimates

The cost estimates of compliance for CS3 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and EPC items.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), SIP and EPC are based on the GP.

The practice based costs for CS3 was $20,590 and represents 3.0% of the gross operating cost (GOC) of the practice. This was mostly attributed to the PIP (94.8%), with a small proportion attributed to EPC programs (5.2%). The bulk of these costs were attributed to the principal GP (88.1%), with few costs associated in other expense categories.

Table 10: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$17,509	-	$1,089	$599	-	$16	$300	$19,513	94.8%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	$631	-	$447	-	-	-	-	$1,078	5.2%
Total	$18,140	-	$1,536	$599	-	$16	$300	$20,590	100.0%
% of Compliance Costs	88.1%	0.0%	7.5%	2.9%	0.0%	0.1%	1.5%	100.0%	

The total GP related compliance costs for the GP interviewed was $42,508 (Table 2). Almost half (46.2%) was attributed vocational registration, and one third (31.0%) to EPC items. The remainder were distributed mostly between the PBS, Centrelink and SIP programs.

GP compliance costs were primarily accounted for by the GP's time with 92.1% being associated with the principal GP. Few costs were associated with other cost categories.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 12.2% of a single GP's 'share' of the practice GOC[5].

Table 11: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	-	$309	-	-	-	-	-	$309	0.7%
SIP	$1,577	-	-	-	-	$191	-	$1,768	4.2%
EPC	$10,628	-	-	$2,443	-	$102	-	$13,173	31.0%
VR	$19,323	-	-	-	-	-	$300	$19,623	46.2%
Centrelink	$5,205	-	-	-	-	-	-	$5,205	12.2%
DVA	$158	-	-	-	-	-	-	$158	0.4%
PBS	$2,271	-	-	-	-	-	-	$2,271	5.3%
Total	$39,163	$309	-	$2,443	-	$293	$300	$42,508	100.0%
% of Compliance Costs	92.1%	0.7%	0.0%	5.7%	0.0%	0.7%	0.7%	100.0%	

[5] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 4:
Solo Inner Metropolitan Practice

1. Contextual Information

1.1 Practice Profile

CS4 is a solo practice situated in an inner city, low SES suburb. Older patients make up the majority of the patient base. 85% of the patients have a health or pensioner card. The practice was established in 1959 by a solo GP who sold the practice to Dr CS4 in 1986. This means that some of the patients have been clients to the practice all their life, and have established a long-term relationship with the GP. Continuity of care, careful follow-up of patients and one-to-one service are important to Dr CS4, who feels he would desert his patients if he had to leave the practice.

The practice is still bulk billing. However, it will stop doing so in January 2003, in order to remain financially viable. Dr CS4 expects a decrease in the number of patients. However, he hopes this drop will be temporary as only a few medical clinics are still bulkbilling in the area.

1.2 Practice size, number of EFT GPs and other staff

Dr CS4 is working full time in the practice. He benefits from the support of one full-time and two casual receptionists.

Dr CS4 conducted 6 sessions (24 hours) in the observation period, and saw 120 patients. His patient base comprises about 1000 people.

2. Overall issues relating to Program Compliance

2.1 General attitude

Dr CS4 feels insulted by the fact that the medical rebate has virtually not increased over the last decade. He thinks that maintaining financial viability for the practice has become increasingly difficult, and feels that he is forced to provide the same level of care without any increase in rebate. He is aware that the survival of his business is threatened by the insufficiency of the income generated by bulkbilled consultations alone.

Dr CS4 is also concerned about the increased amount of paperwork that he has to do, and feels that the *"government has betrayed GPs"*. Despite his reported efforts and dedication to his patients, Dr CS4 is feels overwhelmed by administrative and regulatory requirements, and fears that his practice is going bankrupt.

2.2 Program participation

The practice has just been accredited (September 2002). The process of accreditation was undertaken so that PIP payments could be received. The practice received PIP payments until accreditation became a requirement. Now that the practice has received accreditation, the GP intends to join the PIP again.

At present, Dr CS4 does not take part in the EPC program. It is also his intention to examine the conditions that would allow him to participate. His decision to participate is a purely financial one, as he sees little medical value in the program.

Compliance with the programs is a considerable burden to this GP, who does not rely on his administrative staff to support him. He felt that there is little clinical value attached to the programs, and that the ultimate objective of the government is to push solo practitioners out of business.

3. PIP Program

3.1 Key Issues

Dr CS4 had to stop his participation in the PIP in July 2001, because his practice was not accredited.

For Dr CS4, the primary objective of joining the PIP is a financial one. He felt that he had no choice but to be accredited and join the PIP in order to avoid bankruptcy. He thought that the programs will bring no improvement to patient medical care and may reward bad GPs, who will receive payment for doing things they should have done anyway. *"So I have jumped through the hoops of accreditation so that I can join a program that will get me to fill out a lot of forms to prove what I've been doing for the last 20 years."*

Dr CS4 also questioned the logic of having to be accredited to be able to receive PIP payments.

3.2 Accreditation

The practice received its accreditation in September 2002.

The accreditation process was reported to be time-consuming and mainly a bureaucratic requirement. Dr CS4 reported that he had made few capital improvements because his practice was already run following high standards. The process involved:

- Accreditation preparation time:
  - A three hour formal meeting per week for eight weeks during which the GP and the Practice manager would work through the accreditation manual and implemented changes;
  - A total of 2 hours each (GP and PM) to fill out the accreditation application forms;
  - A total of 6 hours each (PM and GP) to prepare for the self assessment;
  - One hour of GP time and ½ hour of PM time to gather documentary evidence of accreditation.
- Survey time, which took two hours of GP time and 1 hour of the Practice manager's time
- Accreditation fees including $1,100 (AGPAL);
- Capital improvements include:
  - Practice brochure and information $50;
  - Display stand for health information and disease prevention $500;
  - Movable patient screen $450;
  - CD radio and speakers system $200;
  - Removable wheelchair ramp $350;
  - Refrigerator for vaccines $350;
  - Minimum/maximum thermometer $50; and
  - Toilet signs $10.
- Training of practice manager cost $1,000;
- Handyman fees $30.

During the observation period, 15 minutes of GP and 15 minutes of PM time were spent reviewing the stock control system.

3.3 IM/IT

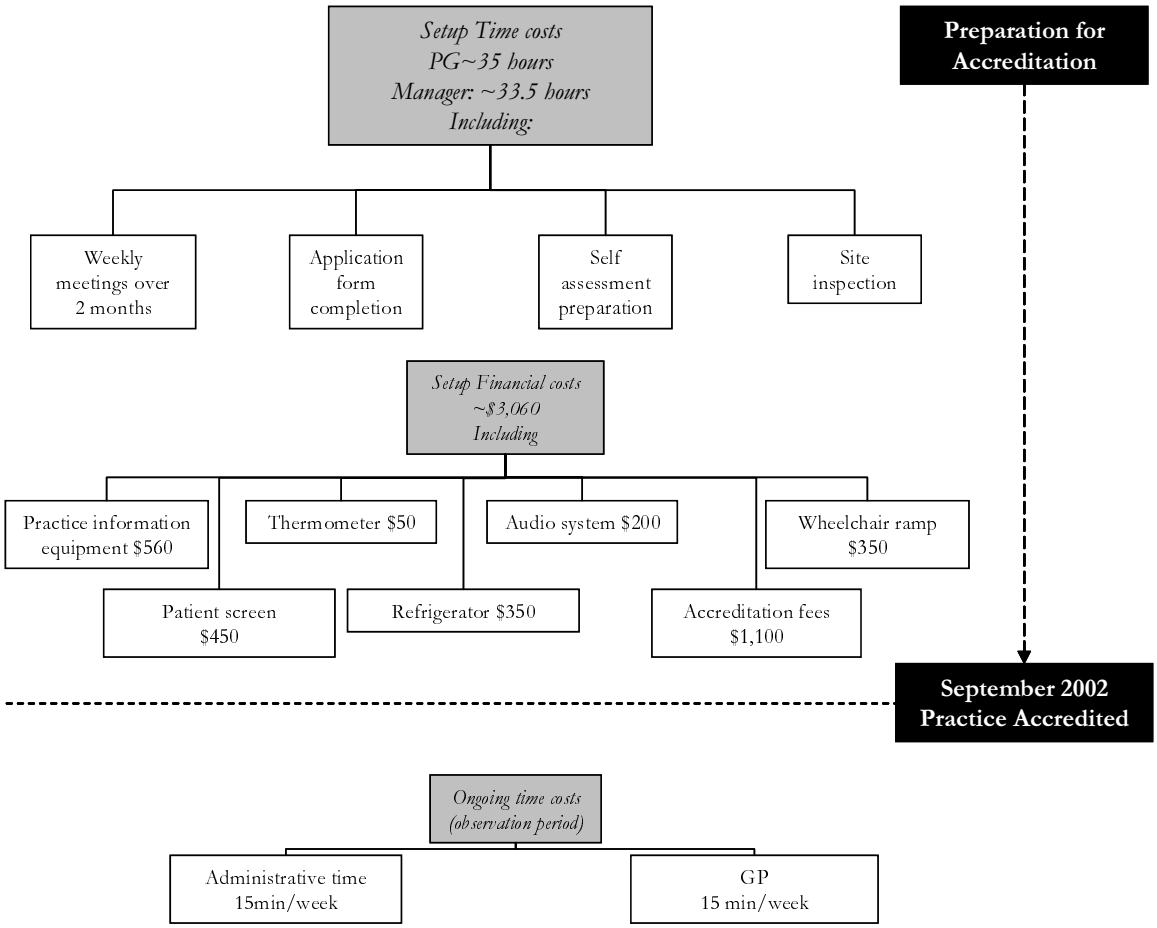
The practice does not receive PIP payments in relation to IM/IT.

The computerisation of the practice occurred before 2001, using the PIP initial incentives. According to Dr CS4, this computerisation would have happened anyway, however the incentives were helpful in implementing it faster and in a more efficient way. Computerisation was also facilitated by the support of the Division.

The practice is equipped with Medical Director, which was purchased outside the PIP because the practice was not then accredited.

DR CS4 spent one hour updating the software during the observation period.

Figure 16: Accreditation Process map



3.4 After Hours Care

The practice does not receive PIP payments in relation to After Hours Care.

$400 is spent yearly to subscribe to a deputising service. Additionally, 12 hours are spent by the GP and 24 hours by the practice manager to read, follow up, and file related paperwork.

3.5 Rural Loading

Not applicable.

3.6 Teaching

The practice does not receive PIP payments in relation to teaching activities.

Dr CS4 does not envisage doing any teaching, as he considers it to be too time-consuming. The remuneration is said to be negligible and not reflecting at all the costs of having a student.

3.7 NPS program

The practice does not receive PIP payments in relation to the NPS program.

3.8 Immunisation Incentive

The practice does not receive PIP payments in relation to the Immunisation Incentive Program.

DR CS4 stressed that his practice is already ensuring that patients complete their immunisation schedule by doing recalls and reviews of patient files.

3.9 SIP

The practice does not receive PIP payments in relation to SIP.

3.9.1 Diabetes SIP

Dr CS4 intends to join the SIP Diabetes Program, because it suits his practice. However, he stresses that he is already delivering the required level of care to his diabetic patients. Therefore, he sees the program as an additional and unnecessary administrative constraint so that he can get paid for what he already does.

3.9.2 Cervical screening SIP

He does not think he will be able to claim any SIP cervical screening payment because very few of his patients have not have had a cervical screening in the past four years, a result of the regular follow-up he gives to his patients. Consequently, he feels he is being *"penalised by the individual follow-up of patients"* he undertakes routinely.

3.9.3 Asthma SIP

Dr CS4 considers that Asthma SIPs are too complicated to organise, and that requiring patients to comply with the three visits is too hard. He doesn't intend to undertake this section of the program. *"How do you ask a patient you have been following for 30 years to come back three times in three months?"*

4. EPC

4.1 Key Issues

Dr CS4 does not undertake any EPC activities. The practice does not have a practice nurse. He is having discussions with a colleague of his about how best to implement these activities and how financially rewarding they might be. His opinion is that the only benefit of the program is financial. Because he has been following his patients for so long, he doesn't expect to discover new elements while undertaking a health assessment or a DMMR.

He doesn't intend to undertake any formal case conferences because of the amount of paperwork required. *"I already do it informally, I just don't get paid for it"*.

Dr CS4 will probably undertake health assessments and DMMR in the future, as he considered them to be suitable to his practice and cost efficient.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

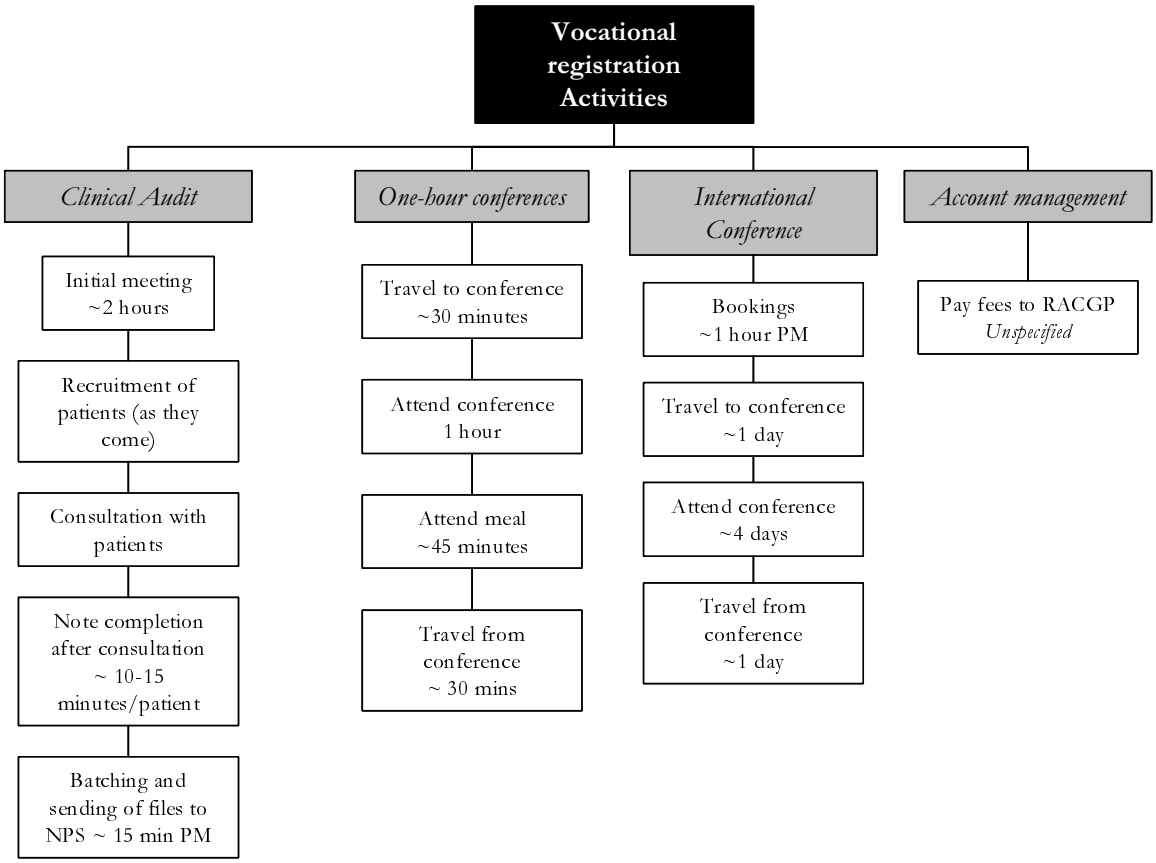
Not Applicable

5.2 Vocational registration

Over the last 18 months Dr CS4 undertook:

- A clinical audit (50 points), involving:
  - Initial meeting (2 hours);
  - Recruitment of 10 patients (10 minutes per patient); and
  - 10 to 15 minutes (additional to consultation time charged) for each patients and for 4 visits (10 to 15 x 10 x 4 = 400 to 600 minutes).
- One 'Check on Check' program (20 points - 5 hours);
- 4 x 1 hour conferences organised by drug companies (1 point):
  - one hour travel (return);
  - one hour conference' and
  - 45 minute dinner (to which Dr CS4 would rather not attend).
- A four-day conference in Bali including:
  - Travel and accommodation costs of around $1,500; and
  - Registration fees $500.

Figure 17: Vocational registration process map



6. Centrelink

6.1 Key Issues

6.2 Disability allowance (TDR)

Dr CS4 reported that the new Centrelink forms are *"disgraceful"*, requiring more time to fill out. A comprehensive approach to these new forms would require 1 hour (including a description of all existing conditions). A realistic approach would require 15 minutes of his time. The amount of information required and the necessity to go back to the patient file notes mean that Dr CS4 cannot fill them out during the consultation. He therefore, cannot be remunerated for the time he spends filling out the disability allowance forms. He fills out about one disability allowance form per week.

6.3 Sickness allowance (Medical certificate)

Dr CS4 estimated that he spends 5 to 10 minutes (consultation time) to fill these forms out, twice a week.

6.4 New Start and Mobility Allowance

These forms are uncommon and Dr CS4 was unsure about them.

6.5 Carer payment/allowance

Dr CS4 did not make a distinction between the two forms (carer allowance and carer payment)

During the observation period, he spent 20 minutes to fill in a medical report and assessment form. Another 5 minutes of PM time was necessary to process the form. He estimated that he has to complete 1 of these forms every fortnight.

7. DVA

Dr CS4 was unsure about the time involved in completing DVA forms, because he has few DVA patients (about 10% of his patients), and the forms do not need to be updated often.

8. PBS

8.1 Phone authorisation

Dr CS4 did 3 phone authorisations during the observation period. It took him a total of 20 minutes. He estimated that he spends about 30 hours per year doing phone authorisations.

8.2 Written authorisation

Dr CS4 did one written authorisation during the observation period. It took him 5 minutes. He estimated that he spends about 6 hours per year doing written authorisations.

9. Cost Estimates

The cost estimates of compliance for CS4 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs were limited to the PIP [including accreditation}.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, and PBS where the costs are GP based.

The practice based costs for CS4 was $1,872 and represents 0.9% of the gross operating cost (GOC) of the practice. This was entirely attributed to PIP with no practice-based costs for SIP and EPC. The bulk of these costs were attributed to annualised expenses associated with accreditation (62.8%). The remainder were primarily associated with the principal GP (27.1%).

Table 12: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$508	-	$189	-	-	-	$1,175	$1,872	100.0%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	$508	-	$189	-	-	-	$1,175	$1,872	100.0%
% of Compliance Costs	27.1%	0.0%	10.1%	0.0%	0.0%	0.0%	62.8%	100.0%	

The total GP related compliance costs for the GP interviewed was $9,727 (Table 2). Almost three quarters of these costs (71.9%) were attributed to vocational registration. The remainder was distributed between the Centrelink (13.6%) and PBS programs (14.5%).

GP compliance costs were primarily due to the GP's time, with 79.1% being associated by the principal GP. The remainder was non-labour cost.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 4.4% of a single GP's 'share' of the practice GOC[6].

Table 13: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	-	-	-	-	-	-	-	-	0.0%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	-	-	-	-	-	-	-	-	0.0%
VR	$4,992	-	-	-	-	-	$2,000	$6,992	71.9%
Centrelink	$1,284	-	$36	-	-	-	-	$1,320	13.6%
DVA	-	-	-	-	-	-	-	-	0.0%
PBS	$1,415	-	-	-	-	-	-	$1,415	14.5%
Total	$7,691	-	$36	-	-	-	$2,000	$9,727	100.0%
% of Compliance Costs	79.1%	0.0%	0.4%	0.0%	0.0%	0.0%	20.6%	100.0%	

[6] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 5:
Inner Metropolitan Corporate Practice

1. Contextual Information

1.1 Practice Profile

CS5 is a corporate practice located in a middle class inner suburb. It has large and new facilities and offers services including general practice (13 GPs), nursing (4 nurses), specialists and allied health (including pharmacy and podiatry). It treats an average of 1,500 patients a week, and employs a total of 14 administrative staff. The medical centre bills privately.

The Medical Centre was accredited in 2001. Because it opened only a year before the accreditation process began, little extra capital investment was required to conform with the accreditation requirements.

The PIP and EPC program are both widely undertaken by the practice, and extensive systems and procedures have been developed to facilitate GPs work, drawing upon resources available from the Corporation Head Office and the Divisions of General Practice. These programs are considered to be useful medical tools by the GP interviewed.

1.2 Participating GP

Dr CS5 is working full time (50 hours a week or more), and sees an average of 150 patients a week. As the other GPs in the centre, he pays a fee for administration services to the medical centre, and receives all the fees generated by his consultations. Additionally, a proportion of the PIP payments is redistributed to him.

He has been working in the medical centre for three years, before which he was working in a two-GP practice. He believes that working in large medical centres (be they corporate, associations of cooperative) is the future of medical practice because of the benefits they offers to the GPs and to the patients (economy of scale, professional development, communication with colleagues, access to allied health and nursing, higher quality care).

Dr CS5 plays an active and executive role in a number of peak general practice organisations, which takes approximately 10 to 15 hours per week of his time in addition to his work in the centre.

2. Overall issues relating to Program Compliance

2.1 General attitude

There is an increasing amount of paperwork in general practice, and Dr CS5 has heard many complaints about this issue from colleagues. He is concerned that the volume of paperwork is increasing to an unacceptable level, and that the remuneration of GPs is becoming seriously affected by the unpaid time spent on paperwork and other administrative tasks. He mentioned the number of telephone calls that GPs have to give for free, whereas other professions (lawyers or accountants) charge for telephone calls.

2.2 Program participation

Dr CS5 has a very good knowledge of how to operate the different PIP and EPC activities and how to integrate them (e.g. SIP followed by care plan). Therefore, he is able to undertake a large number of the PIP and EPC activities, making ample use of the practice nurses, and of the systems and procedures developed by the administrative staff and corporate head office. In addition, he is well

informed of the Division's capacity to support GPs with the programs and is able to draw on the resources available through them.

Dr CS5 believes that the PIP has some positive effects on the quality of care delivered in general practice. The monetary role of PIP is not as significant, he thinks, as the clinical role. Therefore, his participation to PIP is mainly explained by the clinical benefits he sees attached to the program, and not primarily for the income he receives from it.

Dr CS5 doesn't think that the paperwork directly associated with the programs should be a deterrent to GP participation. Paperwork is considered to be part of patient care, and therefore not a problem.

However, Dr CS5 stresses that sometimes the patient load gets too high for him (and his colleagues) to take the time to undertake a PIP or EPC activity. He then will just do a normal consultation rather than take the time to fill out forms. "It is often difficult to get other GPs' participation because they are too busy to fill out forms".

He also believes further efforts should be made to make the documentation required for the programs smoother and more trusting. The present caveats inhibit cooperation and progression.

3. PIP Program

3.1 Accreditation

The practice was accredited in July 2001, and opened a year before that. Therefore, most building arrangement decisions were made with the accreditation standards in mind. Furthermore, most decisions would have been the same with or without the requirements of accreditation (e.g. wheelchair access ramp).

A number of things had to be changed or would not have been done without accreditation:

- Patient files location:
  - They are now in locked files in doctors room and not in pigeonholes in the reception area
  - This change is more time consuming for the reception staff, who have to spend 5 to 6 minutes more per patient using and maintaining the new filing requirements
  - No purchase of equipment was necessary.
- Additional signs (eg. toilets);
- Modification to bars stopping cars on parking lot ($150);
- Electronic prescription is probably something that would not have been implemented so strictly.
  - Purchase of software for 13 GPs (Rx and Locum)
  - Training: 2 one-hour sessions for all GPs with the Head Office IT support team.

The practice manager undertook the preparation for accreditation. It included:

- Reading and implementation of the practice manuals, development of procedures, patient survey (100 hours);
- Training of staff including:
  - Nurses: 10 hours of PM and nurse time (2.5 hours per nurse x 4); and
  - Receptionists: 5 hours of PM and receptionist time (12 receptionists). Additionally, the receptionists would have had to spend 10 to 15 minutes to read and become familiar with the procedures.

- Surveyor visit (1 day) included meetings with:
  - each GP (Dr CS5 = 1 hour);
  - one receptionist (15 minutes);
  - the Second-in-Charge (45 minutes);
  - each nurse (45 minutes each); and
  - the PM, who had to spend all day with them;
- The patient survey administration required 2 minutes per patient (x190) of receptionist time.

3.2 Maintenance of accreditation

Maintenance of accreditation requires:

- Modification to the practice's information sign (GPs on duty);
  - 10 minutes PM time to set up template (one off);
  - 5 minutes of PM time weekly to update sign.
- Nurses work: maintenance of autoclave, drugs expiry dates, documentation: 5 hours per month.
- Order script paper, ensure answering machine and filing system are up-to-date:
  - 10 minutes PM time; and
  - 20 minutes Second-in-Charge time.

3.3 IM/IT

The centre benefits from the dedicated work of one of the GPs who is *"a real whiz"* with computer matters. The practice is Tier 3. Electronic transmission of data would have been undertaken without PIP incentives:

- The prescribing software was purchased in order to conform with the accreditation standards (Rx and Locum x 13 GPs);
- The maintenance and training costs are supported by the corporate head office;
- A second modem was installed to enable the electronic transmission of data;
- The transmission of Medicare data takes 20 to 30 minutes daily of Second-in-Charge time; and
- A nurse spends 15 minutes daily downloading pathology results.

3.4 After Hours Care

The practice is in Tier 2.

Costs mentioned by the PM include:

- Registration with locum service ($50 per month); and
- Receptionist time: 10 minutes per week.

After hours arrangements would be made without PIP incentives.

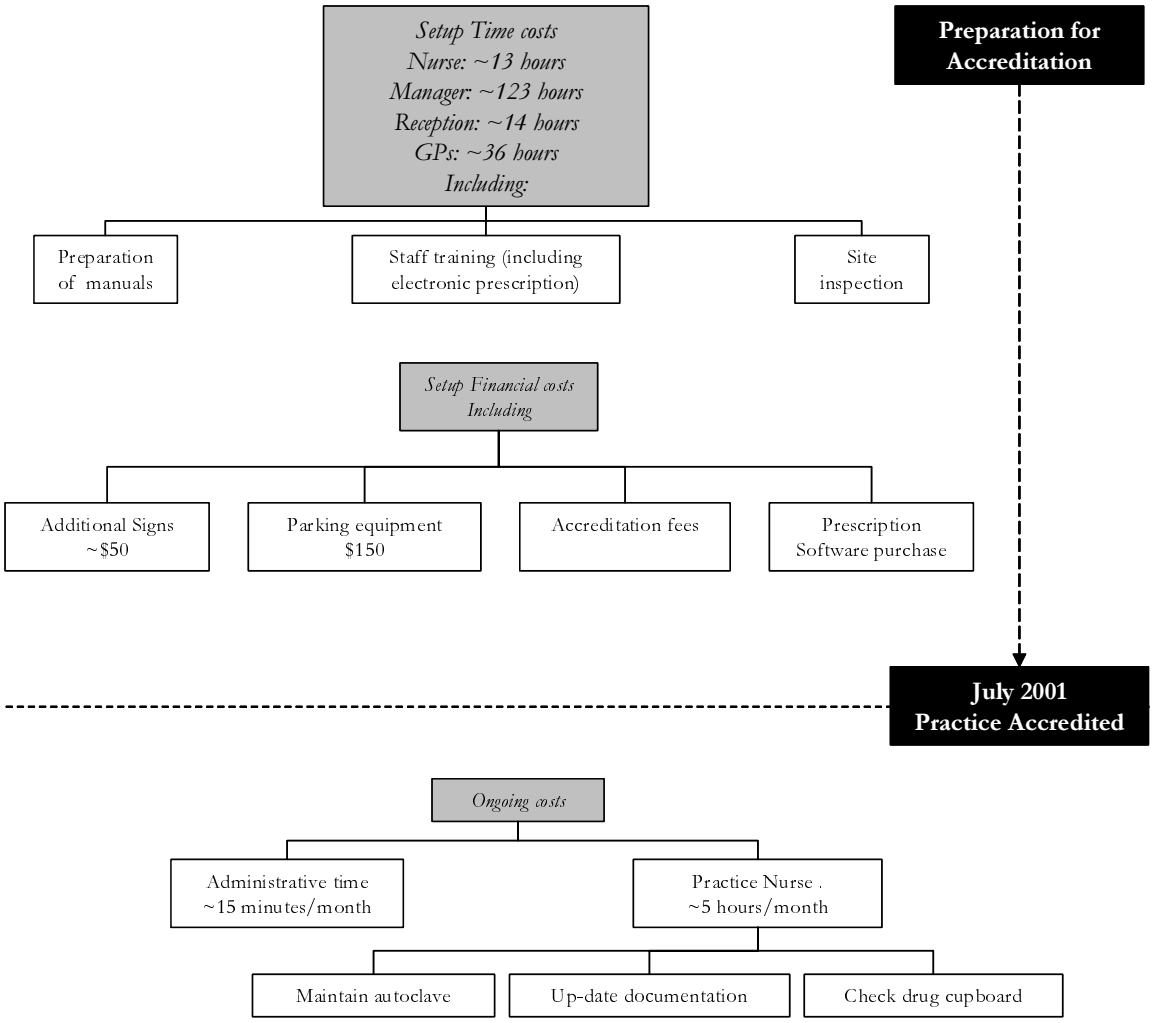
3.5 Rural Loading

Not applicable

3.6 Teaching

Dr CS5 has not had any students this year because of his other commitments in peak organisations. PIP incentives are not factored in to his decision to teach. He has had students in the past without being paid, because he was committed to teaching, despite the large amount of time that it takes. The money paid by the PIP for teaching is said to be insignificant.

Figure 18: Accreditation Process Map



3.7 NPS program

3.7.1 Case studies

Dr CS5 does not undertake case studies.

3.7.2 Practice visit

Dr CS5 does not undertake practice visits.

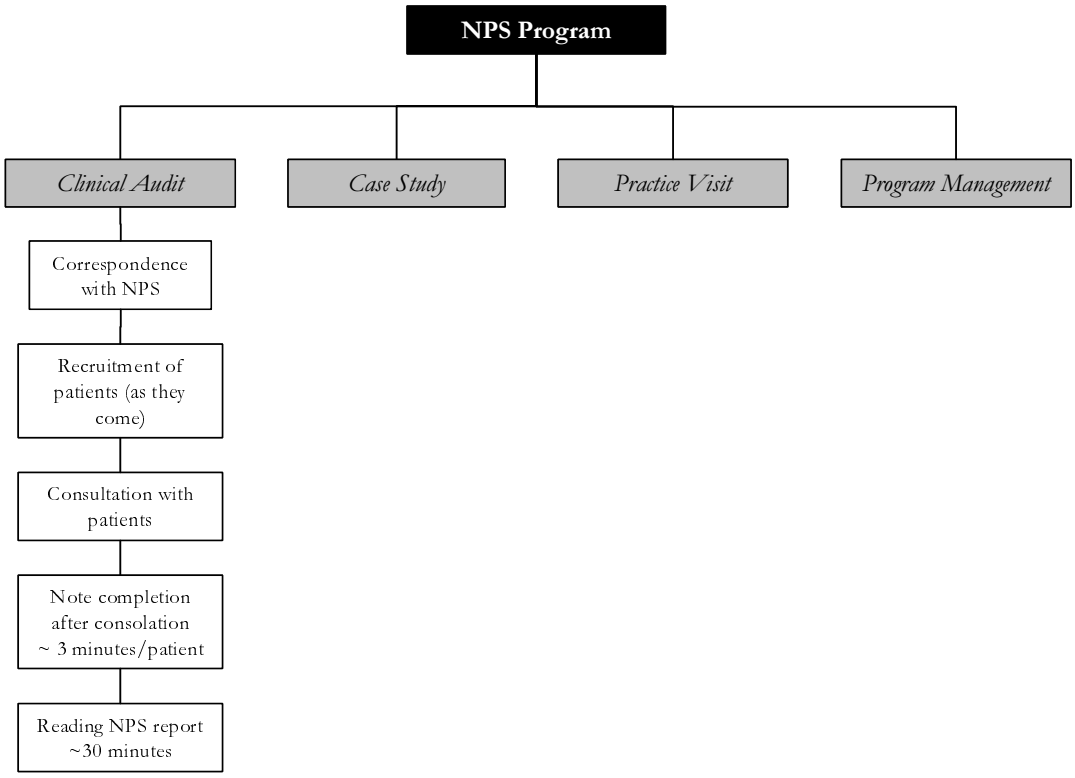
3.7.3 Clinical audit

The last clinical done by Dr CS5 included 100 patients and took place over two weeks. He estimated that he spent:

- 3 minutes per patient writing out notes (after the consultation);
- 30 minutes on correspondence with NPS in total; and
- 30 minutes on the report sent by NPS.

He stressed the value of clinical audits for clinicians who thus have a chance to receive feedback on their work practices. He is not interested by the fact that clinical audits are part of PIP.

Figure 19: NPS Program Process Map



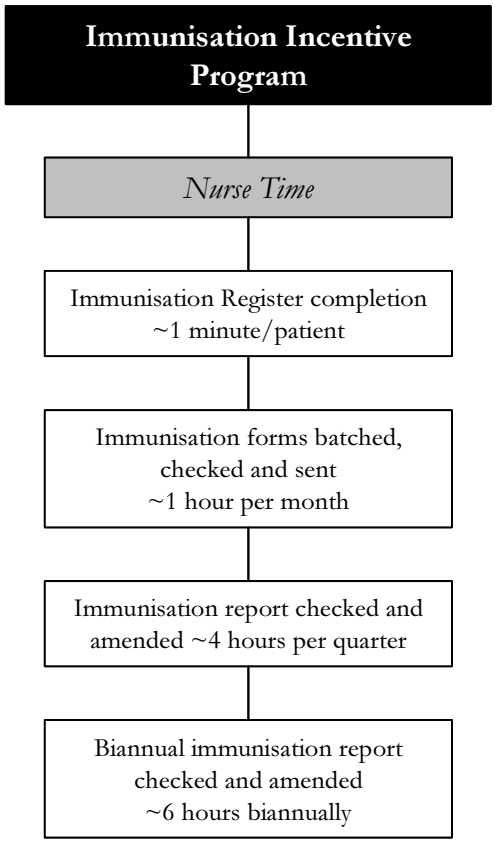
3.8 Immunisation Incentive

Paperwork is not done by the GP as the nursing staff takes care of this aspect of the immunisation process.

Activity map:

- The immunisation register is filled out (nurse: 1 minute) for each patient;
- At the end of the months all the immunisation forms are batched, checked and sent (1 hour nurse time);
- Every quarter the Register sends a report and a nurse has to check and correct all details (4 hours); and
- Twice a year a report is sent of all children who have completed the immunisation cycle, which the nurse needs to check and correct (involving contacting parents). This is said to be very burdensome, requiring a lot of concentration (6 hours).

Figure 20: Immunisation Incentive Process Map



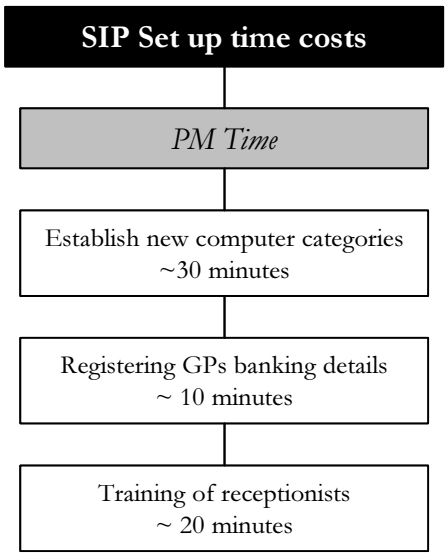
3.9 SIP

Dr CS5 undertakes SIP programs and thinks that they are of medical value but time consuming. They also require considerable paperwork, to which many doctors would be adverse. He doesn't think they would be feasible without administrative and nursing support.

The procedures necessary to establish SIP were developed by the PM and include:

- Establish new computer categories to enter HIC items (30 minutes);
- Entering banking details from GPs (10 minutes); and
- Training of receptionists (20 minutes).

Figure 21: SIP Set-up Process map



3.9.1 Mental health SIP

The program has started only a month ago, and GP CS5 has undertaken 4 Mental Health SIPs during this period (approximately 1 a week). All form completion occurs during the consultation.

Activity map:

- Engagement consultation (Normal consultation during which Dr CS5 invites the patients to come back to initiate a SIP);
- Inform administrative staff that a Mental Health Sip will be undertaken;
- Visit 1 (assessment);
- Visit 2 (plan); and
- Visit 3 (review).

Dr CS5 is the only GP at the practice undertaking Mental Health SIP. He thinks that the paperwork involved for this SIP is acceptable and has actually helped him with managing the disease and keeping track of the treatment course. However, he also acknowledged the supporting role of the administrative staff.

3.9.2 Diabetes SIP

He prefers using Care Plans rather than SIP for diabetic patients, because he is accustomed to the Care Plan format.

3.9.3 Asthma SIP

Dr CS5 conducts about one Asthma SIP per week, with an increased number during winter and allergy season. He estimated that the paperwork is quite acceptable and that the questions asked reflect the normal development of a consultation well. The forms produced by SIP represent a useful way to document disease management. They are *"a good discipline to have, even if the money is not that great."*

Asthma SIP involves the same activities as a Mental Health SIP. A nurse would be involved in Asthma SIP, and would spend about 20 to 30 minutes per SIP.

Figure 22: Mental Health SIP Process Map

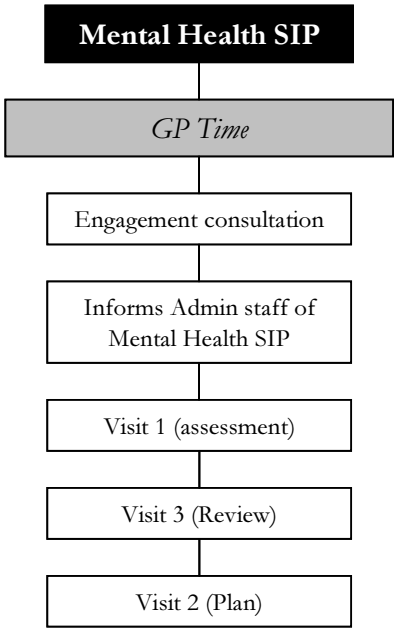
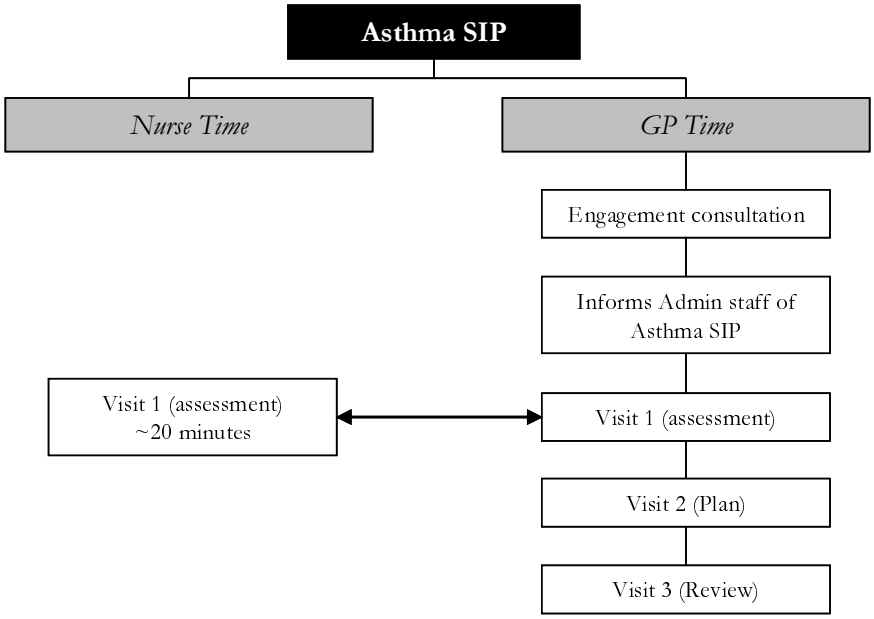


Figure 23: Asthma SIP Process Map



3.10 PIP administration

The practice manager estimated she spends about 10 minutes every month checking payments, before sending the documentation to the Head Office.

On one occurrence, communications with HIC were said to have taken an hour of PM time to check on missing SIP payments for a specific month. The PM is careful to check the payments, as mistakes seem to occur frequently (three times last year).

The PM also mentioned spending 30 minutes with HIC to amend practice details and receive payments in arrear in relation to teaching activities.

4. EPC

4.1 Key Issues

Dr CS5 undertakes Health Assessments and Care Plans. Case Conferences are not practical in a general practice context because it is difficult to gather several health providers together.

4.2 Health Assessment

Dr CS5 reported that Health Assessments *are "a wonderful tool to have a preventative approach and prevent tertiary admission"*. A Health Assessment is envisaged with all patients aged 75 and over, every year. The screening of these patients is done by computer.

Dr CS5 undertakes about 70 health assessments per year. The process is as follows:

- Eligible patients are selected by computer (one hour PM time);
- A letter is sent to them (a template was received from the Head Office; a receptionist spent 1.5 hours to print and send the letters);
- The list of willing patients is sent to the nursing service who will undertake the assessment (two hours PM time);
- The home assessment is done (60 minutes, nurse is paid $68 per patient);
- The medical centre makes appointment with the patients for the GP's assessment (one hour receptionist time);
- A nurse spends 15 minutes prior to the consultation with the patient;
- Then the doctor make the health assessment (30 minutes); and
- Billing is finally undertaken (two minutes receptionist time).

4.3 Care Plan

Dr CS5 stated that Care Plans are a good concept but need to be reviewed to streamline and simplify the documentation. He stated that they also entail a lot of work for the nursing and administrative staff, who may show some reluctance to change their usual work practices.

Dr CS5 undertakes about 30-40 care plans per year. The process includes primarily a consultation during which all paperwork is filled out. A review is then conducted with the patient three months later.

A large folder of forms was developed by the administrative staff and by the Head Office. The PM estimated that she spent one hour per folder (x 10 GPs) and about $10 per folder in expenses. The forms had been developed by the Head Office. Some time was then spent training the doctors on how to use care plans. This was done over a number of lunch meetings (average: one hour per doctor).

The success of the care plans are said to be dependant on the constant follow up of the other care providers, who have to sign and return the care plan forms back to the practice. To ensure this, a receptionist was designated and spends about one hour per week following up care providers.

Figure 24: Set-up and Ongoing Health Assessment Process Map

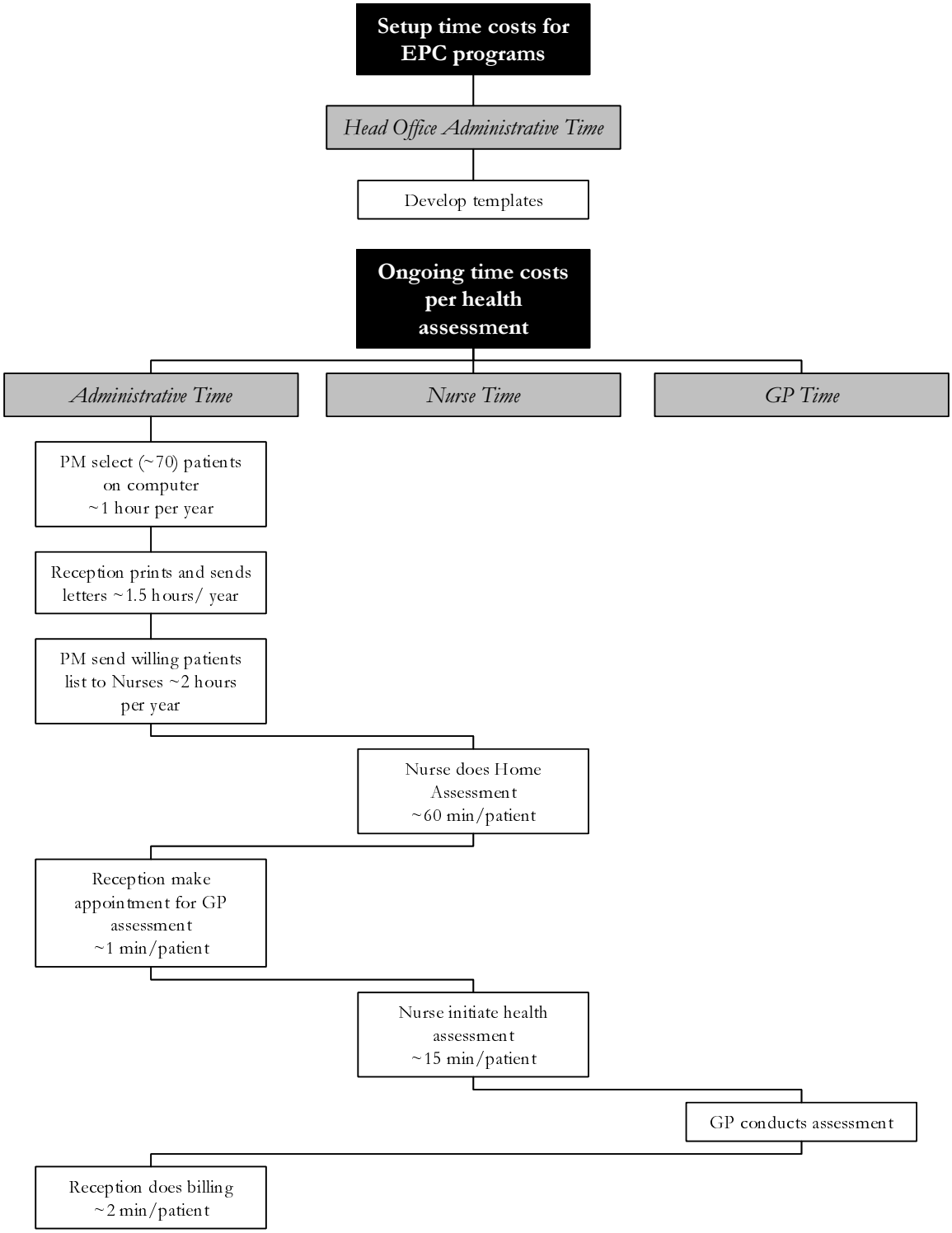
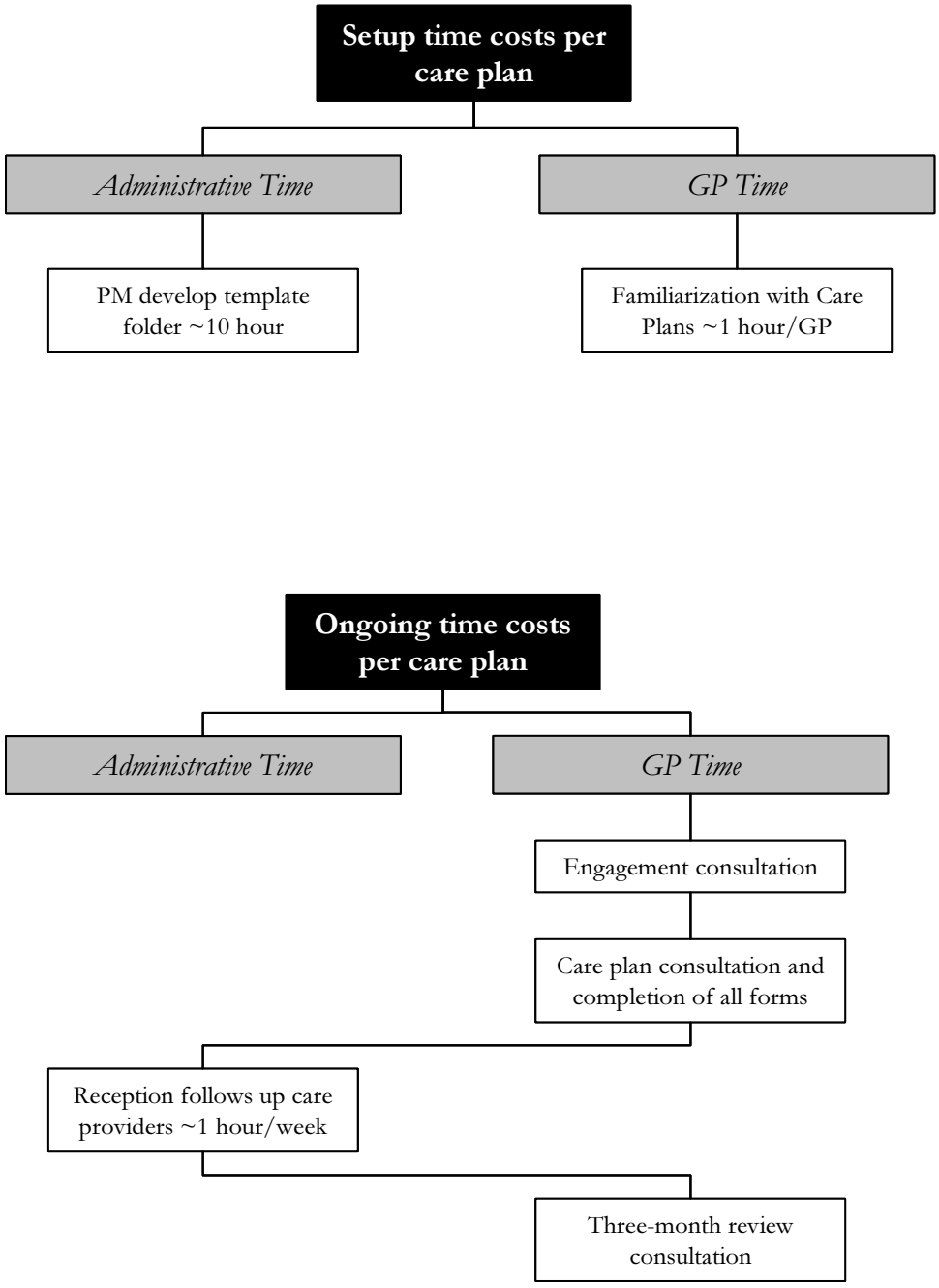


Figure 25: Care Plan Set-up and Ongoing Process Map



5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

Not Applicable.

5.2 Vocational registration

Dr CS5 estimated that he spends two to three hours per week maintaining his vocational registration. He doesn't keep count of his points, and does the different activities to stay informed and up to date.

He stressed that the 1-point meetings are actually worth 2 hours if GP time and not 1 hour as alleged, because of travel time.

He pays $250 per year to the RACGP for managing his point account.

6. Centrelink

6.1 Disability allowance

The time spent completing these forms includes:

- 20 to 45 minutes for new forms; and
- 10 minutes to complete the old forms;

Dr CS5 estimated that on average, he would complete two Centrelink form per week.

6.2 Sickness allowance

These forms involve 10 minutes of consultation time for Dr CS5. He does about three per week.

6.3 New Start/Youth allowance

These forms involve 5 minutes of Dr CS5's time, and take place during consultation. Dr CS5 does about 1 per week.

6.4 Mobility allowance

Unknown.

6.5 Carer payment/allowance

These forms involve 15 minutes of Dr CS5's time during consultation. Dr CS5 does about 2 per month.

7. DVA

7.1 Claim forms

These forms involve 15 minutes consultation time. Dr CS5 does about one DVA claim form per month per month.

7.2 Medical impairment assessment

These forms involve 20 minutes consultation time. Dr CS5 does about one every two months.

7.3 Medical report and diagnostic report

These forms involve 30 minutes consultation time. Dr CS5 does about one every two months.

8. PBS

8.1 Phone authorisation

This process involves 2 minutes consultation time. Dr CS5 does about 20 phone authorisations every week.

8.2 Written authorisation

This process involves 20 minutes consultation time. Dr CS5 does one written authorisation every 3-4 months.

9. Cost Estimates

The cost estimates of compliance for CS5 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and SIP.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), SIP and EPC are based on the GP.

The practice based costs for CS5 was $15,651 and represents 0.8% of the gross operating cost (GOC) of the practice. This was almost entirely attributed to PIP, with a small proportion attributed to SIP. No practice-based costs were attributed to EPC. Just under half (44.4%) of these costs were associated with nursing staff time spent on accreditation. The remainder were primarily associated with annualised expenses (15.6%), and other professional support (13.6%). Only a small proportion of these costs were associated with GPs.

Table 14: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$450	$600	$1,535	$6,942	$2,123	$1,517	$2,447	$15,614	99.8%
SIP	-	-	$30	-	-	$7	-	$37	0.2%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	$450	$600	$1,565	$6,942	$2,123	$1,524	$2,447	$15,651	100.0%
% of Compliance Costs	2.9%	3.8%	10.0%	44.4%	13.6%	9.7%	15.6%	100.0%	

The total GP related compliance costs for the GP interviewed was $39,900 (Table 2). Over one third (35.4%) of these costs were attributed to vocational registration costs. One fifth was attributed to Centrelink (20.9%) and EPC (20.3%) related costs. There were few costs associated with other programs.

GP compliance costs were primarily due to the GP's time with 83.8% being attributed to the principal GP.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 16.8% of a single GP's 'share' of the practice GOC[7].

Table 15: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$540	-	-	$529	-	-	-	$1,069	2.7%
SIP	$3,960	-	-	$742	-	$80	-	$4,782	12.0%
EPC	$3,240	-	$1,170	$2,188	-	$1,142	$350	$8,089	20.3%
VR	$13,860	-	-	-	-	-	$250	$14,110	35.4%
Centrelink	$8,340	-	-	-	-	-	-	$8,340	20.9%
DVA	$270	-	-	-	-	-	-	$270	0.7%
PBS	$3,240	-	-	-	-	-	-	$3,240	8.1%
Total	$33,450	-	$1,170	$3,458	-	$1,222	$600	$39,900	100.0%
% of Compliance Costs	83.8%	0.0%	2.9%	8.7%	0.0%	3.1%	1.5%	100.0%	

[7] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 6:
Rural Group Practice

1. Contextual Information

1.1 Location – SES profile

Case Study six (CS6) is a multi site practice based across a number of rural locations. The case study focuses on one clinic.

1.2 Patient base – practice specialty

In addition to the regular practice, the CS6 clinic also acts as a service company, providing case management services to other medical organisations.

Other services provided by the practice include:

- Family medicine;
- Women's health;
- Immunisations;
- Aged Care; and
- Community Mental Health.

The practice currently bulk bills.

1.3 P*r*actice size, number of EFT GPs and other staff

Employed across the practices are:

- Fifteen EFT GPs;
- One group manager;
- Three EFT administrative staff;
- Three EFT nurses; and
- Ten EFT receptionist staff.

1.4 Participating GP

The Participating Doctor in the CS6 clinic (henceforth Dr CS6) works from four practices in the local area.

2. Overall issues relating to Program Compliance

2.1 General attitude

Dr CS6 considered that it is reasonable that the Government should expect to receive details and paperwork associated with medical subsidies, as medical practitioners are financially subsidised by the Government. However, Dr CS6 also stated that the administrative requirements of running a general practice are high, and offer very little reward for the GP.

Dr CS6 reported that many GPs were already undertaking many of the administrative tasks which are now formalised into Government programs and is critical of the *"stick and carrot"* mentality held by the Commonwealth. He also considers that some of the more recent health care planning programmes place a very high burden on his practice staff.

2.2 Program participation

Dr CS6 takes part in the following programs:

- After hours care;
- Teaching;
- The immunisation incentive; and
- Asthmatic, psychiatric and diabetic SIPs.

3. PIP Program

3.1 Key Issues

Dr CS6 has now gone through the accreditation process in four different clinics. He reported that a moderate amount of GP time is spent in the process, but the practice manager undertakes the bulk of the work. The most time consuming aspect of accreditation was the construction of practice manuals, which once developed, were easily modified for the other practice sites.

Dr CS6 reported there were few ongoing cots associated with maintaining accreditation standards, and that re-accreditation is a far less burdensome task.

3.2 Accreditation

3.2.1 Set up costs

Dr CS6 has gone through the accreditation process on four sites and is in the process of completing accreditation in a fifth practice. He reported that going through the process for the first time was very demanding, but that it became easier each time the process was repeated.

The first time that Dr CS6 went through accreditation was in 2001. He hired an administrative assistant who worked full time on accreditation for three to four weeks. In addition, the nursing staff worked about seven to ten days to meet the accreditation requirements. This time was largely taken up with the construction of practice manuals, and ensuring that the practice met all of the structural requirements for accreditation such as fire escapes.

Dr CS6 reported that his personal involvement was largely taken up with the site visit, which took a full day of his time (between six and eight hours). Dr CS6 was also required to review 25 sets of case notes, which took between three and four hours in total.

In terms of financial cost, Dr CS6 reported that the greatest outlay involved the sterilisation requirements. He estimated that the required equipment cost around $6,000. There was also some other more minor cost including signage and additional waste bins, which he estimated cost about $400.

Dr CS6 is critical of the new sterilisation requirements, stating that the practice's previous procedures were adequate, with few cases of post operative infection. As such, he reported that the new sterilisation procedures would not reduce the incidence of infection at his clinic, and represented an unnecessary administration cost associated with the PIP.

Dr CS6 reported that subsequent accreditations were less time consuming. Although a similar amount of time is required from the Doctors involved, the administrative and nursing time required is reduced. Dr CS6 estimate that the more recent accreditations would have taken about one quarter of the time taken for the first. This is because Dr CS6 was able to use existing practice manuals which need to be tailored for the practice, as opposed to having to write new manuals.

3.2.2 Ongoing costs

Dr CS6 estimated that between two and three hours of GP time, and between 20 and 30 hours of administrative time are required to maintain the accreditation standards and quality improvement each year.

Dr CS6 has not yet gone through the reaccreditation process. However, he is apprehensive about the process as he has heard rumours about *"raising the height of bars"* such that new and more stringent requirements will be introduced.

3.3 IM/IT

3.3.1 Set up costs

The practice was fully computerised *before* they were accredited (the hardware and software systems were installed in 1999, and cost around $40,000 for one clinic). The practice uses the Spectrum and Medical Director Software.

Dr CS6 reported that the GPs were not involved in setting up the computing system. The practice received help from an IT consultant from the Division, and another consultant who also had an interest in software. All together, Dr CS6 estimated that installing the computing systems and training the staff took about six weeks of these consultants' time. In addition, he estimated that it would take a single GP 40 hours to learn how to use the Medical Director Software. That is, for a GP who is new to computers to learn the system from scratch.

At this stage, the practice has a policy that no-one writes a paper note. Dr CS6 estimated that only 5% of his patients would require time to write a paper note.

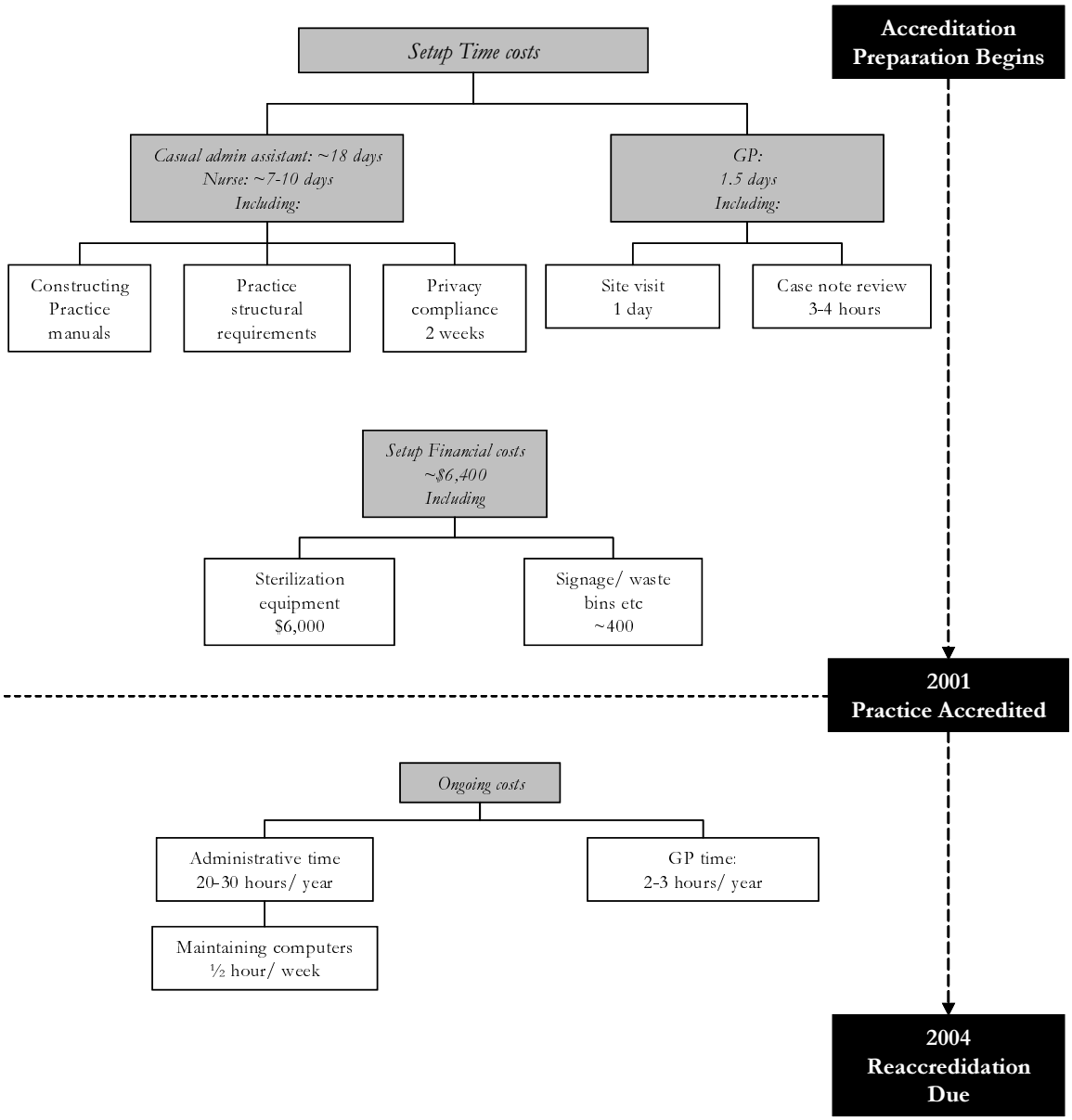
3.3.2 Ongoing costs

Dr CS6 estimated that maintaining the practice's computing systems costs about $1,600 for keeping the software up to date. In addition, about half an hour per week of the Office Manager's time is devoted to maintaining the computing system.

3.3.3 Privacy

Another major cost associated with the IT regulations was ensuring privacy of patient records. Dr CS6 estimated that it took the practice manager about two weeks to come to terms with the requirements, and ensure that the practice was compliant. This process took place for one practice, and was then applied to the other four practices, which required about half a day of administrative time per practice.

Figure 26: Accreditation Process Map



3.4 After Hours Care

The clinics operate on a one in ten roster, with one GP practicing after hours every ten days. The three clinics involved are linked by a central telephone system. After-hours calls are diverted through to the local hospital. This system was in place before The PIP accreditation, and no additional expenses were incurred.

3.5 Teaching

The practice is not a formally recognised teaching practice for the RACGP, but does have students who come from an undergraduate medical school. These students sit in with the GP for two hours per week. Dr CS6 estimated that he spent about 2 hours per week reviewing case notes for his teaching requirements.

3.6 Rural Loading

Dr CS6 was not involved in the application for Rural Loading. However, he estimated that the practice manager spent about two days preparing and filing the application. Dr CS6 reported that there was no time required to maintain Rural Loading on an ongoing basis.

3.7 NPS program

The practice is not involved in any NPS programs. Dr CS6 reported that he could not get enough interest from the other doctors. He tried to them on his own, but found that the program was not viable without a group response from the other GPs.

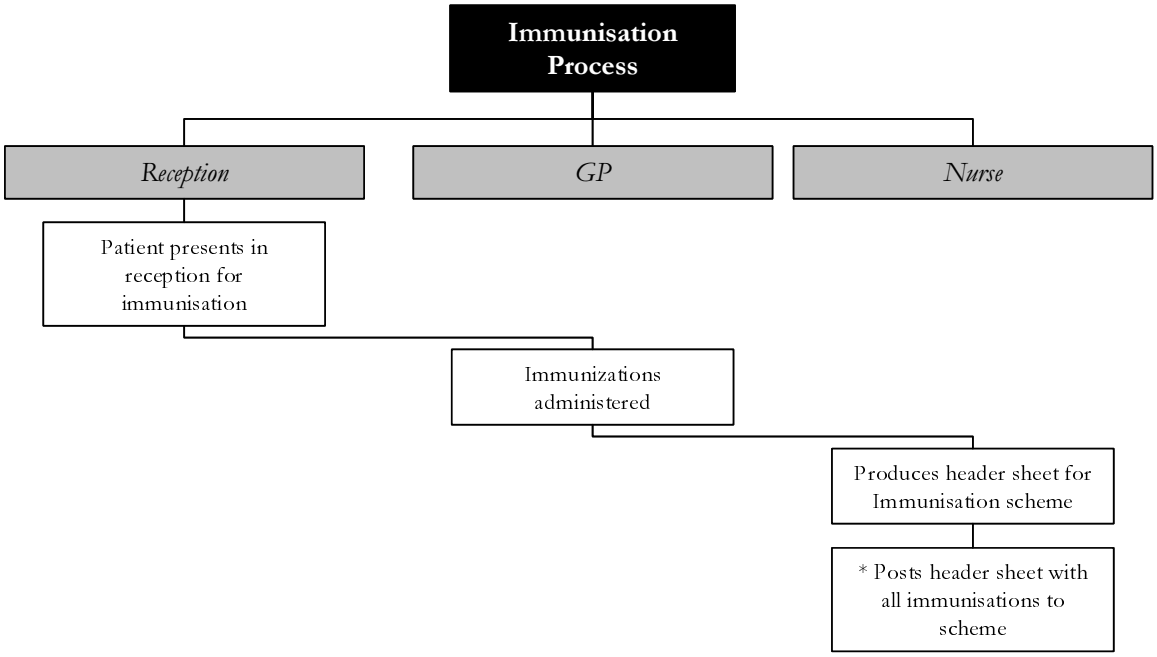
3.8 Immunisation Incentive

Dr CS6 reported that he personally spent very little time with Immunisation Incentive administration *"I just tick a box"*. It would take an administrative staff member about two hours per week to complete the immunisation documentation for GPs in all practices.

The process for completing the immunisation incentive program is:

1. The patient presents at reception for immunisation;
2. The patient is sent through to the GP for the appropriate immunisations;
3. The GP then completes a form, which is a simple matter of selecting tick boxes; and
4. The form is passed to the nurse who produces a header sheet comprising all immunisations from all GPs for sending to the GPII program.

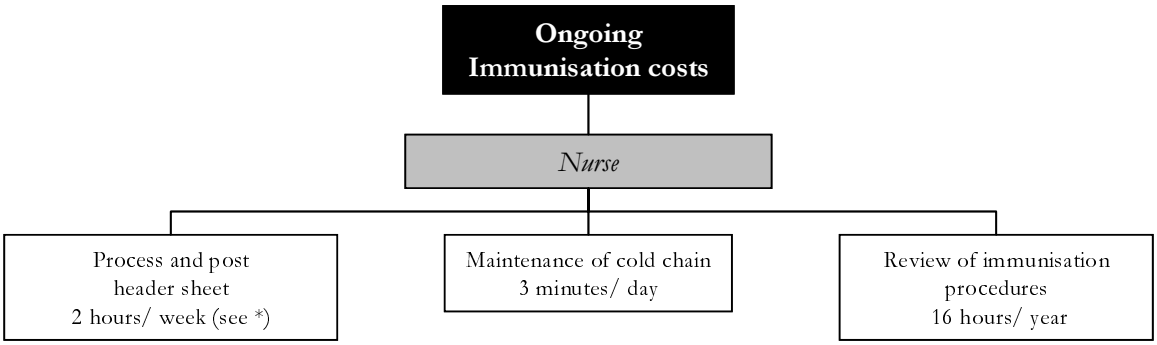
Figure 27: Immunisation Process Map



The practice is currently undertaking a review of their immunisation procedures to ensure that they are above the 'target' levels for immunisation. Dr CS6 estimated that this will take about 16 hours of administrative time over the year.

Dr CS6 reported that the greatest cost associated with GPII is the maintenance of a cold chain to store the vaccines. A nurse must check the temperature of the cold chain, and maintain the stocks stored at the practice. This would take about three minutes of nurse time per day.

Figure 28: Ongoing Immunisation



3.9 SIP

Dr CS6 does not personally take part in any SIP programs currently, but has done so in the past. He considers them to be a *"a waste of time"*.

3.9.1 Mental Health SIP

The group undertakes a limited number of Mental Health SIPs through an associate psychiatrist employed at the local hospital. Dr CS6, and could not give an estimate of the time costs.

3.9.2 Asthma SIP

The group is prepared to undertake asthma PIPs, but has not fully implemented the system yet. They have purchased spirometers at a cost of $1,800 per clinic. The nurses have attended training sessions which took a total of 18 hours (three nurses attending six hour sessions).

3.9.3 Diabetes SIP

3.9.3.1 Set-up costs

Dr CS6 undertook the set-up for the diabetes SIP. The set up was a very simple process, which involved adjusting the existing software to co-ordinate the diabetes assessment. Dr CS6 estimated that this took about half an hour of his time.

3.9.3.2 Ongoing costs

The assessments involve an interview between the GP and the patient which include:

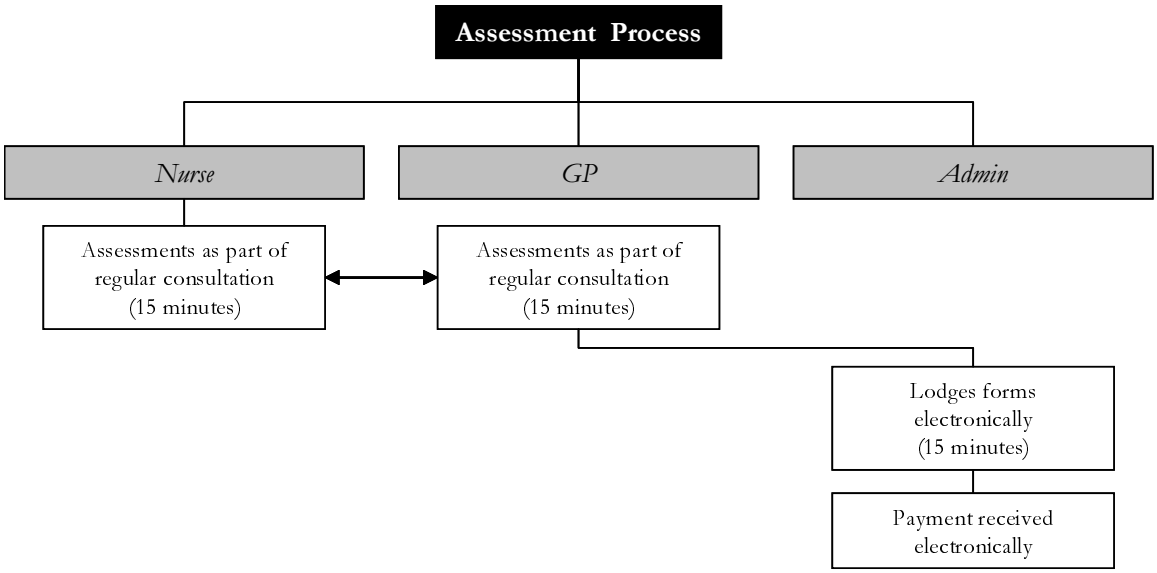
- Regular blood tests (co-ordinated by the pathology department at the clinic);
- Follow ups from specialists consulted by the patient; and
- Review of medications.

The whole process is run through the Medical Director software, and can be included as part of a regular consultation. The forms are lodged electronically with the HIC, who then issues a cheque to the practice manager each month.

The whole process takes:

- Fifteen minutes of nursing time;
- Fifteen minutes of the GPs time; and
- Fifteen minutes of administrative time.

Figure 29: Assessment Process Map



3.10 PIP administration

PIP administration is generally conducted by the practice manager. PIP administration includes:

- One day per quarter spent completing SWPE forms; and
- Two hours per year advising HIC of practice change arrangements (typically the arrival of new GPs).

4. EPC

Dr CS6 does not take part in the EPC program.

5. Vocational Registration & RACGP Fellowship

Dr CS6 was registered with the RACGP some time ago, and was unable to give a reliable estimate of the costs in terms of time or money.

5.1 Vocational registration

To meet the registration requirements, Dr CS6 spent 147 hours attending seminars in 2001/ 02. This also involved about 20 hours travel time.

5.2 Recruitment

Dr CS6 reported that the process of recruiting GPs for rural practices could be quite burdensome. He related difficulties in recruiting new graduates to rural practices. He reported that most of his recruitment takes place overseas, which is very time consuming in terms of reviewing the GPs resume and registering the GP.

Dr CS6 reported that he spent very little of his time in these processes, but estimated that the practice manager would work on the recruitment of a single GP for a total of one week, over a three to four month period.

6. Centrelink

Dr CS6 is generally critical of Centrelink forms. He stated that they are quite time-consuming, as they need to be written out by hand as the forms have not been integrated into the medical Director software.

6.1 Disability Allowance

Dr CS6 reported that the disability allowance takes about twelve minutes of his time, and takes place as part of a regular consultation. He stated that the Centrelink forms come in fits and starts, but that on average, he would probably do about four per week.

6.2 Sickness Allowance

Dr CS6 reported that the sickness allowance forms are very long and complex, requiring a complete case history of the patient. These forms would also take Dr CS6 about twelve minutes. Dr CS6 estimated that he would do about one Sickness Allowance form per week.

Dr CS6 reported that the time he spent on the forms is not covered by the allowance. He is also sceptical about how much Centrelink actually uses the information that he provides, and is critical that he has to complete these forms by hand, and is unable to lodge them electronically. Dr CS6 is pushing for Centrelink to incorporate their forms into the Medical Director Software package.

6.3 New Start/Youth Allowance

Dr CS6 has very little contact with these forms.

6.4 Mobility Allowance

Dr CS6 reported that these forms are shorter than the sickness and disability documentation, and only take about four to six minutes of his time.

7. DVA

Dr CS6 reported that the DVA forms are very long and complex. However, he also stated that GPs are paid well for completing these forms.

He perceived that the process of registration, co-ordination with the Department of Immigration requirements and HIC registration was complex and time consuming.

8. PBS

8.1 Phone authorisation

Dr CS6 reported that phone authorisation takes about four to six minutes.

8.2 Written authorisation

Dr CS6 does not undertake written authorisations.

9. Cost Estimates

The cost estimates of compliance for CS6 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and SIP items.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some SIP costs are based on the individual GP.

The practice based costs for CS6 was $14,312 and represents 2.8% of the gross operating cost (GOC) of the practice. This was almost entirely attributed to PIP with a small proportion attributed to SIP, and no practice-based costs for EPC. The bulk of these costs were attributed to the practice nurse (31.3%) and practice manager time (25.6%) associated with PIP.

Table 16: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$1,356	-	$3,662	$3,963	-	$1,493	$2,933	$13,407	93.7%
SIP	$34	-	-	$511	-	-	$360	$904	6.3%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	$1,390	-	$3,662	$4,474	-	$1,493	$3,293	$14,312	100.0%
% of Compliance Costs	9.7%	0.0%	25.6%	31.3%	0.0%	10.4%	23.0%	100.0%	

The total GP related compliance costs for the GP interviewed was $18,159 (Table 2). Half (54.4%) of these costs were associated with vocational registration, and one fifth for both Centrelink (18.0%) and PBS (24.1%).

Almost all (99.9%) of these costs were associated with the principal GP.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 7.0% of a single GP's 'share' of the practice GOC[8].

Table 17: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	-	-	-	-	-	-	-	-	0.0%
SIP	$17	-	-	$7	-	$4	-	$28	0.2%
EPC	-	-	-	-	-	-	-	-	0.0%
VR	$9,886	-	-	-	-	-	-	$9,886	54.4%
Centrelink	$3,268	-	-	-	-	-	-	$3,268	18.0%
DVA	$605	-	-	-	-	-	-	$605	3.3%
PBS	$4,371	-	-	-	-	-	-	$4,371	24.1%
Total	$18,147	-	-	$7	-	$4	-	$18,159	100.0%
% of Compliance Costs	99.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	

[8] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 7:
Outer Metro Group Practice

1. Contextual Information

1.1 Practice Profile

CS7 is an outer-metropolitan group practice. The practice was established about 22 years ago. The practice has no satellite braches, though the GP interviewed sometimes practiced from home. Additionally, the practice sometimes sold GP time to other medical institutions.

1.1.1 Location – SES profile

CS7's patient load largely comprises people from lower socio-economic backgrounds. The area in which CS7 operates has a high level of unemployment, largely due to industry closure. The area also has a substantial immigrant population. The GP noted that the closure of an immigrant hostel in the area has adversely affected this population.

1.1.2 Patient base – practice specialty

In addition to the general practice, the CS7 clinic provides a wide range of services to its patients, from surgical procedures such as vasectomies to a methadone treatment clinic.

1.1.3 Practice size, number of EFT GPs and other staff

CS7 employs 7.5 EFT GPs, and around 12 EFT administrative staff. This equates to a ration of 1.6 Administrative staff per GP. The practice also employs one full time practice nurse. The exact number of EFT staff was difficult to estimate, as the practice utilises casual labour from a variety of sources to deal with administrative tasks.

1.1.4 Participating GP

The participating GP was the practice principal (henceforth referred to as Dr CS7). In addition to his regular patient load, Dr CS7 has also made structural alterations to the practice premises himself. He also coordinated the purchase, installation, and maintenance of the computing system for the practice. Dr CS7 also plays an active role in a peak body organisation. He estimated that he works about 60-70 hours per week at the practice.

This case study also includes material from the practice manager and two administrative staff who were interviewed after the Practice Principal.

2. Overall issues relating to Program Compliance

2.1 General attitude

Dr CS7 stated that the current requirements of program compliance were *"suffocating and overwhelming"* for both the administrative staff and himself. Dr CS7 estimated that around 10% of his working day was spent dealing with administrative tasks, citing Centrelink forms and BAS statements as the most burdensome.

2.2 Program participation

The CS7 clinic takes part in the following programs:

- After hours care;
- Teaching;
- Practice Visits;
- Clinical Audits;
- Case Studies; and
- The immunisation incentive.

2.3 Program periodicity and burden

Dr CS7 reported that none of the activities associated with program compliance was particularly time consuming, nor difficult *on their own*. The burdensome, suffocating nature of compliance was the due to the *accumulation* of many small administrative tasks.

3. PIP Program

3.1 Key Issues

Dr CS7 reported that the initial PIP accreditation process was very time consuming, occupying about six months before the practice met all of the requirements. Re-accreditation was reported to be less time consuming. However, many meetings and conferences were necessary to ensure that all of the practice staff were properly trained, and understood the requirements of the program.

The cost of installing and maintaining the necessary IT systems was reported to be very high, both in terms of time and cost to the practice.

3.2 Accreditation

3.2.1 Set up costs

The CS7 practice was accredited in 1998, and was re-accredited about three months ago. Dr CS7 reported that most of the work done for accreditation was undertaken by the practice manager, and stated that accreditation was something that he would rather not do as part of his practice.

Although most of the accreditation process was undertaken by the practice manager, Dr CS7 estimated that:

- Preparation for accreditation took about 10 hours of his time; and
- Accreditation survey time took about 2 hours.

The administrative staff also found it hard to quantify the time spent on initial accreditation. The practice manager reported that the entire process spanned six months, with one administrative staff member working almost full time on the project.

Other set up costs included a music system for reception, which was installed in accordance with accreditation guidelines. This was estimated to cost about $300.

3.2.2 Ongoing costs

The CS7 practice manager could give a better estimation of the time spent on re-accreditation, given that it had happened more recently, and was a more simple process. The practice manager estimated that time spent for re-accreditation includes:

- One four hour meeting involving all staff to discuss the requirements of re-accreditation (however, only half of the GPs attended this meeting);
- Three one-hour meetings with nurses and administrative staff to discuss the necessary procedures for re-accreditation;
- A weekly two-hour meeting involving all administrative staff to ensure that all policies are being enforced;
- Around 20 hours of admin staff per month spent on continuous Quality Improvement; and
- The audit of payments for GP follow up took about one and a half hours per quarter.

The total fiscal cost for each re-accreditation for the practice was thought to be about $500.

3.3 IM/IT

3.3.1 Set up costs

The practice had spent a lot of time and money installing and maintaining a computer network to deal with the requirements for accreditation.

In terms of time, Dr CS7 estimated that he spent one week installing the system.

In terms of fiscal cost to the practice, Dr CS7 estimated that:

- $60,000 had been spent all together on the hardware and software components of the system; and
- Of this, about $5,000 was spent on medical software.

Dr CS7 had outsourced some of the network administration to an IT consultant. However, he did not know how much time the consultant spent on network administration, or how much the consultations cost.

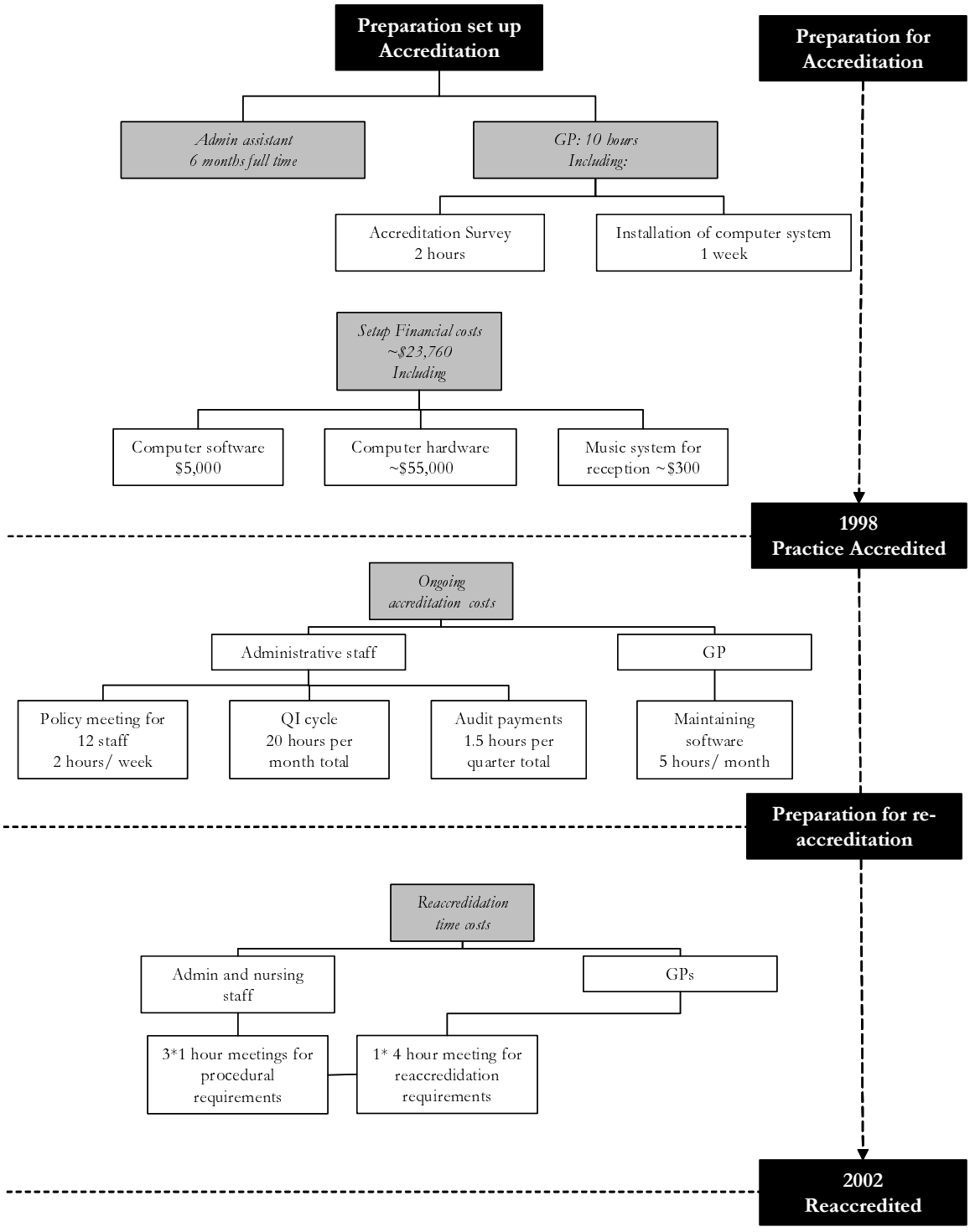
Dr CS7 reported that all of the IM/ IT systems used in the practice were purchased cheaply from 'no-name' manufacturers. The cost of the system was also reduced, because Dr CS7 had installed it himself.

3.3.2 Ongoing costs

Dr CS7 spends about five hours per month maintaining the software and hardware systems on the network.

Dr CS7 believed that the computing system used in the practice was more advanced and organised than those found in other practices. He emphasised that the practice tried to be as efficient and as automated as possible through the use of their computing system. However, he also stated that few efficiencies had been gained through the use of the system, as there has been little integration at any level with regards to the submission of online forms.

Figure 30: Accreditation Process Map



3.4 After Hours Care

The practice is open 14 hours per day, seven days a week. Outside of these hours, a locum service is used.

3.5 Rural Loading

Not applicable to the practice.

3.6 Teaching

The practice employs one registrar. Dr CS7 estimated that he spends around one hour with this registrar each day. However, he also reported that the subsidy he receives did not cover the actual costs associated with the registrar. This loss to the practice was seen as an 'opportunity cost', whereby time spent with the registrar was time not spent seeing patients. This loss of patient contact was not offset by the subsidy received.

The practice manager reported that about 2 hours every month are spent completing and submitting paperwork associated with the registrar.

3.7 NPS program

3.7.1 Practice visit

Dr CS7 reported that he organises lunchtime group visits to address the requirements of the NPS Program. These conferences take about one hour and are attended by eight doctors. The conferences incur a cost of about $20.00 per head (paid for by the practice). An additional half an hour of administrative time is required to organise these group visits. Dr CS7 indicated that he would prefer a one-on-one practice visit from the NPS to the current conferences.

3.7.2 Clinical audit

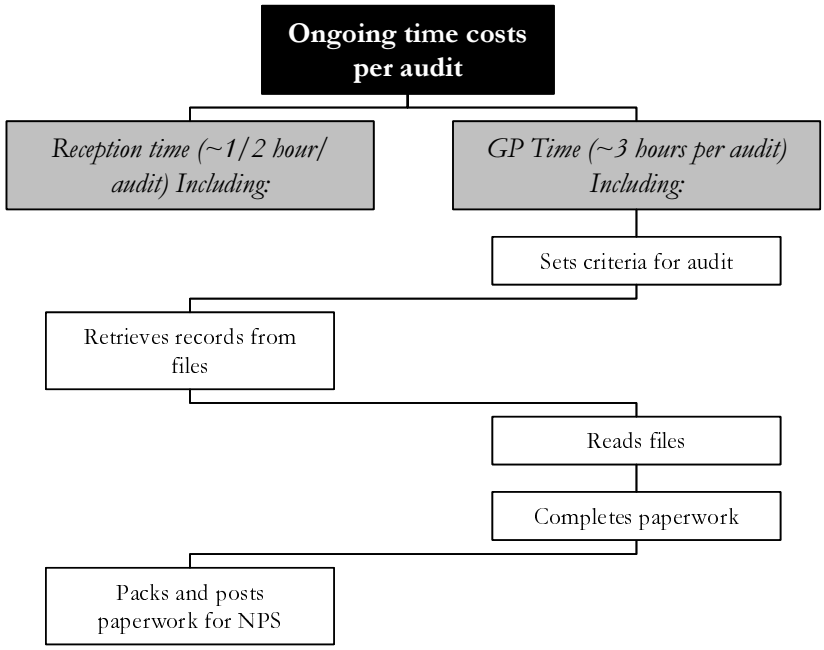
Dr CS7 estimated that an NPS audit takes about three hours, and that the he conducts an audit three times per year (to get the points required for accreditation).

The practice manager reported that the process for a clinical audit involves:

- The GP sets the criteria for the audit;
- The receptionist selects the appropriate files from the patient database;
- The GP reads the files and completes the paperwork; and
- The receptionist packs and posts the paperwork, and sends it to the NPS.

This process takes about half an hour of administrative time.

Figure 31: Clinical Audit Process Map



3.7.3 Case studies

Dr CS7 estimated that a case study would take about half an hour of his time. An additional half an hour of administrative staff time is required to select the patients, and post the paperwork. The practice conducts about four case studies per year.

The practice manager estimated that an additional one hour of administrative time every six months is required to keep the NPS filing up to date.

3.8 Immunisation Incentive

Dr CS7 reported that each GP at the practice (7.5 EFT) has to address about one problem with the GPII program each month. These problems typically concern incorrect immunisation history and contact detail information. These problems take 20 minutes to half an hour to resolve. Dr CS7 reported that these problems typically arose because of communication issues between the Immunisation Board, Local Councils, and Medicare.

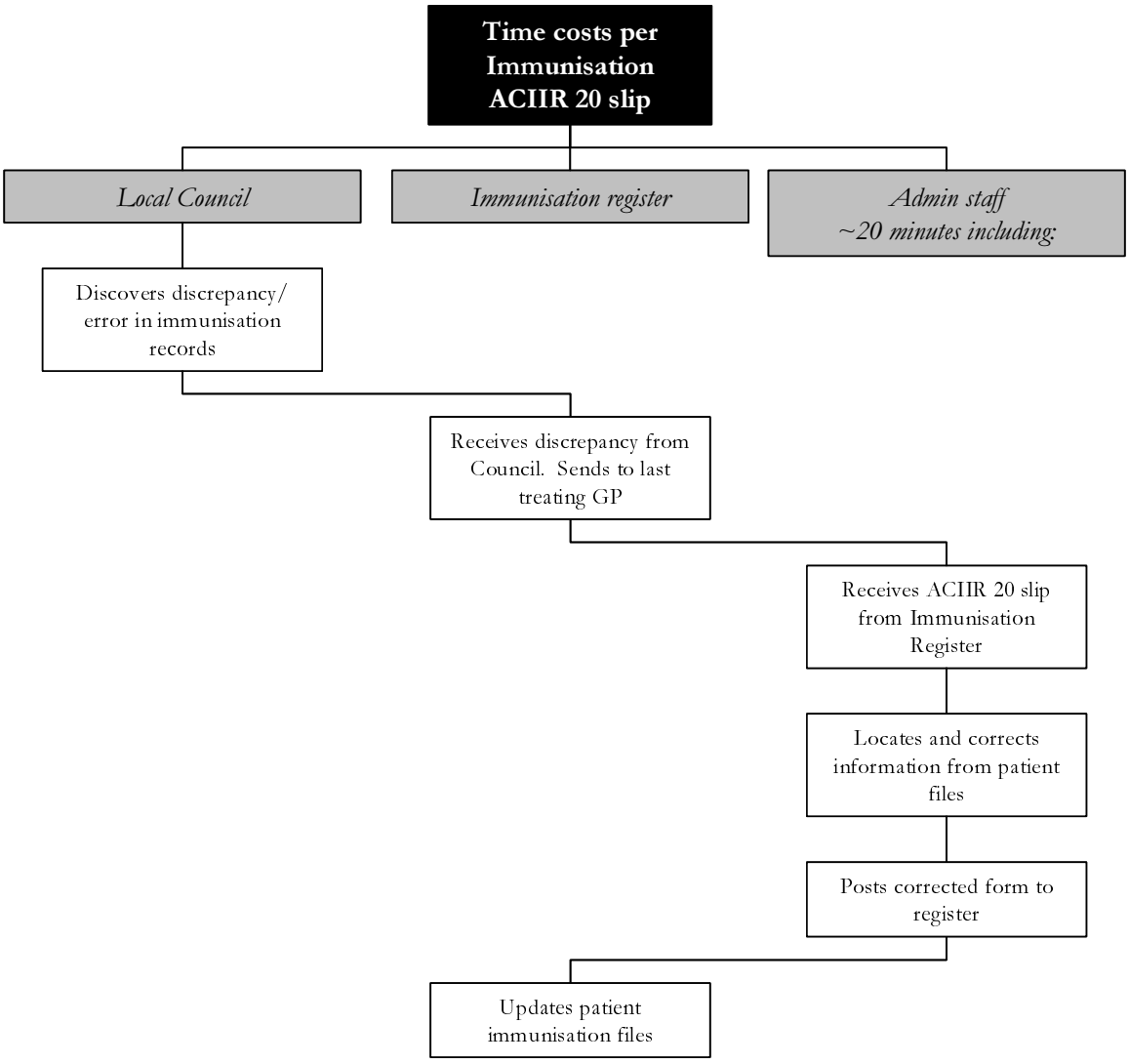
ACIIR 20 slips were reported to be particularly problematic. The practice manager reported that the ACIIR 20s are *"clean up reports"* issued by local councils when a patient's immunisation or contact details are thought to be incorrect.

The practice manager reported that the clinic uses the following process to handle ACIIR 20 forms:

1. The local council sends an incorrect patient immunisation file to the Immunisation Register.
2. The Immunisation Register form is sent to the practice. The Immunisation Register sends the form to the last GP who treated the patient, even if the treatment did not involve an immunisation.
3. An administrative staff member needs to check that the form has been filled out correctly, and updates contact or immunisation information from their patient files.

The practice manager estimated that it would take administrative staff take about 20 hours to complete these forms every financial quarter.

Figure 32: ACIIR20 Process Map



3.8.1 Recalls

Patient recalls are performed on a four-year cycle. One of the administrative staff spends about six hours per month co-ordinating patient recalls.

3.9 SIP

Dr CS7 reported that the practice was not *"up to speed"* with the SIP program. He indicated that he was the only GP in the practice who was currently taking part in the SIP program, and that he had only filled out one of the diabetes forms. The other GPs at the practice found the program too cumbersome, and do not take part.

He reported that the main barrier to effectively implementing the SIP program was the need for a complex database of patient records.

4. EPC

4.1 Key Issues

The practice is not currently undertaking any EPC Health Assessments, or Care Plans. Dr CS7 reported that the system might be too great a burden for the practice staff. As with the SIP program, the main barrier to effective implementation of this system is the need for a complex database system. Dr CS7 reported that the practice had started to put a system for ECP in place, but had not got very far. To date, Dr CS7 reported that he had spent about four hours on the program, with an additional three hours of administrative staff time.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

Dr CS7 completed his pre-fellowship in 1980, and was unable to estimate the amount of time spent in the process.

5.2 Vocational registration

The practice manager estimated that she would have to lodge or renew a GP's vocational registration every six months. She reported that each of these activities took about three hours. She also indicated that the process could take up to six hours for new GPs as the requirements of vocational registration would need to be explained, and the new GP would need to read the information packs relating to registration.

5.2.1 Professional Education

Dr CS7 attends CME courses or conferences ten or more times per year in order to obtain the necessary points for registration. Each course typically takes one day, and costs the practice about $1,000. In addition to this, Dr CS7 estimated that travel time to and from these courses equates to about 3 days per year, as many of these courses and conferences are held interstate.

Dr CS7 generally tries to avoid courses that he has to pay for.

6. Centrelink

6.1 Key Issues

The greatest costs associated with Centrelink documentation involve reading the information packs from each program. Each Centrelink program produces an information pack to accompany their forms. Dr CS7 stated that these forms are very long and involved, and take up to half an hour to read. Dr CS7 estimated that he would spend about ten hours per month reading these information packs, and related forms.

Dr CS7 was also dissatisfied with the revised Centrelink forms that were created in consultation with the RACGP. According to Dr CS7, the new forms take ten minutes more to complete than their predecessors. He reported that this is a step backwards, and was sceptical about the RACGP's involvement in the revision of the forms.

6.1.1 Sickness Allowance forms

The greatest costs associated with Centrelink documentation involve filling out sickness allowance forms for Centrelink patients with multiple diagnoses. The forms require that all conditions are listed each time the form is completed, and can become very repetitive if the patient has a long medical history. One of these forms can take between 10 and 20 minutes to fill out, and must be completed by the GP. Dr CS7 reported that he would fill out three of these forms every week. Because of the repetitive nature of the task, photocopies of the previous assessments are used to ensure consistency (with appropriate reviews where changes in conditions are observed).

6.1.2 Disability Allowance forms

Dr CS7 would fill out a disability allowance form about once a week. This would take about 12 minutes.

6.1.3 Medical Certificates

Dr CS7 also reported dissatisfaction with the Medical Certificates used by Centrelink for unemployed people. The GP is required to write a medical certificate stating that the patient is unfit to work, this certificate is then presented to Centrelink. The certificate is not done as part of a separate appointment, and takes about 20 minutes of unpaid time. If a certificate is not issued, the patient becomes annoyed, and is unlikely to return to the practice. Medical certificates are typically requested about once per month.

6.1.4 Carer Payments

Dr CS7 would fill out about one carer payment/ allowance forms per week. This would take about six minutes.

7. DVA

Dr CS7 considered that the DVA forms associated were *"suspect from a medical point of view"*, and asked a lot of repetitive questions. However, Dr CS7 reported that completing the DVA forms attracted the largest subsidy, and as such he did not mind doing them.

Dr CS3 estimated that he would fill out one disability form every week. This would take him about half an hour.

8. PBS

8.1 Phone authorisation

Dr CS7 would conduct between two and five PBS phone authorisations per day. In total, Dr CS7 would spend a minimum of ten minutes doing phone authorisations each week. Dr CS7 expressed concerns about the questions asked by the PBS operator, stating that often the questions were not listed in the PBS guidelines. Dr CS7 refuses to answer these questions.

8.2 Written authorisation

Dr CS7 does not do written PBS authorisations he reported that they take too much time.

9. Cost Estimates

The cost estimates of compliance for CS7 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and EPC.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS) are based on the GP.

The practice based costs for CS7 was $24,808 and represents 1.3% of the gross operating cost (GOC) of the practice. This was almost entirely attributed to PIP, with a small proportion attributed to EPC, with no practice-based costs for SIP. Over half (57.9%) of these costs were associated with annualised accreditation expenses, with the GP accounting for the remainder.

Table 18: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$6,326	-	$1,664	$828	-	$1,200	$14,367	$24,385	98.3%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	$351	-	$72	-	-	-	-	$423	1.7%
Total	$6,678	-	$1,736	$828	-	$1,200	$14,367	$24,808	100.0%
% of Compliance Costs	26.9%	0.0%	7.0%	3.3%	0.0%	4.8%	57.9%	100.0%	

The total GP related compliance costs for the GP interviewed was $19,172 (Table 2). Over half of these costs (53.6%) were associated with vocational registration, and one quarter (24.9%) were associated with Centrelink. There were few costs associated with other programs.

GP compliance costs were primarily associated with the GP's time (90.5%).

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 7.6% of a single GP's 'share' of the practice GOC[9].

[9] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Table 19: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$615	-	$576	$46	-	$68	-	$1,305	6.8%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	-	-	-	-	-	-	-	-	0.0%
VR	$9,138	-	-	$138	-	-	$1,000	$10,276	53.6%
Centrelink	$4,780	-	-	-	-	-	-	$4,780	24.9%
DVA	$2,109	-	-	-	-	-	-	$2,109	11.0%
PBS	$703	-	-	-	-	-	-	$703	3.7%
Total	$17,344	-	$576	$184	-	$68	$1,000	$19,172	100.0%
% of Compliance Costs	90.5%	0.0%	3.0%	1.0%	0.0%	0.4%	5.2%	100.0%	

Case Study 8:
Inner Metropolitan Fringe Group Practice

1. Contextual Information

1.1 Location – SES profile

CS8 is a group practice located in a lower SES suburb about fifteen kilometres from the capital city centre. It offers the services of 9 GPs and of 4 specialists (surgeon, paediatrician, orthopaedic, psychotherapist). The practice also maintains clinic nurses, a pharmacy, pathology, two physiotherapist and three psychologists. The practice is bulk billing during business hours.

1.2 Practice size, number of EFT GPs and other staff

The clinic employs:

- Seven Receptionists, 4.2 EFT;
- Two Nurses (34 h/w and 12 h/w);
- One Bookkeeper (0.5 EFT);
- Two Registrars (for year 2001/2002); and
- Nine GPs.

This equates to about six EFT Administrative staff per five GPs. The other health care providers present are renting space from the practice.

1.3 Participating GP

Dr CS8 is one of the two practice principals and co-founder of the clinic. He works full time (about 60 hours per week) and spends an additional 7 hours working as a GP liaison for a mental health community care organisation.

1.4 Number of patients seen per session by participating GP

Over the six four-hour sessions during which the logbook was completed, Dr CS8 saw 102 patients (17 per session).

2. Overall issues relating to Program Compliance

Because the clinic bulk bills, it is not possible to increase the clinic income by increasing the price of the consultations. Therefore the decision to participate in the programs was perceived to be a means to *"chase the payments"*. As CS8 explains, *"It is good to focus on better patient management, but the clinic's participation in PIP and EPC is primarily a financial drive."*

Dr CS8 reported that receiving program payment is also a way to be funded for services that were used to be delivered for free. For instance the practice used to run an asthma clinic, and now can integrate this activity into a SIP. The programs reward a more systematic approach to general practice, that cannot be funded through a payment-per-consultation approach.

However, participation in the programs requires substantial changes to systems and procedures, and Dr CS8 is not sure that the financial benefit is worth the efforts to establish new systems and procedures.

3. PIP Program

3.1 Key Issues

The HIC conducted an audit of the practice, which took 1 hour of Dr CS8's time, and 3 hours of the PM time.

3.2 Accreditation

Re-accreditation is due in November 2002.

The preparation for re-accreditation involved:

- One month of PM time;
- Four hours of Dr CS8's time;
- Ten hours of cleaner time; and
- Laying a new carpet (which would have been changed in time, but was done earlier because of re-accreditation) $11,000.

The training of reception staff took ten hours PM and reception time in total.

The survey took:

- Four hours of the PM's time;
- One hour of Dr CS8's time; and
- 30 minutes of a nurse's time

The **maintenance** of accreditation requires:

- Two hours PM per week; and
- One hour nurse per week.

3.3 IM/IT

The practice computers were upgraded to allow for recalls and advanced functions of Medical Director (which cost $11,000, including a laptop for the nurses' room). An employee of the Division came to the practice and trained the GPs and administrative staff on how to conduct recalls. This took 20 minutes per GP.

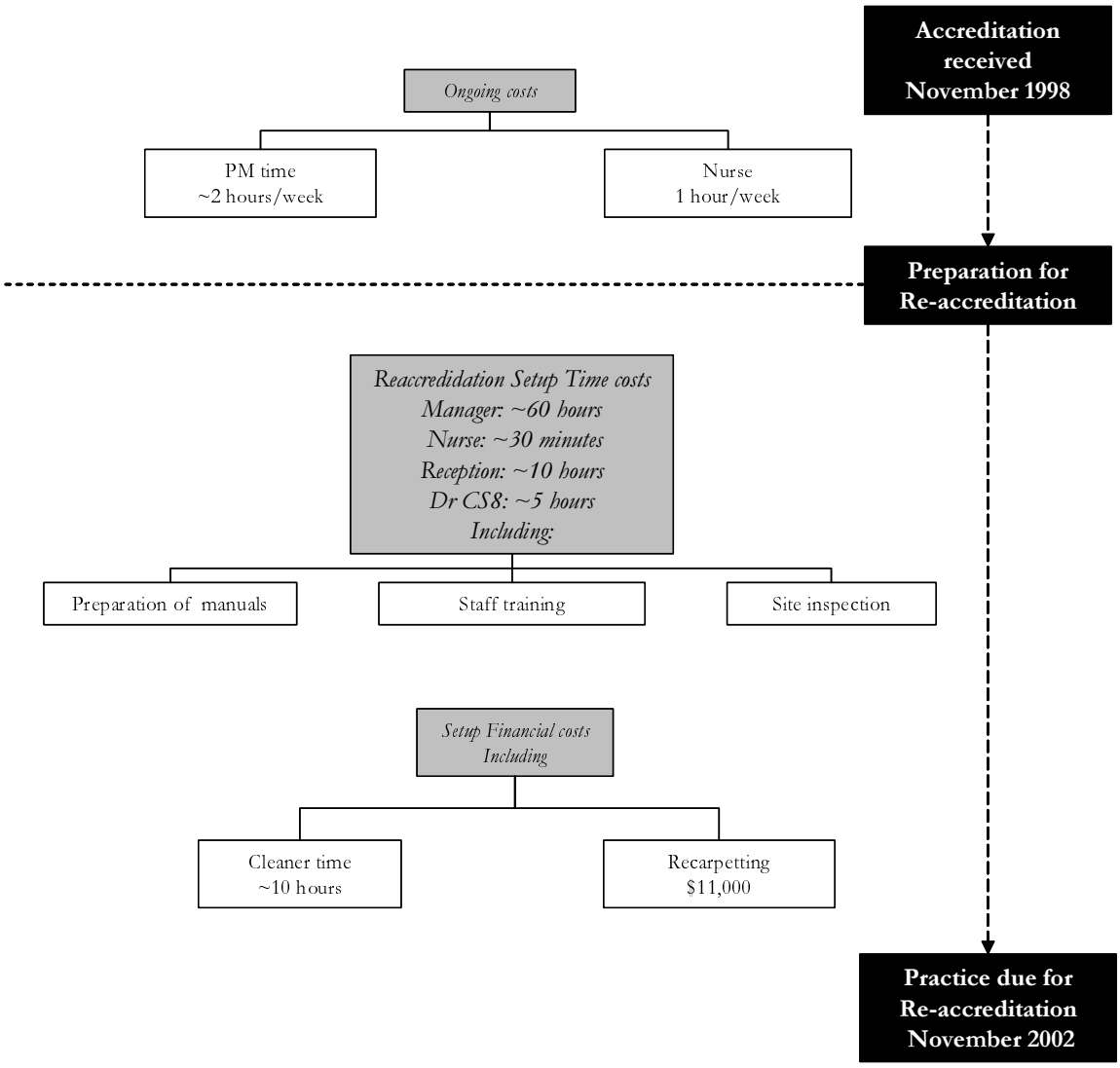
The recalls are also used for the Immunisation Incentive Program. Another objective of the computer up-grade was to enable Internet and e-mail access in the doctor's rooms, and to be able to receive PIP payments. The practice wouldn't have been able to afford this upgrade without PIP payments.

Licences for the Medical Director software cost $1,100 per quarter. The software is reported to be indispensable. *"We would still have it without accreditation".*

IT/IM maintenance costs were $7,000 from June 2002 to November 2002. About $2,500 of this was dedicated purely to PIP compliance.

The Medicare electronic data transmission was undertaken because of the high number of patients, and the benefits of receiving payments quickly, rather than for the PIP payments associated with it. Similarly, electronic transmission of pathology was undertaken because of the benefits in terms of time and practicality for the practice, rather than for the PIP payments. *"PIP was an incentive to do more than we were doing and earlier. That was very good."*

Figure 33: Accreditation Process Map



3.4 After Hours Care

After-hours locum services cost $1,400 per quarter. Dr CS8 reported that the PIP payments were an incentive to renew the registration with a locum service. Without PIP, the practice would have had stopped using the locum services. *"It was an incentive to go back to it".*

3.5 Rural Loading

Not Applicable.

3.6 Teaching

Dr CS8 teaches college registrars on a regular basis. This gives him a number of CME points. Dr CS8 reported that the reasons for his teaching are not related to the PIP payments. He does it because *"It's fun"*, and because he hopes that the registrars will come to work in the practice later on (recruitment of GPs is an issue in the area). Teaching takes him 4 hours per week (2x 2 hours) in a one-to-one session

with the registrar. He does not take registrars with him during consultations because it is too time consuming and the patient load is too great.

Every six months, the practice GPs spend 2 ½ days interviewing candidate registrars. An additional 20 hours of the PM time is required to manage the registrars.

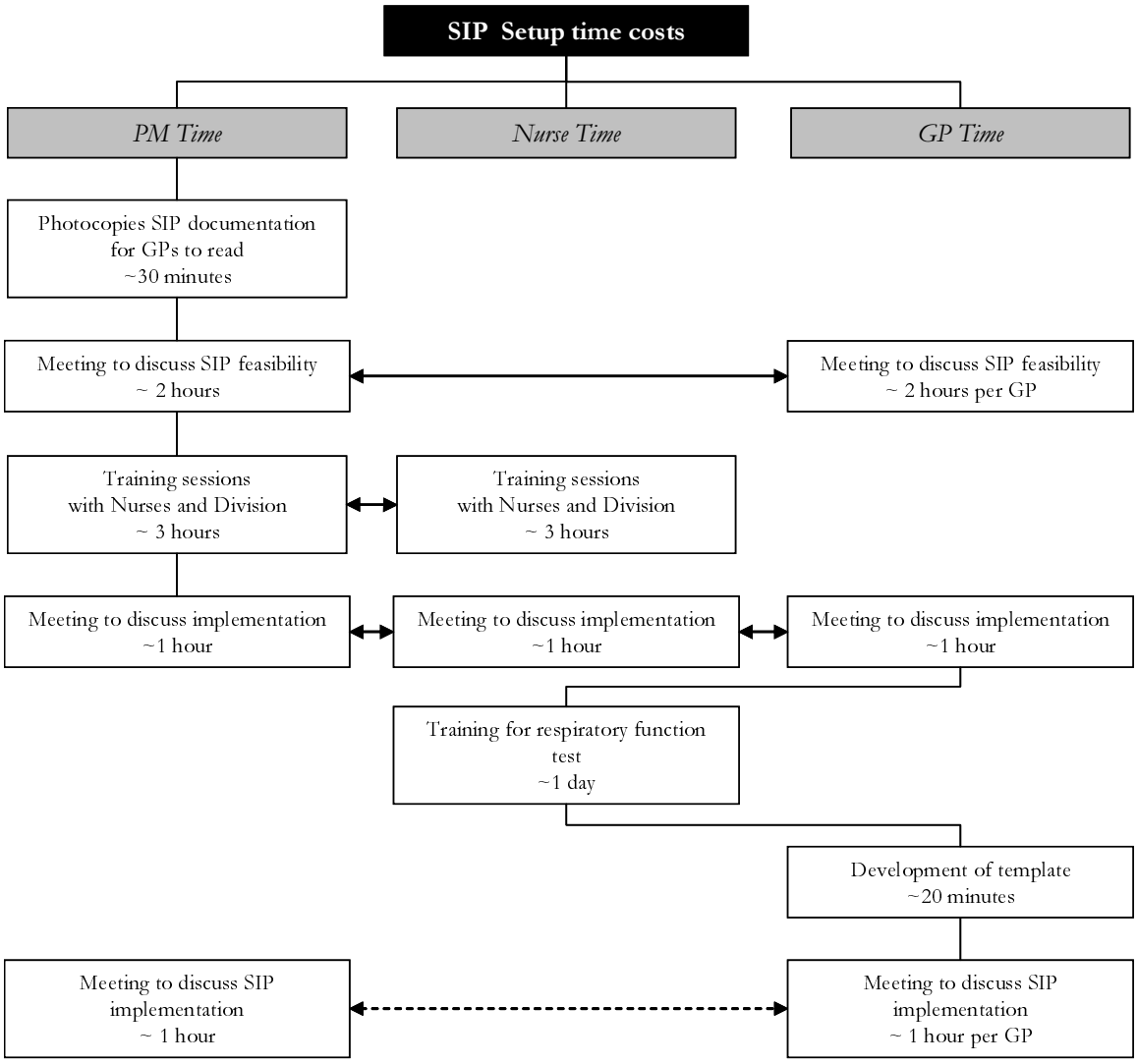
3.7 NPS program

The quality Prescribing Initiative is said to be *"too time consuming and not worth the dollar"*.

3.8 SIP

The practice is doing Asthma and Diabetes SIPs. Dr CS8 does two to three SIPs per day. He reported that the program is a good way to be funded for extra-consultation activities and the paperwork is acceptable. However, he also reported that some requirements are too rigid. For example, all patients doing an Asthma SIP must do a respiratory function test, which Dr CS8 does not think should be systematic. Because of this requirement, the practice nurse had to be trained to perform the test (1 day training at $230). Dr CS8 believed that SIPs would be more easily performed if the forms were on the computer.

Figure 34: SIP Set-up Process Map



Preparation for SIP

This process involved:

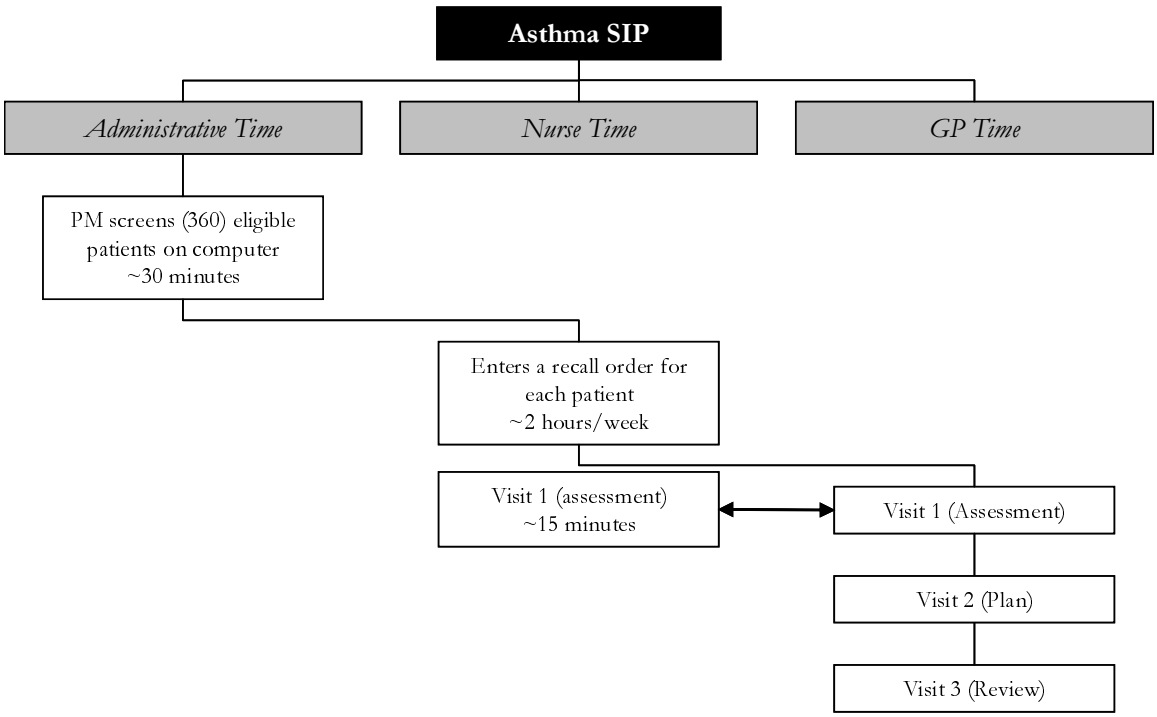
- The information arrived 18 months ago and was photocopied for each GP (30 minutes of the PM's time);
- Initially, the decision to take part in SIPs was made during a weekend meeting organised and paid for by the practice to discuss work issues. About two hours of the weekend were dedicated to discussing the possibility of SIP and EPC participation. The total cost for the ten-hour meeting was $6,000;
- Three meetings with the Division were held (3 hours of PM and Nurse time);
- Familiarisation with SIP procedure took one hour of PM, nurse and Dr CS8 time;
- Dr CS8 had to write a template (20 minutes).
- Another discussion with all GPs took 30 minutes of weekly meeting time (lunch hour).

SIP Implementation (Asthma)

This process involves:

- The PM screens the patients (30 minutes) - 360 patients were deemed to be eligible;
- Nurse enters a recall order for each patient (2 hours per week); and
- Three consultations take place:
  - One of 25 minutes (including 15 minutes of nurse time)
  - Two of 15 minutes.

Figure 35: Asthma SIP Process Map

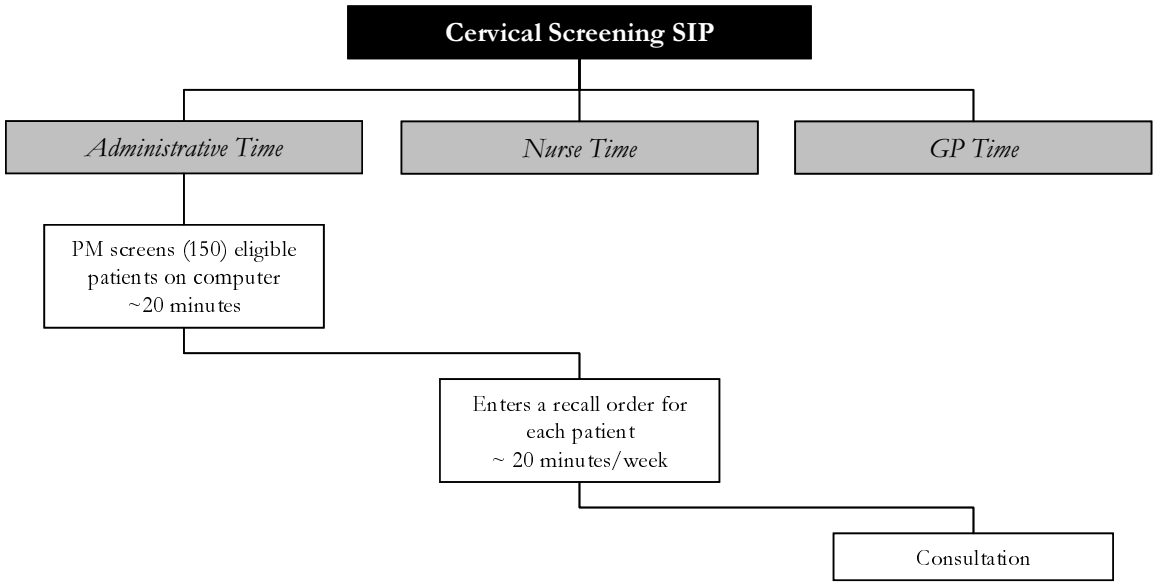


SIP Implementation (Cervical Screening)

This process involves:

- Screening of eligible patients (20 minutes PM time); and
- Recall (20 minutes Nurse time) – 150 patients.

Figure 36: Cervical Smear SIP Process Map



SIP Implementation (Diabetes)

This process involves:

- Screening of eligible patients by PM (5 minutes); and
- Recalls by nurse (2 hours per week).

4. EPC

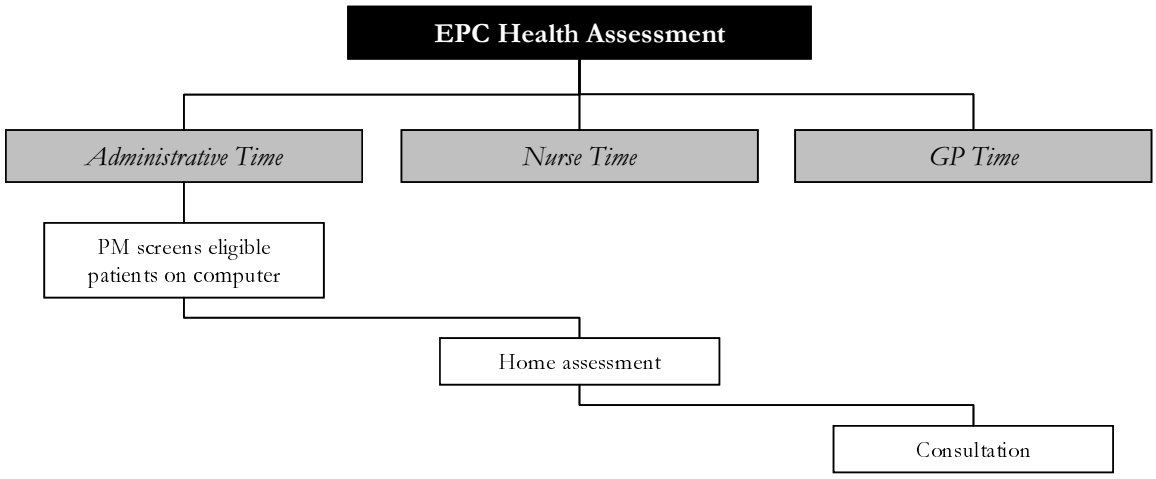
4.1 Health Assessment

Dr CS8 has taken part in about 50 health assessments in total. The nurse is paid $60 per patient. Dr CS8 questioned the clinical benefits of these health assessments. He also wondered if the payments received were *"worth the headache"*. Receptionist time for each health assessment is about 20 minutes (including time taken to make photocopies and appointments). Set-up costs were included in a weekend practice meeting (2 hours for consideration of SIP and EPC items), and templates were received from the RACGP.

Activity map:

- Normal consultation during which eligible patients are identified and a health assessment is engaged (10-15 minutes);
- Long consultation (40 minutes);
- Home assessment (1 hour); and
- Standard Consultation (10-15 minutes).

Figure 37: Health Assessment Process Map



4.2 Care Plan

Dr CS8 considered Care Plans to be too hard to complete because the practice needs to get information back from other participating health providers. The only Care Plans that were organised are for new diabetic patients because the practice has a diabetic nurse on site and has a good working relationship with a local dietician.

It takes approximately 1.5 hours administrative time per week to set up and follow up care plans. Dr CS8 undertakes about one Care Plan per week.

4.3 Case Conference

No participation.

4.4 DMMR

Dr CS8 reported that only one DMMR (Domiciliary Medication Management Review) has been undertaken so far. They take 30 minutes of Dr CS8's time. He stated that they are beneficial but require a good working relationship with a registered pharmacist. No administrative time is required.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

Dr CS8 chose not to take the RACGP fellowship because he does not see any advantage for him. He benefited from the 'Grandfather Clause'.

5.2 Vocational registration

Dr CS8 participates in the set-up and moderation of a 'small learning group' on Mental Health. It takes:

- 1.5 hours per months over 8 months to conduct the groups;
- 2 hours initially to register and set up a learning plan; and
- Some PM time to set-up the meetings (15 minutes per 8 meetings).

Dr CS8 does not undertake these activities in order to gain vocational points. He considered that it is his duty to stay informed and that the work he does will also be beneficial to the Division.

Clinical Audit

Dr CS8 does not do any clinical audits because he perceived them to be too time consuming.

6. Centrelink

Although WorkCover certificates are not part of the programs examined, it is worth reporting that they were mentioned as particularly time consuming.

Centrelink forms are completed very frequently in the practice. Dr CS8 estimated he would write at least one Centrelink form every day. He finds them very burdensome, and gets irritated that Centrelink requires the GPs to repeatedly fill out the same information on the same forms because Centrelink does not keep the patient history.

6.1 Disability allowance

Dr CS8 reported that the new medical certificate (TDR) is particularly frustrating because a complete patient history is required, and can take up to 30 minutes to write. Dr CS8 completes about two Disability Allowance forms every two weeks.

In order to save time when a patient is required to fill out a Centrelink form more than once, the practice keeps a photocopy of the form so that the GP simply has to copy the details over to the new form. This clerical task is perceived as demeaning and a waste of GP time. "*For example, children with a disability are born with it, it is not going to change over time. Why can't Centrelink keep the history?*"

6.2 Sickness allowance

Simple medical certificate take five minutes to fill out. Dr CS8 does one to two per day.

6.3 New Start/Youth allowance

Dr CS8 reported that these forms are filled out "*Very occasionally,* and take 5 minutes.

6.4 Mobility allowance

This form involves:

- Dr CS8 fills out these forms once or twice a year; and
- They take him 5 minutes.

6.5 Carer payment/allowance

This form takes Dr CS8 about ten minutes to fill out. Dr CS8 would fill out two to three of these forms per months.

6.6 Other Centrelink Activity

Dr CS8 reported that he needs to make an occasional telephone call to Centrelink. Dr CS8 made one such call during the observation period, which took 20 minutes.

7. DVA

Dr CS8 reported that DVA forms are rare because the patients at the CS8 clinic are mainly young families. Dr CS8 reported that he would only do 1-2 DVA forms per year.

8. PBS

8.1 Phone authorisation

Dr CS8 estimated that he makes four phone authorisations per day, each lasting between one and three minutes.

8.2 Written authorisation

Dr CS8 reported that written authorisation are rare.

9. Cost Estimates

The cost estimates of compliance for CS8 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies, SIP, and EPC programs.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), SIP and EPC are based on the GP.

The practice based costs for CS8 was $23,397 and represents 2.7% of the gross operating cost (GOC) of the practice. Over half of these costs (52.6%) were attributed to annualised expenses associated with accreditation. The remainder were primarily associated with the practice manager (23.7%), and nursing staff (21.3%). GP time accounted for a very small proportion of the practice related costs.

Table 20: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$132	-	$5,272	$973	-	$131	$12,300	$18,809	80.4%
SIP	$215	-	$206	$3,960	-	-	-	$4,380	18.7%
EPC	$99	-	$69	$40	-	-	-	$208	0.9%
Total	$446	-	$5,547	$4,973	-	$131	$12,300	$23,397	100.0%
% of Compliance Costs	1.9%	0.0%	23.7%	21.3%	0.0%	0.6%	52.6%	100.0%	

The total GP related compliance costs for the GP interviewed was $26,557 (Table 2). Almost half of these costs (46.4%) were associated with SIP items, and one quarter (26.3%) with EPC items.

GP compliance costs were primarily due to the GP's time with 78.5% being attributed to the principal GP. The practice nurse and other administrative staff accounted for the remaining compliance costs, with minimal costs associated with other cost categories.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 21.7% of a single GP's 'share' of the practice GOC[10].

Table 21: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$17	$264	$686	-	-	-	-	$966	3.6%
SIP	$11,885	-	$31	$323	-	-	$77	$12,316	46.4%
EPC	$2,707	-	-	$2,525	-	$1,742	-	$6,975	26.3%
VR	$693	-	$69	-	-	-	-	$762	2.9%
Centrelink	$3,797	-	-	-	-	-	-	$3,797	14.3%
DVA	$25	-	-	-	-	-	-	$25	0.1%
PBS	$1,717	-	-	-	-	-	-	$1,717	6.5%
Total	$20,840	$264	$786	$2,849	-	$1,742	$77	$26,557	100.0%
% of Compliance Costs	78.5%	1.0%	3.0%	10.7%	0.0%	6.6%	0.3%	100.0%	

[10] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 9:
Fringe Outer Metro Corporate Practice

1. Contextual Information

1.1.1 Location – SES profile

The practice (CS9) caters largely to low SES, blue-collar patients. CS9 is a medical centre providing a range of services to patients from a large area.

The practice has been part of a Corporate Health Care Group for the last two years. The practice was privately owned before joining the group. The group comprises seven medical practices in both metro and outer-metro locations. The practice in question is outer metro.

1.1.2 Patient base – practice specialty

The practice has stopped bulkbilling and subsequently lost about 30% of its patient load, which was compensated by the increase in income. The practice decided to stop bulkbilling in an attempt to keep their GPs.

1.1.3 Practice size, number of EFT GPs and other staff

The practice employs 12 GPs who work all part time, ranging from 3-23 hours per week each. This equates to about 3 EFT GPs for the practice, as follows:

- GP 1 23 hours;
- GP 2 15 hours;
- GP 3 3 hours;
- GP 4 3 hours;
- **GP 5 18 hours Dr CS9;**
- GP 6 26 hours;
- GP 7 15 hours;
- GP 8 8 hours;
- GP 9 6 hours ; and
- GP 10 7 hours.

2. Key Issues

The practice does not employ a Practice Principal as such, but certain GPs within the practice are recognised as 'senior'. The practice lost their two full time GPs in the past few months, and is having trouble filling in these positions. Because of the location of the practice and of the low SES patient base, it is difficult to recruit and keep GPs.

The practice also employs:

- 1 FT receptionist and pathology collector;
- 1 PT nurse;
- 7-8 casual staff; and
- 1 PT practice manager (20 h/week, also employed as the regional manager for the corporate)

As a corporate practice, the GPs do not undertake any administrative work, and focus solely on their patients. The administrative staff undertakes all administrative and financial tasks.

2.1.1 Participating Staff

Dr CS9 works at the practice approximately 18 hours per week and has been working at the practice for 22 months. He also works as a teacher at a nearby university. He sees four to five patients per hour.

Before coming to work for the corporate practice, he worked in a private clinic. He left private practice because he wanted to reduce the number of hours that he worked. Dr CS9 reported that he was required to do a large amount of paperwork at his old practice, which he did not enjoy. Dr CS9 reported that he does almost no paperwork now that he is working in a corporate practice.

The interview was conducted with both the practice manager and with Dr CS9.

3. PIP

3.1 Key Issues

The practice manager reported that although the PIP was certainly an incentive to go through accreditation, she is a great believer in accreditation and the maintenance of standards for GPs and practices. The practice staff was also very supportive of the idea. Doctors were *"slower to come around because they always think they do things right"*. However, she also felt that some of the requirements for accreditation were *"a little bit over the top"*.

The practice manager reported that the accreditation process was long and *"draining"*. However, she reported that the CS9 practice already met most of the requirements for accreditation, and was accredited straight away.

As a Corporate Practice, all PIP payments are paid to the company. The clinic does mainly practice based PIP activities, rather than care based activities. The practice manager explained that there are two reasons for this choice:

- The GPs are not supportive of care-based PIP and EPC activities. *"We don't push the GPs to do them and they don't like them because they feel it's too much red tape, too much paperwork, too many meetings. They chose to work for us precisely to avoid paperwork and meetings. They don't want to go back to it."*
  Dr CS9 confirmed that his decision to join a corporate practice was partly motivated by the desire to reduce the amount of paperwork that had become *"intolerable"*. He particularly enjoys not having any paperwork to do at the CS9 practice. Not having to do after-hours calls also is a benefit; and
- She will have to employ a nurse full time to undertake these activities because of the amount of paperwork required. She may eventually do this, not to receive PIP payments because she doubts the profitability, but so that she doesn't have to reduce existing staff hours.

Dr CS9 will be willing to take part in SIP when they are organised in the practice, because he knows he will not have any paperwork responsibility. He also questions the rationale behind the programs: *"The time and effort you waste are not worth the money. It's a complete waste of time. What is the philosophy behind these programs?"*

He also thinks that SIP and EPC encourage the patients not to be responsible for their own health, shifting this responsibility on the GP who must ensure that they comply with the different programs. *"The onus is on us, the patient has no responsibilities. Medicine is stressful enough without this sort of hassle. That's the trend in medico-legal issues. All the responsibility is on the doctor, not on the patient."*

Finally he thinks that SIP and EPC programs are encouraging GPs to do things for a financial reward which they should do anyway.

3.2 Accreditation

The practice was first accredited in July 2001, and intends to begin re-accreditation in 2004. The practice manager was responsible for the accreditation process for each of the clinics in the group (though the centres were not accredited at the same time. The last centre to be accredited received accreditation two months ago). CS9 was the first practice of the group to be accredited, and one of the first to register for accreditation, which she thinks resulted in additional time spent because of the learning process on AGPAL's behalf.

The whole accreditation process for all clinics spanned two years, from first registration, to full accreditation.

3.2.1 Set-up costs

The practice manager was almost solely responsible for the accreditation of all ten practices. She reported that the CS9 practice was well set up and run before accreditation, and as such it did not take too long to meet the accreditation requirements. However, she estimated that it took one year of full time work to meet all of the requirements for all ten centres. The bulk of that time was spent on:

- Compiling the procedure manuals (this was done over six weekends, or 12 working days. The manuals are used for all practices);
- Training staff on the requirements, procedures and protocols (about 250 hours per centre);
- Adjusting the medical records system (including some time computerising records);
- Meetings with staff and contractors; and
- Checking the premises to ensure compliance (about 14-16 hours of administrative time per practice).

The practice manager could not estimate how long each practice took to accredit on its own. She reported that the first practice took far longer to accredit than the other practices, as many of the procedures and manuals could simply be transferred between practices.

3.2.2 Maintenance

The practice manager reported that maintenance of accreditation standards includes:

- Continuous checking and spot checks of all staff to ensure that they are maintaining accreditation standards;
- Checking the standards of the steriliser and of the cold chain;
- Continuous training for all staff;
- Staff meetings to discuss accreditation issues;
- Maintaining the medical reference library; and
- Updating procedure manuals.

In addition, a nurse would need to undertake such tasks as checking:

- Doctor's bags;
- Doctor's rooms for stocks; and
- The oxygen and cold chain.

The practice manager would spend about two hours each per week undertaking these tasks. The nurse would spend approximately 2 hours per day. However, the practice manager also reported that the practice would undertake these tasks irrespective of accreditation compliance.

3.3 HIC documentation

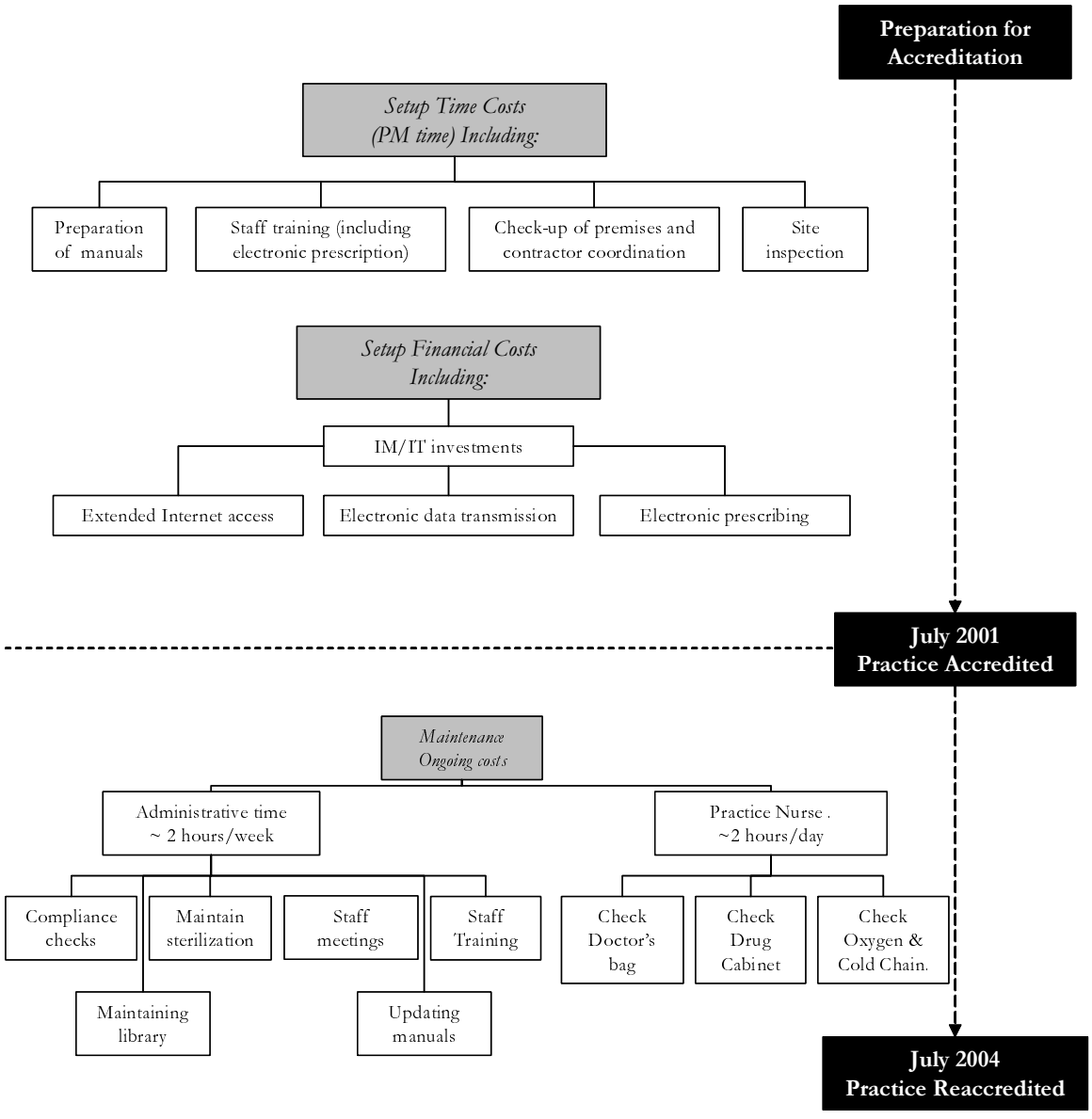
The practice manager reported a number of administrative tasks that are required to keep the HIC informed of the changes within the practice including:

- Changes in staff such as the appointment or resignation of a GP;
- Change in ownership of the practice; and
- Change in the services provided.

The practice manager estimated that she would spend about four hours per month to keep the HIC informed of changes to one practice.

She is critical of the lack of communication between the HIC and affiliated government departments. Due to this, GPs are required to complete a range of different forms for HIC registrations and authorisations, which creates a great deal of paperwork and takes a lot of time.

Figure 38: Accreditation Process Map



3.4 IM/IT

3.4.1 Set-up Costs

Dr CS9 reported that he had to spend some time teaching himself how to use the computer software associated with the practice. He attended some lessons on computer use in his own time. At this stage, Dr CS9 uses the Medical Director software for prescriptions.

The practice manager also reported that new computing systems had to be put in place to address the accreditation requirements including:

- Internet access (including installing new phone lines for the clinic);
- Lines to the locum service (which incurs an extra fee);
- Transmitting patient data directly to Medicare;
- Downloading pathology results;
- Computerisation of script writing; and
- Unlimited battery backup.

The upgrading of the clinic's computing systems began in 1999. The practice manager identified a specific issue relating to the cost of computers that are powerful enough to handle all of these requirements.

The practice manager could not estimate the cost of these upgrades and other IT maintenance as the processes were all conducted through head office, with no consultation at the individual clinics.

3.5 After Hours Care

Dr CS9 does not do any after-hours care or house calls.

The practice manager described the process for handling after-hours calls:

1. The phones in the clinic are switched over after hours to a locum service such that all calls to the clinic are transferred to the locum GP;
2. The locum GP typically recommends that the patient go to a hospital; and
3. If the locum feels that a consultation is required with the treating GP, the call is transferred to the practice manager, who then directs the call to the treating GP. This does not happen often, and calling the GP after hours is avoided where possible.

This system of transferring calls was implemented recently as part of the accreditation process. The practice manager was not sure if the locum service's fees had increased as a result of the change in the telephone system.

The practice receives a financial incentive every year ($2.00 per SWPE) because they provide more than 15 hours per week of after-hours care.

The practice manager also reported that the locum service needed to be kept updated with any changes to the practice structure such as the appointment or resignation of GPs etc.

3.6 Rural Loading

Rural Loading Payments are not applicable to the CS9 practice.

3.7 Teaching

Dr CS9 does not do any teaching in relation to the PIP program, (however he does do some teaching at a nearby university). He would like to teach at the CS9 practice, and would even be willing to teach without payment. However, Dr CS9 has not been asked to teach at the practice.

3.8 NPS program

The practice manager reported that the clinic does do a small number of case studies, but that they are not enough to meet the NPS quota.

3.8.1 Key Issues

Dr CS9 used to take part in a number of NPS programs when he was working in private practice. However, he stopped taking part when he moved to the corporate practice. Dr CS9 believes that GPs should be taking part in these programs as part of their working day and that there should not be incentives to take part. He is critical of GPs who only take part in programs or workshops if they get paid.

3.8.2 Case studies

Dr CS9 has not taken part in any case studies at the practice.

3.8.3 Practice visit

Dr CS9 has done practice visits with GPs specialising in diabetes, asthma, and hypertension at previous practices, but not at the CS9 practice. However, he is willing to take part in practice visits, should the opportunity arise.

The process for the practice visit comprises visit from a GP with specialist medical knowledge to the surgery to discuss current treatments. Each visit takes about half an hour.

3.8.4 Clinical audit

Dr CS9 has not taken part in a clinical audit at the CS9 practice.

3.9 Immunisation Incentive

Dr CS9 does take part in the Immunisation Incentive Program.

Dr CS9 reported that the process is not time-consuming under the corporate practice, but took a lot of time to complete when he was working in private practice.

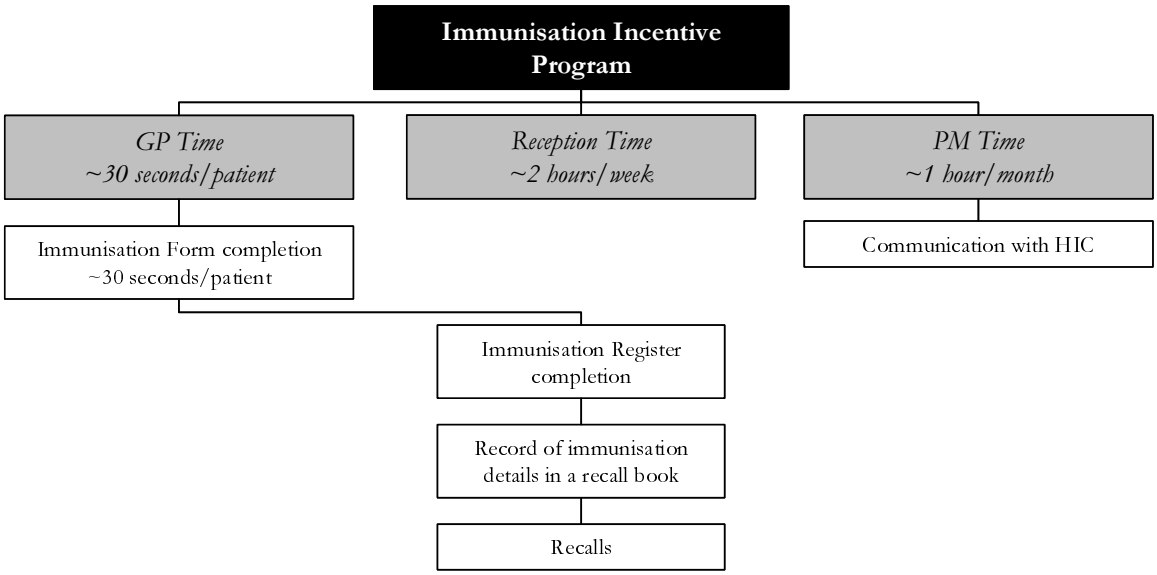
The process involves here:

1. Parents present at reception inquiring about keeping their children's immunisations up to date;
2. The GP works to a set immunisation schedule, and administers the required immunisation to the patient;
3. The GP fills out a form detailing the child's immunisation requirements, as well as the child's 'health book'. This usually takes no more than 30 seconds of the GPs time;
4. The form is passed to the receptionist, who then files the details with the Immunisation Register. At this stage, the practice lodges the forms manually, as their software does not allow them to lodge the forms electronically;
5. Once the form is filed, a payment is received directly into the practice's account; and

6. The form is stored in the patient's medical file, and the details of the immunisation are recorded in a book so that appropriate recalls can be made.

The practice manager estimated that the paperwork and administration for immunisation would take a nurse about 2 hours per month. HIC documentation relating to immunisation would take 1 hour of her time per month.

Figure 39: Immunisation Incentive Program Process Map



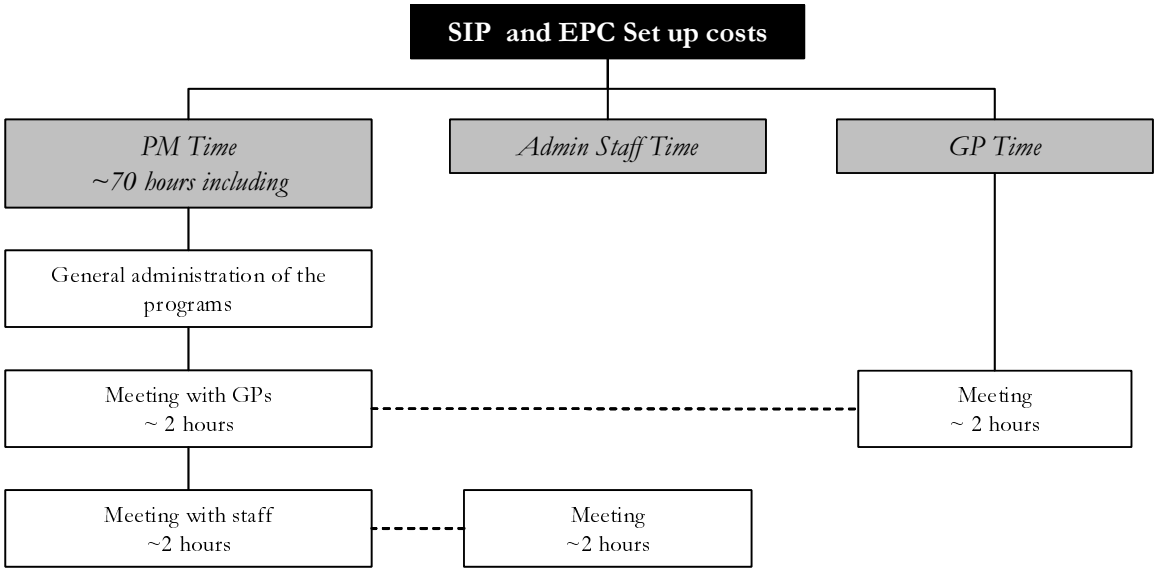
4. EPC

At this stage, the practice does not take part in the SIP program, or the EPC programs. However, steps have been taken to implement the programs within the practice. These arrangements began about a year ago, and the practice manager estimated that she has spent about 70 hours undertaking the administration and consultation required for setting up the programs. Included in this time was:

- A two-hour staff meeting with four GPs to discuss what was required for the programs; and
- A two-hour staff meeting with all staff to discuss the new roles and responsibilities under the program.

However the GPs so far have not supported the programs. Care plans were judged to be inappropriate medically, and created resentment on behalf of clients who would have to pay for specialists. Until now, SIP and EPC items have been *"shelved"*. They are about to be re-introduced because the head office has advised the practice on their potential profitability for patients, GPs and the practice.

Figure 40: SIP and EPC Set-up Process Map



4.1.1 SIP Implementation

Dr CS9 has not currently taken part in the SIP program at this practice. He anticipates problems with the program due to difficulties in getting the patient to return to the clinic for the repeat visits that are required.

The practice manager also reported that it is difficult to do recalls for SIP. She indicated that the program will need to be computerised to make it worthwhile. She indicated that the staff would need to be trained how to use the recall system before the program can be fully implemented.

4.1.2 EPC Implementation

At this stage, the practice does not take part in the EPC program. However, the practice manager anticipates having more time to be involved in assessments and planning now that the practice has made the shift from bulk billing to private billing (due to decrease in patient number). She reported that she would need to recruit one more full time administrative assistant to cope with the administration of EPC programs, and hopes that the EPC payments will cover that staff member's position.

The practice manager reported that she has had little success getting the GPs involved in programs. She reported that the GPs felt that there was *"too much red-tape with no added value"* involved in the EPC programs. The GPs were also reluctant to take part in EPC programs for fear that they would *"loose some of their autonomy because the government asks for so much information from the practice, and that the procedures were too rigid to be able to practice freely"*. She thinks that GPs may have less incentive to undertake these activities because they receive only a percentage of the payment (the rest goes to the practice).

Dr CS9 anticipates that the EPC programs will be introduced in the CS9 practice, but that he will try to avoid doing them.

Dr CS9 has not done any health assessments, care plans, or case conferences at the CS9 practice. He has taken part in EPC programs in the past, and is generally critical of the way the programs are run. Dr CS9 stated:

"I get no satisfaction from the EPC program. I feel that it is a complete waste of government money. I have not seen that (the program) has altered the treatment or management of any of the (patients) that I have done it for…it has not altered the patient's health one iota".

4.2 Health Assessment

Dr CS9 stated that health assessments are *"not satisfying medicine"*. He reported that none of the recommendations made in his previous EPC assessments have been acted on. Also, these patients generally do not understand what the GPs are talking about, and do not follow the recommendations because the health assessment patients are over 75, and that many suffer from dementia. He also considered that doctors should carry out the home assessments, rather than nurses.

4.3 Care Plan

Dr CS9 stated that care plans have even bigger problems than health assessments. He considered that care plans become very time consuming given the number of people involved, and difficulties in getting these people to cooperate.

The practice manager reported that the diabetic care plans are the most cumbersome of all of the programs. Locating all of the specialists and other medical practitioners for a single Care Plan is very time consuming. It becomes more expensive as the patient visits more practitioners.

The practice manager reported that she had presented the idea of taking on Care Plans as part of the practice to the GPs, but the GPs decided not to take part in the program.

4.4 Case Conference

Dr CS9 does not do any case conferences at the practice.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

RACGP fellowship is not relevant to Dr CS9 as he was admitted under the 'Grandfather Clause'.

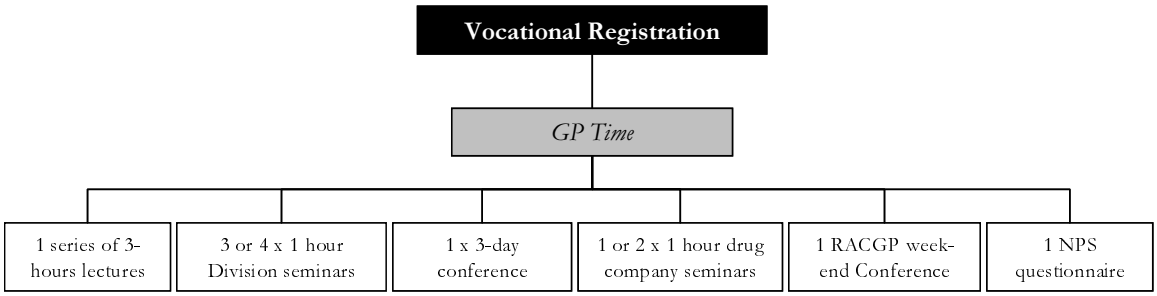
5.2 Vocational Registration

Dr CS9 reported that he undertakes a range of activities for his vocational registration including:

- Attending lectures;
- Completing questionnaires from Modern Medicine magazine; and
- Attending 3 day medical education conferences

Dr CS9 reported that he gets many more points through these activities than are required for the program. He sees these activities as necessary for keeping up to date in the profession.

Figure 41: Vocational registration Process Map



5.2.1 Professional Education

In a typical year, Dr CS9 will undertake the following:

- One series of three three-hour lectures that Dr CS9 attended recently cost $60 each (thus $180 for nine hours);
- One three-day conference in the capital city cost him $350 registration fees and three days loss of income;
- One RACGP conference at $110 for a 3 hour conference on the week-end;
- Three to four one-hour free seminars organised by the Divisions;
- One to two one-hour free seminars organised by drug companies; and
- One questionnaire (four topics taking 45 minutes each to complete, plus 10 minutes reading the NPS report)

Dr CS9 attends conferences and seminars in areas where he feels his medical knowledge is lacking. However, he also considers some of the courses that he attends to be very expensive.

He pays $150 to the RACGP for this account management.

6. Centrelink

6.1 Key Issues

Dr CS9 reported that he does not particularly enjoy filling out Centrelink forms. He often feels that by filling out Centrelink forms, he is just repeating what the Centrelink clerk requires for the patient to receive payments. *"I write what I am being told"*. He also resents the fact that the number of forms has increased over the years, and that Centrelink seems to require more and more paperwork.

6.2 Disability allowance

Dr CS6 estimated that he would complete two Disability Allowance forms per month, and that they would take 20 to 30 minutes each. He reported that the number of Disability Allowance forms that he has to fill out has been increasing over the last few years.

6.3 Sickness allowance

Dr CS6 estimated that he would complete two to three Sickness Allowance (medical certificate) forms per month, and that they would take 10 to 15 minutes each.

6.4 New Start/Youth allowance

Dr CS9 does not deal with the New Start Allowance forms often enough to remember them clearly.

6.5 Mobility allowance

Dr CS9 does not deal with the New Mobility allowance forms often enough to remember them clearly.

6.6 Carer payment/allowance

Dr CS6 estimated that he would complete one Carer Payment/allowance form per month, and that they would take 10 to 15 minutes each. He is not sure of the difference between allowance and payment forms.

7. DVA

Dr CS9 fills out about one claim form every 3 months, which takes him 5 minutes. There are only a few DVA patients among his patients (1 or 2).

8. PBS

8.1 Phone authorisation

Dr CS9 reported that Phone Authorisations take five to seven minutes each. Dr CS9 does about two phone authorisation per week.

8.2 Written authorisation

Written authorisations are not done by Dr CS9.

9. Cost Estimates

The cost estimates of compliance for CS9 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies, SIP and EPC.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some costs, SIP and are based on the GP.

The practice based costs for CS9 was $32,373, and represents 6.3% of the gross operating cost (GOC) of the practice. This is the highest ratio of practice cost to GOC for all of the Case Studies. The bulk of these costs were associated with practice nurse (42.1%) and practice manager time (27.7%), and annualised costs for PIP. A small proportion of practice related costs (0.5%) was attributed to the GPs.

Table 22: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	-	-	$7,488	$13,600	-	$1,677	$7,900	$30,665	94.7%
SIP	$82	-	$540	-	-	$17	-	$639	2.0%
EPC	$82	-	$945	$25	-	$17	-	$1,069	3.3%
Total	$164	-	$8,973	$13,625	-	$1,711	$7,900	$32,373	100.0%
% of Compliance Costs	0.5%	0.0%	27.7%	42.1%	0.0%	5.3%	24.4%	100.0%	

The total GP related compliance costs for the GP interviewed was $7,247 (Table 2). Two thirds (62.0%) these were attributed to vocational registration activities, and one quarter (22.6%) to Centrelink forms. There were few costs associated with other programs.

GP compliance costs were primarily due to the GP's time with 83.2% being attributed to the principal GP.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 4.2% of a single GP's 'share' of the practice GOC[11].

Table 23: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	-	-	-	-	-	-	-	-	0.0%
SIP	-	-	$405	$25	-	-	-	$430	5.9%
EPC	-	-	-	-	-	-	-	-	0.0%
VR	$3,704	-	-	-	-	-	$790	$4,494	62.0%
Centrelink	$1,640	-	-	-	-	-	-	$1,640	22.6%
DVA	$27	-	-	-	-	-	-	$27	0.4%
PBS	$656	-	-	-	-	-	-	$656	9.1%
Total	$6,027	-	$405	$25	-	-	$790	$7,247	100.0%
% of Compliance Costs	83.2%	0.0%	5.6%	0.3%	0.0%	0.0%	10.9%	100.0%	

[11] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 10:
Rural Small Practice

1. Contextual Information

1.1.1 Location – SES profile

The practice operates in an area that Dr CS10 describes as *"fairly average"*. He reported that the practice caters for a higher proportion of elderly patients and a lower proportion of infants, because Dr CS10 stopped doing obstetrics a few years ago

1.1.2 Patient base – practice specialty

Dr CS10 reported that the practice does not have a speciality, or specific service delivery focus. The practice tries to provide a complete range of services to their patients. This includes some procedural work. The practice does not bulk bill, Dr CS10 reported that the practice was the first in the area not to bulk bill.

1.1.3 Practice size, number of EFT GPs and other staff

The CS10 practice employs:

- Three part time GPs, (totalling 1.5 EFT);
- One part time practice administrator (Ds CS10's wife, 0.6 EFT);
- One full time receptionist, who works eleven hour days, four days a week (1.0 EFT).
- A casual administrative assistant (0.1 EFT); and
- A part time practice nurse (0.4 EFT).

This equates to be about 1.7 EFT administrative staff per EFT GP.

1.1.4 Participating GP

The GP interviewed (Dr CS10) works between three and four days at the CS10 practice per week. He also works at another practice in the area.

1.1.5 Number of patients seen per session by participating GP

Dr CS10 saw 71 patients over 5-6 sessions during the observation period.

2. Overall issues relating to Program Compliance

2.1 General attitude

Dr CS10 reported that some of the Commonwealth programs have had a great impact on his practice. He stated that some of the programs seemed to be worthwhile when he first looked into them, but became unworkable and burdensome as he became more involved.

Dr CS10 estimated that he would spend about six hours completing administrative work every week. This administrative work would take place outside of consulting hours. It included administration for state programs such as WorkCover, as well as commonwealth programs. He estimated that administrative tasks add about six minutes to each consultation. Thus if Dr CS10 sees 30 patients in a week, he would need to complete an additional three hours of administrative work. Administrative work is restricted to Commonwealth government programs. It included:

- Writing letters to lawyers;
- Generating reports;

- Completing forms; and
- Obtaining pathology results.

Dr CS10 is eager to see all of the PKI (Public Key Infrastructure) systems become computerised, with all information transmitted electronically. He considered that this will save a lot of time for both GPs and administrative staff.

2.2 Program participation

Dr CS10 takes part in:

- After hours care;
- The Immunisation Incentive;
- Diabetic assessments; and
- Health Assessments.

3. PIP Program

3.1 Key Issues

Dr CS10 reported that the accreditation process involved a lot of work, for both the administrative staff, and the GPs at the practice. He noted that the practice staff spent a lot of time constructing manuals and procedures to ensure compliance.

Dr CS10 questioned the need for repeatedly informing the HIC of the practice's medical indemnity and registration details, as they do not change from year to year. This is an issue for GPs who work in more than one location and need to be registered for each location, when it would seem easy to use the base provider number (indicating the doctor' identity), rather than the full provider number (indicating the location in addition).

3.2 Accreditation

3.2.1 Set up costs

The practice was first accredited in November 2000. Dr CS10 estimated that the entire process of accreditation took about two years.

Dr CS10 reported that the practice had to move to a new building as part of the accreditation process. Before the move, the practice had investigated the possibility of renovating their current premises. This involved a consultation with an architect, which cost about $1,000.

Dr CS10 considered that the old premises were "*perfectly fine*", but would not have been up to accreditation standards. Issues with the old premises included:

- difficulties installing ramp access,
- patient privacy issues related to the lay out of the office; and
- difficulties installing a disabled toilet.

Dr CS10 reported that the practice did not close during the move, so no consulting time was lost.

Dr CS10 estimated that the move took about five days of his time, two days of the other GPs time, and two days of the practice manager's time.

In addition to the time spent moving, Dr CS10 estimated that accreditation required:

- Attendance at a five half-day meetings put on by the Division for Dr CS10 and the practice manager;
- Two days of Dr CS10's time at an out of town conference put on by the Division;
- Six meetings lasting two hours each for all staff;
- 16 hours of Dr CS10's time to read the accreditation documentation;
- Three weeks full time work for the practice manager to organise the required protocols, and liaise with staff to ensure compliance;
- Four hours of Dr CS10's time to complete the survey that was required for accreditation.

3.2.2 Ongoing costs

Dr CS10 reported that the practice holds a meeting twice a year to discuss issues relating to accreditation.

Dr CS10 reported that there have been some uncertainty regarding the sterilisation procedures required for accreditation. He reported that he has received a number of different accounts of what is required for accreditation. He estimated that he had spent two hours dealing with these compliance issues over the last year. In addition, the practice nurse spent between 20 and 30 hours attending meetings and seminars about sterilisation over the last year.

Other ongoing costs involve the administration of the practice's public liability insurance. Dr CS10 reported that he had spent about three hours per year reviewing the practice's insurance. He estimated that the practice manager spends an additional half day per year on this task.

3.2.3 HIC documentation

Dr CS10 reported that he spends two hours per year completing the documentation required for the HIC such as changes in staffing, and practice structure. In addition, he would review this documentation for about half an hour every three months.

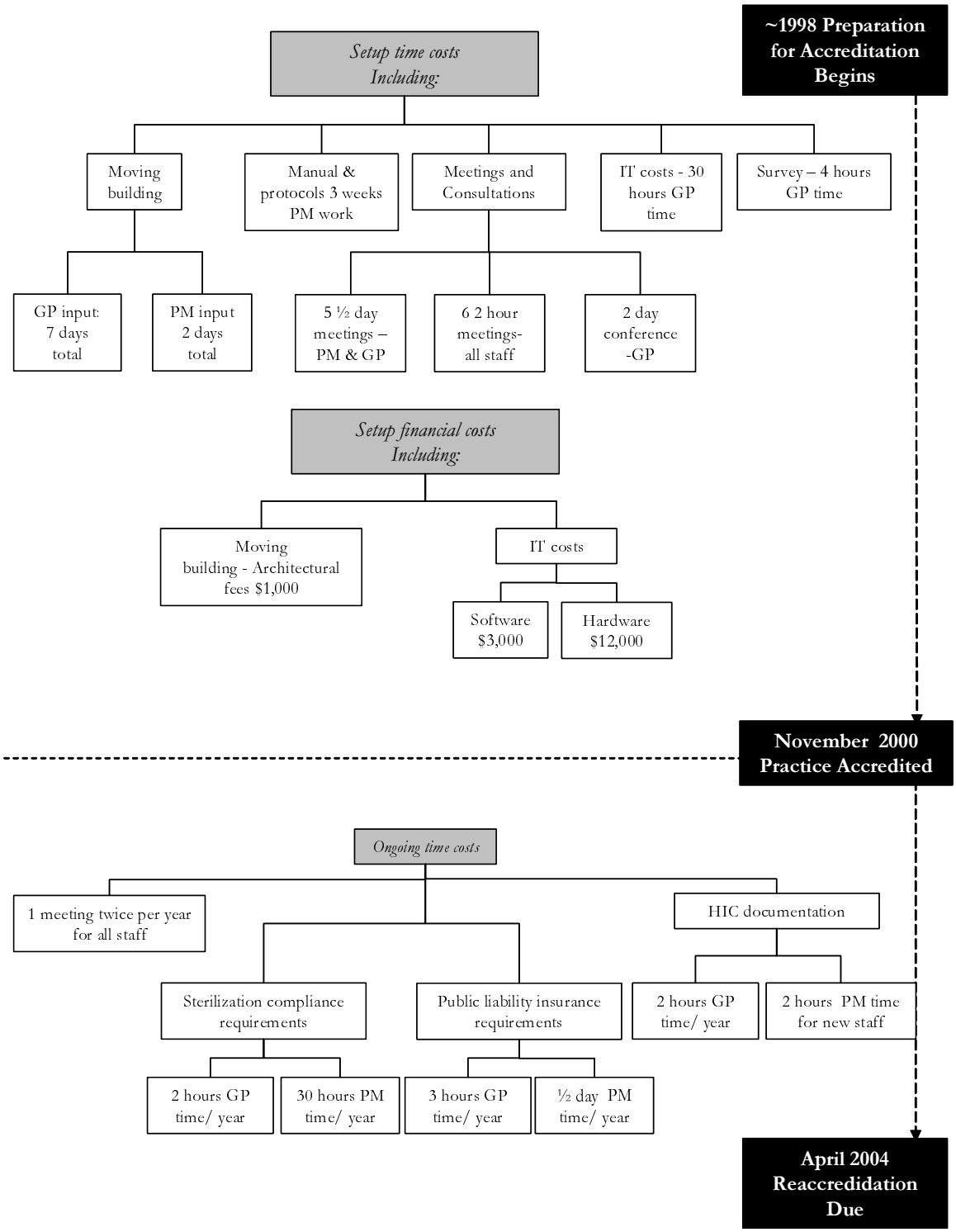
He reported that the practice manager spends about two hours completing the HIC documentation each time a new member of staff joins. However, Dr CS10 stated that this does not happen very often.

The CS10 practice has had some minor disputes with the HIC over the reimbursement of patients. These disputes were not considered to be a big issue, and Dr CS10 estimated that it would have taken up about half an hour of his time over the last year.

3.2.4 Privacy

Dr CS10 considered the privacy regulations for General Practice to be unnecessarily restrictive, and are in place so that the "*Government can absolve itself of any responsibility*". He reported that a practice would not be able to continue business if they complied "*to the letter of the law*".

Figure 42: Accreditation Process Map



3.3 IM/IT

3.3.1 Set up costs

The practice uses the Genie Medical software. Dr CS10 reported that he does not use the Medical Director software because it causes problems on the computer network.

Dr CS10 reported that the Genie software cost about $3,000. Dr CS10 researched the various software options before purchasing Genie, which took him about 30 hours. He reported that patient files are currently computerised, but that the practice's accounts are not.

Dr CS10 reported that the hardware for the network in the clinic cost about $12,000.

3.3.2 Ongoing costs

Updating and backing up the computing systems takes Dr CS10 about four hours. Dr CS10 updates the system once per year.

3.4 After Hours Care

The CS10 practice is a Tier 2 after-hours provider. They provide after hours care for 12 days out of 14; the practice pays another GP to cover every second weekend.

3.4.1 Set up costs

Dr CS10 reported that it took practice manager about two hours to write a contract between the practice and the GP who covered every second weekend. He reported that there are no ongoing costs for after-hours care.

3.5 Rural Loading

Dr CS10 reported that the time spent on Rural Loading documentation is minimal, as the HIC calculates the payment.

3.6 Teaching

Dr CS10 does not do any teaching.

3.7 NPS program

Dr CS10 reported that the NPS completes most of the paperwork associated with the NPS programs.

3.7.1 Case studies

Dr CS10 has not done a case study recently. He reported that they take between half an hour to an hour. He would undertake the case studies on his own, extracting the necessary information directly from the computerised patient files.

3.7.2 Practice visit

Dr CS10 has not had a practice visit.

3.7.3 Clinical audit

Dr CS10 reported that he has two or three audits underway at the moment. He has completed two audits in the last six months (a total of eight to ten hours per year). He reported that he would not do the audits if they were not associated with the PIP.

He estimated that an audit takes about 15 minutes per patient. Thus an audit of 15 patients takes about three hours.

3.8 Immunisation Incentive

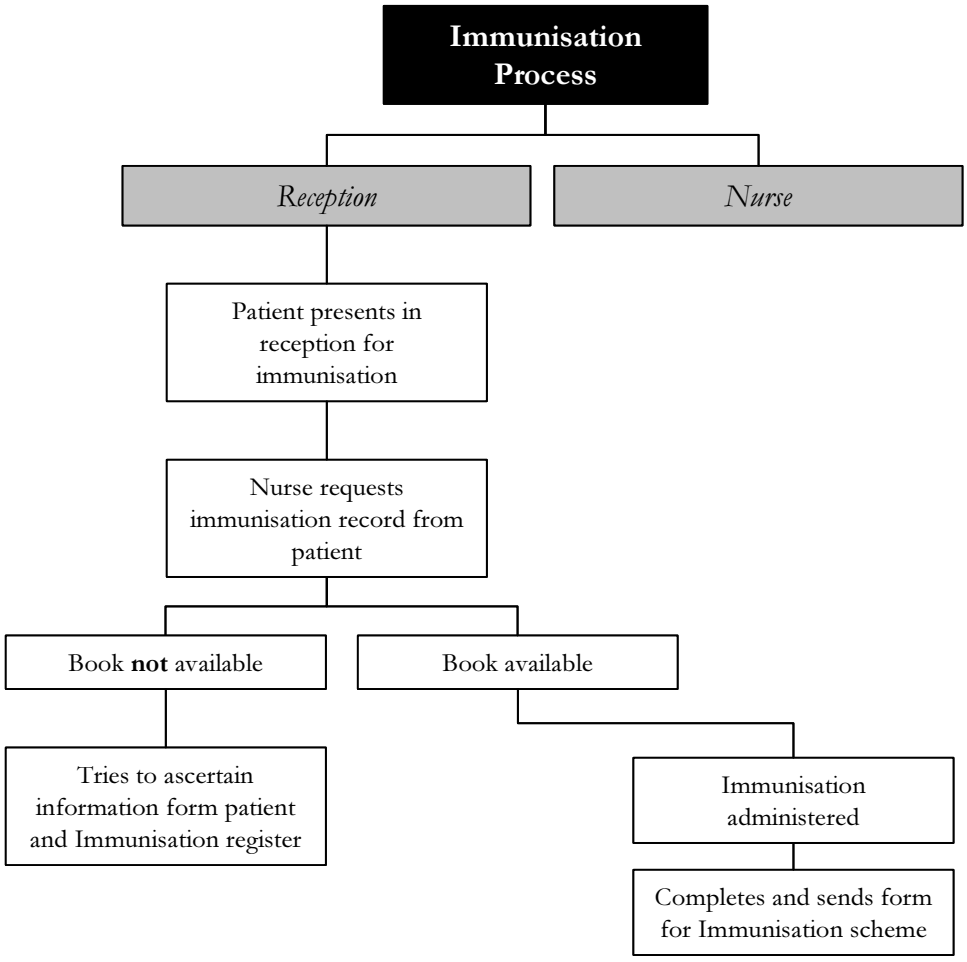
Dr CS10 is critical of the Immunisation Register, reporting that the system is "*the dog's breakfast*" compared to the immunisation system that he has seen while working in England. He is critical of the fact that patient records are tied to a single practice, and are not tracked across practices.

He reported that the practice manager had spent a great deal of time tracking patients who have already been immunised. He estimated that the practice manager has spent 100 hours trying to find information immunisation for new patients. He reported that this took up to three-quarters of an hour per patient. Now that the register has been comprehensively checked, much less time is required to correct the quarterly report.

Dr CS10 reported that the process for tracking immunisation information involves:

1. A new patient presents at the clinic. This patient has often been immunised through another practice;
2. The receptionist asks for the patient's immunisation record book. If the patient has the book with them, the process is very simple, as all of the necessary information is readily available;
3. The practice nurse administers the appropriate immunisations, and then informs the Immunisation Register;
4. If the patient does not have their immunisation book, the process becomes more complicated. The receptionist must try to track the patient's immunisation history, by asking the patient to remember where and when they were last immunised. This information can be very difficult to track down.

Figure 43: Immunisation Incentive Process Map



3.9 SIP

3.9.1 Diabetes SIP

Dr CS10 undertakes diabetic assessments under the SIP program. Dr CS10 reported that the process for the assessment is structured as part of the regular patient consultation. Each diabetic on the practice's files is scheduled for a three monthly consultation. If the patient does not attend this consultation, a reminder is issued using the practice's computerised record keeping system. The SIP assessment is conducted as part of this three-monthly cycle.

A SIP form is filled out with each assessment which details what was done at the last assessment, and what needs to be done at the next. Dr CS10 reported that these forms take very little time, and are completed as part of the regular consultation.

3.9.2 Cervical Screening SIP

Dr CS10 was critical of Cervical Smear SIPs. He believed that the program "*rewarded practices that had been slack"* with their cervical smear recalls.

Dr CS10 reported that he did very few cervical smears, as most of his patients who require smears had either declined to undergo the procedure, or had left the area. He reported that examining the patient

files for cervical smear recalls took about two hours of his time. Only six patients were eligible for Cervical Screening SIP, showing that his files were very up to date.

3.9.3 Asthma 3+ SIP

Dr CS10 reported that he does not do asthma assessments, as he believes that they are unworkable for his practice. In relation to the recall requirements of the program, he stated that "*that's not the way asthma works in the real world.* (The program) *might work if you are an obsessive compulsive asthma specialist, but 99% of our asthmatic patients are getting on OK with their lives, and don't want to go to the Doctor, and you can't convince them to come in*".

3.9.4 Mental Health SIP

Dr CS10 reported that he does not do Psychiatric Assessments, as he is unwilling to devote the training time required (about ten hours). He is also put off by the amount of paperwork required, stating "*there is more paperwork than clinical benefit*".

4. EPC

4.1 Health Assessment

Dr CS10 recently undertook a large number of Health Assessments. The process involves:

1. The GP identifies the patients aged 75 and over who would benefit from a health assessment from the patient records (about 100 were identified);
2. The practice manager constructed a letter and sent it out to these patients inviting them to take part in the assessment;
3. The nurse followed up the letters a few days later by telephone (this took about ten minutes per patient);
4. Between 60 and 70 patients took part in the program following the phone calls. The nurse conducted a home visit to each patient. About one and a half hours was allowed per patient. The home visit assessed psychosocial and environmental factors that might effect the patient's health;
5. The patients came into the clinic for a consultation with the GP. About half an hour was allowed for each consultation. The administrative forms required for the program were completed and signed by the patient during this consultation; and
6. The practice nurse then followed up the consultation with each patient by telephone. This follow up took about half an hour per patient.

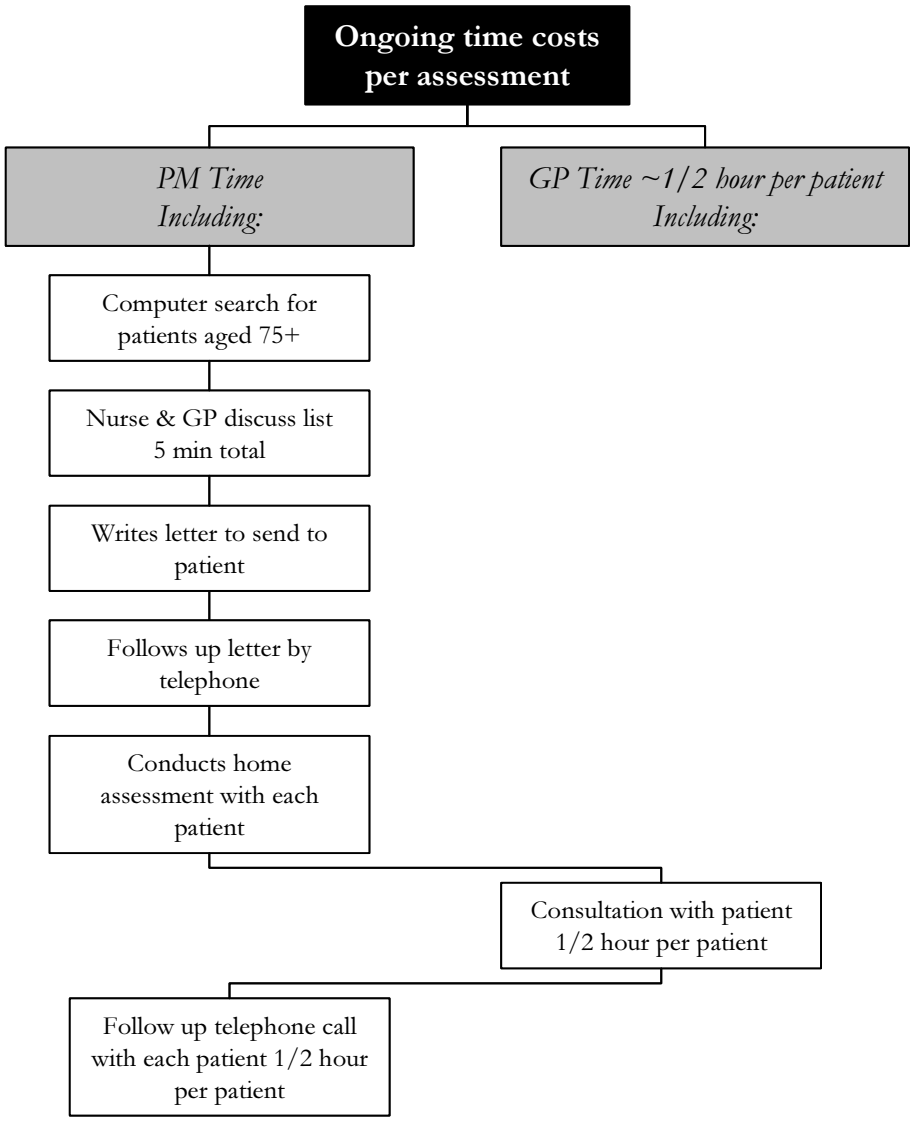
4.2 Care Plan

Dr CS10 reported that he has done three Care Plans in the past, but decided that "*they were not worth it, as they were too cumbersome with not enough clinical benefit*". He reported that the practice was already undertaking most of the requirements of the Care Plans, and was unwilling to take the extra time to fill out the paperwork associated with the program. He was also unwilling to spend the time calling patients, and communicating with specialists. He reported that these tasks need to be done manually, by the GP, and take too much time.

4.3 Case Conference

Dr CS10 reported that he does not do Case Conferences, as it is too hard and time consuming to bring all of the required people together. He reported that it was easier to either talk to each person individually, or to get them to talk to each other. He reported that the paperwork is also very time consuming.

Figure 44: Health Assessment Process Map



5. Vocational Registration & RACGP Fellowship

5.1 Professional Education

Dr CS10 is part of a program, which organises satellite post-graduate education in the area. As part of this program, he would spend one hour, eight times per year setting up the procedures. In addition, he would attend these procedures five times per year, which would take about two hours per time (total time 28 hours per year).

Dr CS10 reported that he would spend about 40 hours per year attending other CME programs. This includes:

- Two conferences per year, taking eight to twelve hours each; and
- About 20 hours attending seminars and peer review meetings held locally.

Dr CS10 reported that most of the paperwork for CME is completed by the provider of the seminars or conferences. Dr CS10 reported that he would spend about two hours per year completing additional paperwork for the courses.

6. Centrelink

6.1 Key Issues

Dr CS10 reported that the practice does not do a lot of Centrelink forms. He stated that he does not see many Centrelink patients, as the practice does not bulk bill. Centrelink patients in the area prefer to go to another practice nearby, which does bulk-bill.

Dr CS10 reported that he feels uncomfortable in the GPs role as *"judge"* when filling out Centrelink forms. He stated that the GP's primary role is to treat the patient, and not to become involved in patients' financial affairs. He indicates that the "*flavour*" of the Centrelink forms might be different if they were not filled out in the presence of the patient. He reported that the absence of the patient might give GPs the opportunity to be more "*expressive*" in their assessments.

He stated that GPs do have the opportunity to discuss a particular patient with Centrelink in private, by ticking a box on the form. However, he also reported that he is unable to discuss complex medical issues with the Centrelink staff who call, given the staff's level of understanding.

6.2 Disability allowance

Dr CS10 reported that he would complete one Disability Allowance form per week. He reported that the time taken can vary a lot, depending on the complexity of the patient's condition, and that the most complicated case can take up to 40 minutes.

7. DVA

Dr CS10 considered that the DVA system is largely "*a waste of time*", as most of the eligible veterans are already on a 'gold card' and are fully catered for medically.

He reported that a DVA assessment can take up to an hour of the GP's time, and about five to ten minutes of administrative time. Dr CS10 would do about one DVA assessment per month. Additionally, many of the DVA patients present a form that charges the cost of their travel to the DVA. This would take an additional ten minutes of the GPs time.

Dr CS10 reported that the time spent on DVA forms is covered by the incentive.

8. PBS

8.1 Phone authorisation

Dr CS10 reported that he would do about seven PBS phone authorisations every week. Each of these would take between three and five minutes.

8.2 Written authorisation

Dr CS10 does not do written authorisations, as the practice employs a largely electronic system, he stated that he "*has nothing to write on*".

9. Cost Estimates

The cost estimates of compliance for CS10 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and SIP.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), SIP and EPC are based on the GP.

The practice based costs for CS10 was $12,732 and represents 2.7% of the gross operating cost (GOC) of the practice. Under half of (40.8%) were non labour costs associated with accreditation. GPs accounted for a similar proportion (41.5%) of the practice related costs, and practice manager time accounted for 12.4%. There were almost no costs associated with SIP.

Table 24: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$4,119	$1,008	$1,576	$592	-	$79	$5,200	$12,575	98.8%
SIP	$158	-	-	-	-	-	-	$158	1.2%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	$4,277	$1,008	$1,576	$592	-	$79	$5,200	$12,732	100.0%
% of Compliance Costs	33.6%	7.9%	12.4%	4.7%	0.0%	0.6%	40.8%	100.0%	

The total GP related compliance costs for the GP interviewed was $26,620 (Table 2). Three quarters of these costs were spread among:

- SIP (26.0%);
- EPC (22.0%); and
- Vocational registration (17.8%).

Each of the other programs accounted for about one tenth of the GP related compliance cost.

GP compliance costs were primarily due to the GP's time with 78.0% being associated with the principal GP.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 8.6% of a single GP's 'share' of the practice GOC[12].

Table 25: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$711	-	$2,541	-	-	-	-	$3,251	12.2%
SIP	$6,909	-	-	-	-	-	-	$6,909	26.0%
EPC	$2,685	-	$42	$3,120	-	-	-	$5,847	22.0%
VR	$4,737	-	-	-	-	-	-	$4,737	17.8%
Centrelink	$1,895	-	-	-	-	-	-	$1,895	7.1%
DVA	$2,053	-	-	-	-	$159	-	$2,212	8.3%
PBS	$1,769	-	-	-	-	-	-	$1,769	6.6%
Total	$20,758	-	$2,583	$3,120	-	$159	-	$26,620	100.0%
% of Compliance Costs	78.0%	0.0%	9.7%	11.7%	0.0%	0.6%	0.0%	100.0%	

[12] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 11:
Solo Remote Practice

1. Contextual Information

1.1.1 Location – SES profile

Dr CS11 is a solo GP working in a rural town of 1,600 inhabitants located 350 kilometres from the capital city. The area is very depressed economically, having had to suffer the consequences of the draught and a high level of unemployment due to the closure of public companies and infrastructure some years ago. Employment and education opportunities are limited. A significant part of the male population works out of the town and is absent during weekdays. The town however is very well maintained and has preserved many architectural buildings, which makes it attractive. It also benefits from a beautiful environment. Consequently, tourism is now the towns' primary source of revenue.

The town has a Health Precinct including a hospital, a nursing home and a surgery.

1.1.2 Participating GP

Dr CS11 is the only doctor in the area, working both in the hospital, where he is the Principal Medical Officer, and in the surgery. The surgery is privately owned, and Dr CS11 works as a contractor for the hospital. He occasionally works in regional hospitals where he has medical rights.

Dr CS11 is originally from the country and graduated in 1987. He has been working in the town for ten years. His wife is also a medical doctor and works independently in a regional centre 50 kilometres away. She takes charge of the practice management of CS11.

1.1.3 Patient base – practice specialty

The patient base is very comprehensive, as DR CS1 is the only GP for the town and the area. According to Dr CS11, everyone in the town is a patient of his. Consequently Dr CS11 offers comprehensive medical services, ranging from obstetrics to surgical interventions. He has approximately 1500 patients, some of whom travel great distance form the outback because of Dr CS11's reputation as a country doctor.

1.1.4 Practice size, number of EFT GPs and other staff

Dr CS11 works full time in the surgery. He has two receptionists (one working 0.8 EFT and the other 0.6 EFT). There is a practice nurse who is present one day a week in the surgery (paid by the Division). The nurse also works at the hospital, where among other tasks she is the diabetic nurse and organises the 'Outreach' program.

The practice bulk bills around 70% of the patients (the elderly and the aboriginal patients in particular).

2. Overall Issues Relating to Program Compliance

Dr CS11's overall opinion about paperwork in general practice is that it keeps the GPs away from their core skills and role. Dr CS11 believes that knowing and understanding the patients, their family and social context is more critical to medical care in a small rural town than trying to fit into the requirements of government programs designed by and for urban people. He thinks that programs that try to dictate the GPs decisions (SIP, EPC) are *"an insult to the doctor's intelligence"*. The increased amount of paperwork is difficult to cope with: *"After a 12-hour day and having to face dilemmas all day, the last thing I want to do is more paperwork. The people who design these programs don't understand that here we have to work hard and we have to do difficult procedures. So the programs are a waste of my time. I would go to bed a 1 am and get up at 4 am if I wanted to do all of these."*

Although Dr CS11 recognises that computerisation can be beneficial in specific situations, he tries to limit the use of computers in his practice because he thinks that they are an intrusion in the patient-doctor relationship. He is fully dedicated to his practice and to the stressful work involved in country medicine and is thankful that his wife is able to take care of all the business aspects of the practice.

3. PIP Program

3.1 Accreditation

The accreditation is described as *"bureaucracy gone mad"*. Although some requirements are perceived positively and allow the practice to maintain high standards, other requirements are said to be excessive. The procedure manual for instance, is said to require a considerable amount of time for a very limited utilisation once the accreditation is completed. *"How many doctors have looked into the manual between accreditation? – None."*

The accreditation process was also said to be hardest for solo and small practice because no economy of scale can be realised. Furthermore, the lack of administrative staff in solo practice makes the amount of paperwork difficult to tackle.

The practice was first accredited in 1999, and reaccredidation was completed in October 2002. Dr CS11 had only little to do with it. The practice manager and the receptionists undertook most of the work. The main tasks related to ensuring that the practice was up to date with the standards and procedures and to implementing the required changes.

In total, preparation for re-accreditation took 23 hours of the receptionist's time and 30 hours of the practice manager's time. The RACGP also charged $150 to analyse the data from the patient survey.

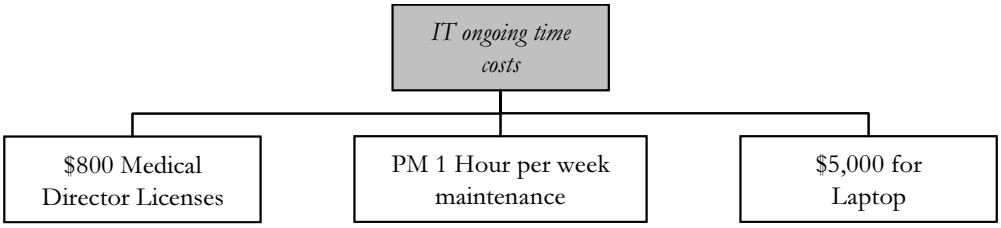
The surveyors' visit occurred over a morning, during which the practice was closed to patients. Both receptionists and the practice manager had to be present for the four-hour long visit. The GP had to be present for one hour.

The accreditation fee was reported to be around $700.

3.2 IM/IT

Dr CS11 uses his computer as little as he can, mainly to generate the 50% of prescriptions required by PIP. The practice does not keep its medical records electronically. It does however transmit data to the HIC and receives pathology results electronically.

Figure 45: IM/ IT ongoing costs process map

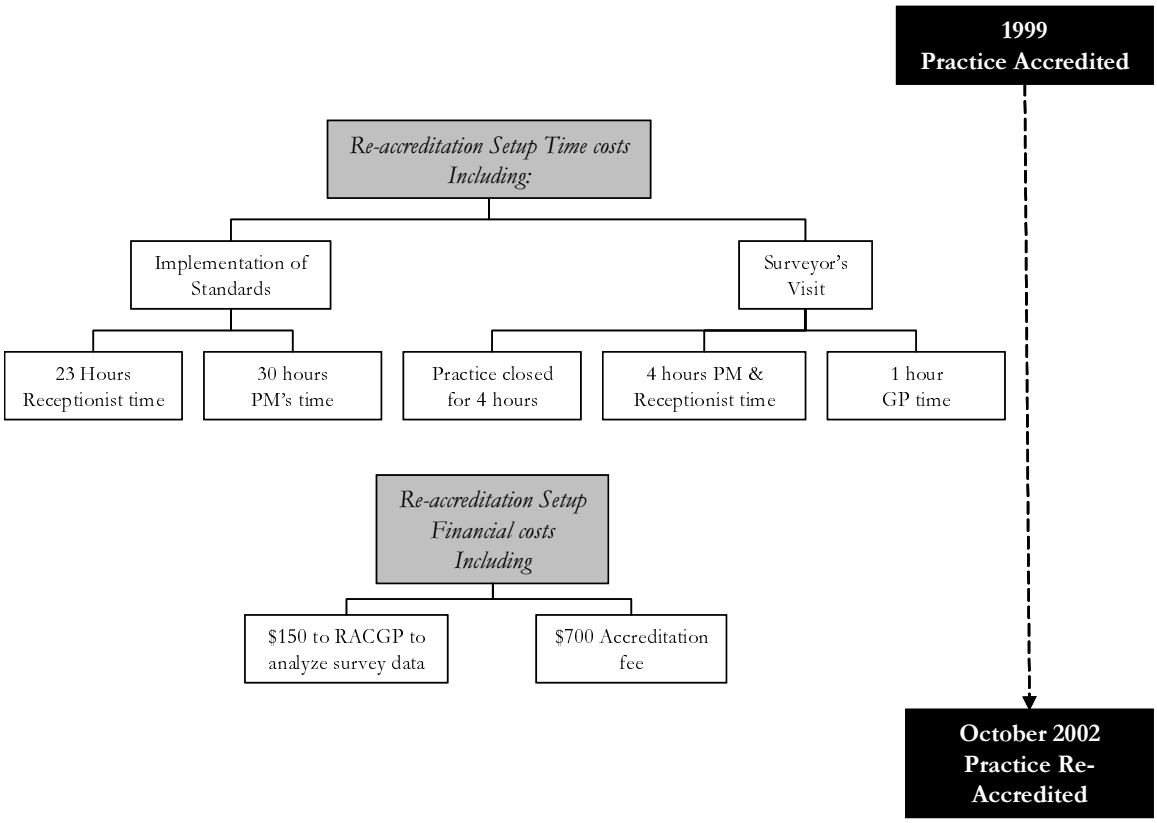


3.2.1 Set up costs and on-going costs

A lot of work was undertaken three years ago by the practice manager to equip the practice electronically. The ongoing costs are limited now, to about one hour every two weeks of the practice manager's time. Two laptops were bought recently ($5000), and the Medical Director registration fees cost $800 per year.

The next task is to network the computers, but this is said to be too time consuming and not worth the investment for a solo practice. It also increases the practice dependence on technology. However it is envisaged that the networking of the computer will need to be undertaken.

Figure 46: Accreditation & re-accreditation costs process map



3.3 After Hours Care

Dr CS11 provides 24 hour medical care. After hours patients contact the hospital which then contact the GP.

The practice manager spends about five minutes every month communicating with HIC regarding the provision of after-hours care.

3.4 Rural Loading

CS11 is eligible for rural loading. No costs were identified in relation to this program.

3.5 Teaching

Dr CS11 reported that he does a lot of teaching. He had three medical students last year for a total of ten weeks. He estimated that he cuts down his productivity by about 30% when he works with a student. Additionally, 1.5 hours paperwork is required for each student.

The practice does not generate enough work to be able to employ a registrar.

3.6 NPS program

Dr CS11 does not participate in the NPS program, because he says that he does not have enough time, as he is constantly busy with acute treatment of patients.

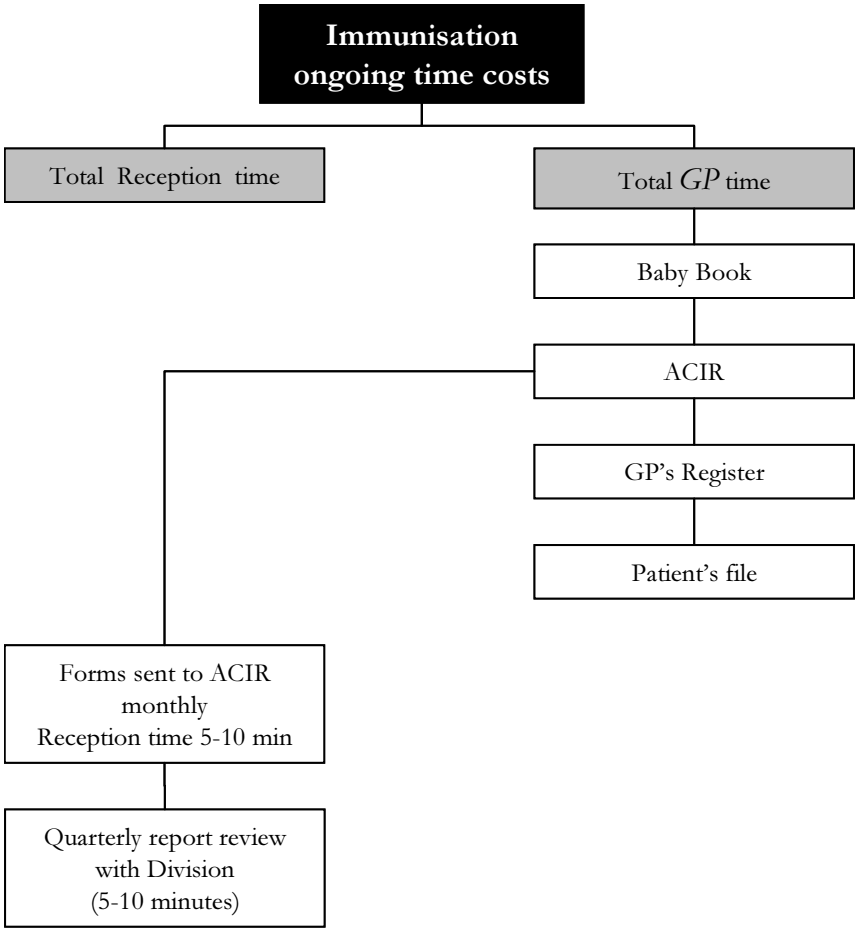
3.7 Immunisation Incentive

The practice is part of the program, and Dr CS11 reported that he has high immunisation performance results. The GP vaccinates most patients himself (between six and seven per month). Each form takes about 20 minutes because four records need to be completed for each immunisation (five minutes per record):

- The baby book;
- The ACIR;
- The GPs personal register; and
- The patient file.

The receptionist sends the ACIIR forms every month, which takes between five and ten minutes. The quarterly reports requires only a minimum amount of time (between five and ten minutes) because *"the population is easy to track"* and because the Division provides some support.

Figure 47: Immunisation Incentive process map



3.8 SIP

3.8.1 Diabetes SIP

Diabetes SIPs have not been undertaken by the practice because of the amount of paperwork involved. Also, Dr CS11 feels that the item does not allow him to treat diabetes cases correctly, and he feels insulted by the incentives attached to the items, which he interpreted as a *"bribe to influence GPs clinical decisions"*.

3.8.2 Cervical Screening

Cervical Screenings are the only SIP items currently undertaken by the practice, because Dr CS11 recognises that "*it is something that we did not do properly"*. Learning how to do recalls was time consuming and is still not entirely completed. The nurse, supported by Division staff spent up to 30 hours retrieving files for recalls. Additionally, the two receptionists spent between three and four hours to learn the how the system works. The letters have been drafted by the practice manager (30 minutes) and are ready to be sent in the coming months.

3.8.3 Asthma 3+

Asthma SIPs are said to be "an insult to the doctor's intelligence" because of the implication that GPs are not treating asthma patients correctly. They are also hard to implement because the patients do not want to have to attend and pay for three visits when they do not feel they are acutely sick. Dr CS11 reported that most asthma patients have their condition under control. Others are well identified and monitored thanks to the Outreach program. The philosophy behind the program is said to be irrelevant in small towns where the population is well known to the GP and the Practice nurse. *"We know everyone, all the kids go to the same school and I've delivered most of them. We are doing our job, we don't need a fat cat turkey from Canberra to tell us how to do our job, and then prostitute us by offering us incentives".*

Consequently, no Asthma 3+ has been undertaken by the practice.

3.8.4 Rural Nurse

Dr CS11 stated that the new SIP, which subsidises practices who employ a full time nurse, is not relevant in a small isolated practice where there is insufficient work for a full time nurse.

4. EPC

4.1 Health Assessment

Dr CS11 stated that Health Assessments are a *"waste of time"*, because the he and the nurse know almost all of the elderly patients well. This in-depth knowledge is a result of the town having a defined population that has access to only one GP, and also because the practice nurse runs the Outreach program for older people.

75 patients were identified as eligible, of which about half volunteered for a health assessment. *"The other half got scared that they were going to be sent in nursing homes".* The practice manager, supported by the receptionists, did all the preparatory work leading to the selection of and communication with the 75 eligible patients. It took five hours of practice manager's time and two hours of receptionist's time.

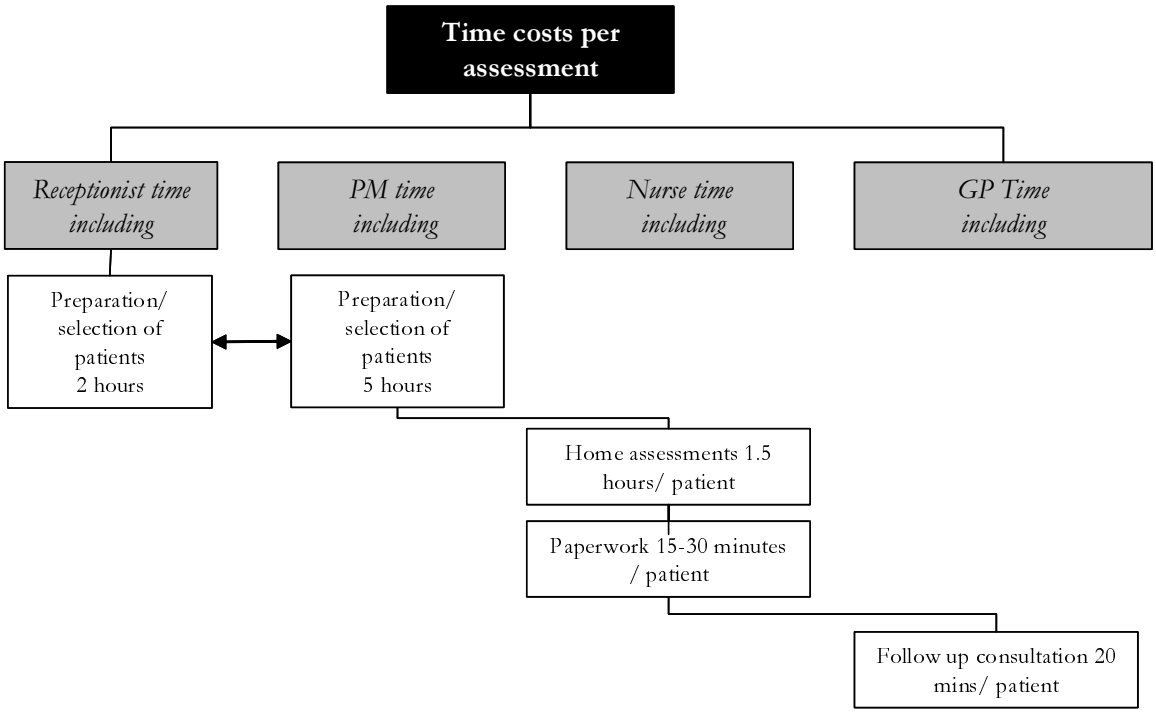
The nurse spent 1.5 hour per home assessment. This was followed by 15 to 30 minutes paperwork for each patient assessed. The GP then spent 20 minutes in consultation with each patient. These health assessments were said to be of benefits for only one or two patients.

The recalls have not been undertaken as yet and were reported to be of limited use because of the regular patients' visits to the practice.

4.2 Care Plan

Dr CS11 has not undertaken any care plans.

Figure 48: Health assessment process map



4.3 Case Conference

Dr CS11 has not undertaken any case conferences. One of the reasons for not using case conferences was because that they need to be organised on video and that the technology is too cumbersome. *"Video-conferences are good for distance learning, but for case conferences, it's technology looking for a use"*. Another off-putting aspect was the time delay in verbal utterances. The same results are said to be reached, although without financial retribution, with a simple telephone call with a specialist and the practice nurse. *"I'd rather do it for nothing rather than fiddle around and mess around and then have the paperwork to complete"*.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

Dr CS11 is vocationally registered but not a member of the RACGP.

5.2 Continuing Professional Development

Dr CS11 reported having far more points than necessary because of the procedural work he is required to do as part of his country practice. CPD is said to require a considerable amount of time. However Dr CS11 tries to make CPD activities cost neutral, either by getting the Division to subsidise them (by paying for a locum doctor for the duration of the training), or by going to conferences paid for by drug companies. Dr CS11 does not claim personal expenses related to CDP activities (such as travel expenses) and stated that these are *"negligible"*. He estimated that about 20% of the cost of the CPD activities are not subsidized.

Activities that are undertaken regularly include:

- Evening conference, once a fortnight for four hours (including travel);
- Two week- update on obstetrics every year (locum is paid for and GP is paid for his work in hospital);
- One-week Sydney Conference where registration fees ($1600), travel and accommodation can be claimed back as part of the Rural Doctors federal government project;
- Ad-hoc training during week-ends (eg plastic surgery) about three times a year for four hours; and
- Visits from specialists for half days (eg radiologist, anaesthetist) four times a year.

6. Centrelink

6.1 Key Issues

Centrelink forms requires the GP to make the decision on the patients' eligibility which may be difficult in small, tightly knitted communities.

Another form, the Patient Assisted Transport Scheme (PATS) require little time (2 minutes) from rural GPs and are seen frequently (ten per week).

6.2 Disability allowance

Dr CS11 reported that Disability Allowance forms take between 15 to 20 minutes to complete and Dr CS11 completes about one TDR per fortnight. He will complete approximately 20 to 30% outside consultation time.

Dr CS11 thinks that it is normal for the forms to exist and to be completed by the GP. However he thinks GPs should be paid to do this work, the same way they are paid by insurance companies and lawyers when they have to do administrative work.

6.3 Sickness Allowance

The medical certificates are completed during consultation and take about two minutes to complete. Dr CS11 completes about 1 medical certificate per month.

6.4 New Start/Youth Allowance

Dr CS11 reported that New Start forms are rare.

6.5 Mobility Allowance

Dr CS11 reported that he has never seen a Mobility Allowance form.

6.6 Carer payment/allowance

Dr CS11 reported that he completes about one Carer Payment form per fortnight, which takes up to ten minutes each.

7. DVA

Dr CS11 has only a few DVA patients, most of whom are farmers providing for themselves. Dr CS11 cannot remember the last time he had to fill out a DVA form.

8. PBS

8.1 Phone authorisation

Dr CS11 undertakes around 20 phone authorisations per week, each taking about three minutes. He doesn't mind them, and thinks that it is normal to keep a check on what is prescribed.

8.2 Written authorisation

Dr CS11 makes about 1 written authorisation per month. They require about three minutes and a further five minutes of receptionist time to call the patients upon reception of the drug.

9. Cost Estimates

The cost estimates of compliance for CS11 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and after hours services, and EPC.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), SIP and EPC are based on the GP.

The practice based costs for CS11 was $4,334 and represents 1.8% of the gross operating cost (GOC) of the practice. This was mostly attributed to PIP with no practice-based costs for SIP and few costs associated with EPC. Nearly two thirds (63.5%) of these costs were attributed to annualised expenses associated with accreditation. The remainder was primarily attributed to labour costs for the practice manager, who was responsible for accreditation.

Table 26: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$11	-	$1,195	-	-	$186	$2,750	$4,142	95.6%
SIP	-	-	-	-	-	-	-	-	0.0%
EPC	-	-	$156	-	-	$35	-	$191	4.4%
Total	$11	-	$1,351	-	-	$222	$2,750	$4,334	100.0%
% of Compliance Costs	0.2%	0.0%	31.2%	0.0%	0.0%	5.1%	63.5%	100.0%	

The total GP related compliance costs for the GP interviewed was $8,897 (Table 2). Nearly two thirds (62.8%) of these costs were associated with vocational registration, and one fifth (18.0%) to PBS.

GP compliance costs were nearly all due to the GP's time with 98.2% being attributed to the principal GP.

The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 3.6% of a single GP's 'share' of the practice GOC[13].

Table 27: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$358	-	-	-	-	-	-	$358	4.0%
SIP	-	-	$16	-	-	$124	-	$140	1.6%
EPC	$813	-	-	-	-	-	-	$813	9.1%
VR	$5,590	-	-	-	-	-	-	$5,590	62.8%
Centrelink	-	-	-	-	-	-	-	-	0.0%
DVA	$400	-	-	-	-	-	-	$400	4.5%
PBS	$1,580	-	-	-	-	$18	-	$1,597	18.0%
Total	$8,740	-	$16	-	-	$142	-	$8,897	100.0%
% of Compliance Costs	98.2%	0.0%	0.2%	0.0%	0.0%	1.6%	0.0%	100.0%	

[13] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Case Study 12:
Inner Metropolitan Group Practice

1. Contextual Information

1.1.1 Location – SES profile

CS12 is a group practice with three locations, across three suburbs of the inner city:

- One in a post-industrial zone which has recently been renovated and restructured as a residential area;
- One in a working class suburb, where a large number of pensioners and health-card holders are living; and
- One in a middle to upper-middle class suburb with dominantly double income families.

1.1.2 Practice size, number of EFT GPs and other staff

Fourteen GPs and two registrars work across the three locations. Eight GPs work nine sessions a week, and five GPs work part time:

- One GPs work seven sessions per week;
- Two GPs work six sessions per week; and
- Two GPs work three sessions per week.

Dr CS12 is employed and earns around $3,120 per fortnight ($81,120 per annum plus on-costs). This does not include the GPEA (General Practitioner Education Australia) reimbursements.

It is not uncommon for doctors to work in more than one location. The practice is owned by five partners.

In addition to the GPs, the practice employs:

- Ten EFT Reception staff, who earn between $20 and 25 an hour (average $22.50 inclusive of on-costs)
- Four EFT Nursing staff, who earn $30 an hour (inclusive of on-costs)
- 1.5 EFT practice manager, who earns $50 an hour (inclusive of on-costs)

1.1.3 Participating GP

Dr CS12 is one of the two registrars at the practice. He has been in the practice for 4 months, and is doing his advanced training[14]. He is working full time in the practice, across two of the three locations[15].

Once employed, the registrars are paid by the practice following the GPEA awards, and are subsidised by GPEA. Dr CS12's salary is calculated using the greater of either Dr CS12's consulting time or 45% of his billed consultations.

[14] Registrars have to undertake a 2-year training in general practice after their medical degree and their internship: six months as 'basic' trainee, 6 months as 'advanced' trainee and twelve months as 'mentor' trainee.

[15] A full time registrar is expected to do a minimum of 30 hours of consultation per week and five hours of teaching and administrative tasks. Every fortnight the registrar must go to the RACGP to undergo a three-hour formal training session. Additionally, between two and six full days of training at the RACGP are required per six-month period.

2. Overall Issues Relating to Program Compliance

The registrar does not take part in many of the programs. He does very few SIPs and EPC items, and of course, no teaching. Because he is in a teaching program himself, he does not other CPD activities.

Furthermore, Dr CS12 has been in the practice for four months only, and will leave the practice within two months. This also limits his participation to the programs.

Partial information was collected in relation to other doctors' participation to the programs, however this information cannot be comprehensive because it was collected from the practice manager and not directly from the other doctors.

Furthermore, the practice principals refused to communicate the financial information required to undertake a comprehensive cost analysis. This prevented undertaking a cost analysis for this case study. It was only possible to determine the cost of the time provided by staff on the programs.

3. PIP Program

3.1 Accreditation

3.1.1 Set up costs

The practice was accredited in 2001. The main reason given by the practice manager to undertake the accreditation process is the requirement to be accredited to join the training program. Being able to have a registrar was seen as critical to the continuity of medical service at the practice. The PIP payments were also reported as a sufficient incentive to undertake the process. Finally, the accreditation was said to be a good process to *"take a step back and look at our practices."* The practice manager recognises that the accreditation process is very demanding and the effort required was facilitated by the fact that the practice had most of the equipment that was required due to its large size.

- The first step in the process was the application for registration in early 2001, which required providing a brief summary for each individual site. This took three hours of the practice manager's time. The fee for registering the three sites was $1,200 per EFT GP.
- Three preliminary meetings took place to help the two practice managers to get familiar with the process. These were run in the evening by the Association of Practice Managers, took three hours each, and were attended by the two practice managers.
- Additionally, a half-day training session (lasting four hours) was organised by AGPAL and was attended by two practice managers
- The practice manager then divided the tasks that needed to be undertaken in order to reach the standards into three lists, one for GPs, reception staff, and nurses. Each task list had to be handled by the relevant staff.
- The practice manager monitored the process through meetings every two months in each location. Each meeting took 1.5 hours and included all the site staff.
- The doctors' main task was to enhance their computer skills. The practice manager organised a training session about recall systems for the doctors, delivered by the Division and subsidised by a drug company. This session lasted three hours. Another training session was organised to handle electronic transmission of pathology results. This session also lasted three hours.

- Additionally, all doctors had to attend three meetings about accreditation standards. Each meeting lasted three hours.
- The practice manager could not assess the amount of individual time spent by each doctors on the accreditation process. In particular, time spent to up-date computer skill can be highly variable depending on the doctor's skills and level of interest.
- The practice manager introduced the manual of standards and procedures during a 1.5-hour meeting with all reception staff. He estimated that it would have taken 45 minutes for each staff member to read and get familiar with the manual.
- Apart from the practice manager, the nurses spent the most time on accreditation preparation. A 1.5-hour meeting took place with the nurses and the practice manager. Then the head nurse would have spent approximately 20 hours to prepare for accreditation.
- 150 patients were needed to complete the patient survey. The reception spent two minutes per patient to explain and collect the survey.
- The surveyor's visit took two full days across the three sites. The practice manager was present all the time. At each site, the time required for the survey included:
  - Two hours of reception staff time;
  - A total of 7.5 hours was spent with the GPs on all three sites (excluding the Registrars); and
  - A total of three hours of nurse time for all three sites.
- A number of additional requirements had to be met after the survey. These took 16 hours of the practice manager's time. Meetings also took up a total of 30 hours of staff reception time.

The practice physical improvements included:

- Teaching program signage: $50;
- Publication for practice: $1,300;
- Washing basin in consulting rooms: $5,000;
- Bio-hazard symbol stickers: $50;
- Sharps containers: $200;
- New chairs: $500;
- No smoking and toilet signs: $50;
- Doctor's bag: $150;
- External signage: $2,000; and
- A new server to undertake electronic prescription: $1,200.

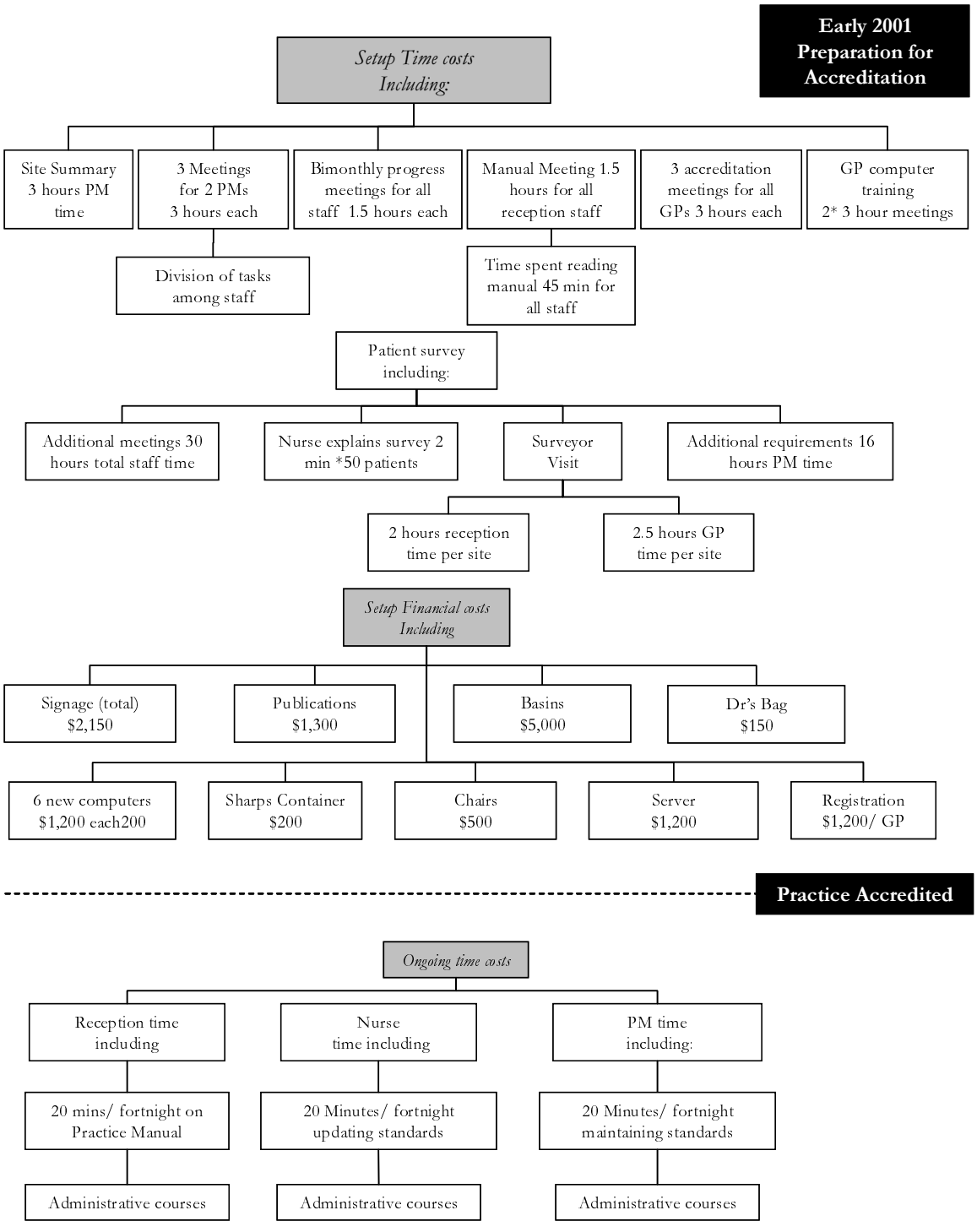
3.1.2 On-going costs

The practice manager estimated he also spends 20 minutes fortnightly to continually up-date the standards.

The nurses would spend about 30 minutes fortnightly maintaining the standards of accreditation.

Another condition of accreditation was that the practice offered its staff the opportunity to participate in regular training sessions. The practice pays for the costs of the courses, but asks its participating staff to attend the course on their own time. The last financial year $2,200 was spent on courses for admin and nursing staff. Other courses that did not incur any cost to the practice (as they were sponsored), were also suggested to staff.

Figure 49: Accreditation process map



3.2 IM/IT

Six new computers at $1,200 each were bought to receive the IM/IT PIP payments.

3.3 After Hours Care

The practice is probably in Tier 2, although the practice manager was unsure. He did not identify any on-going costs after the initial time spent informing the HIC of the After Hours Care arrangements of the practice.

3.4 Rural Loading

Rural Loading not applicable to the CS12 practice

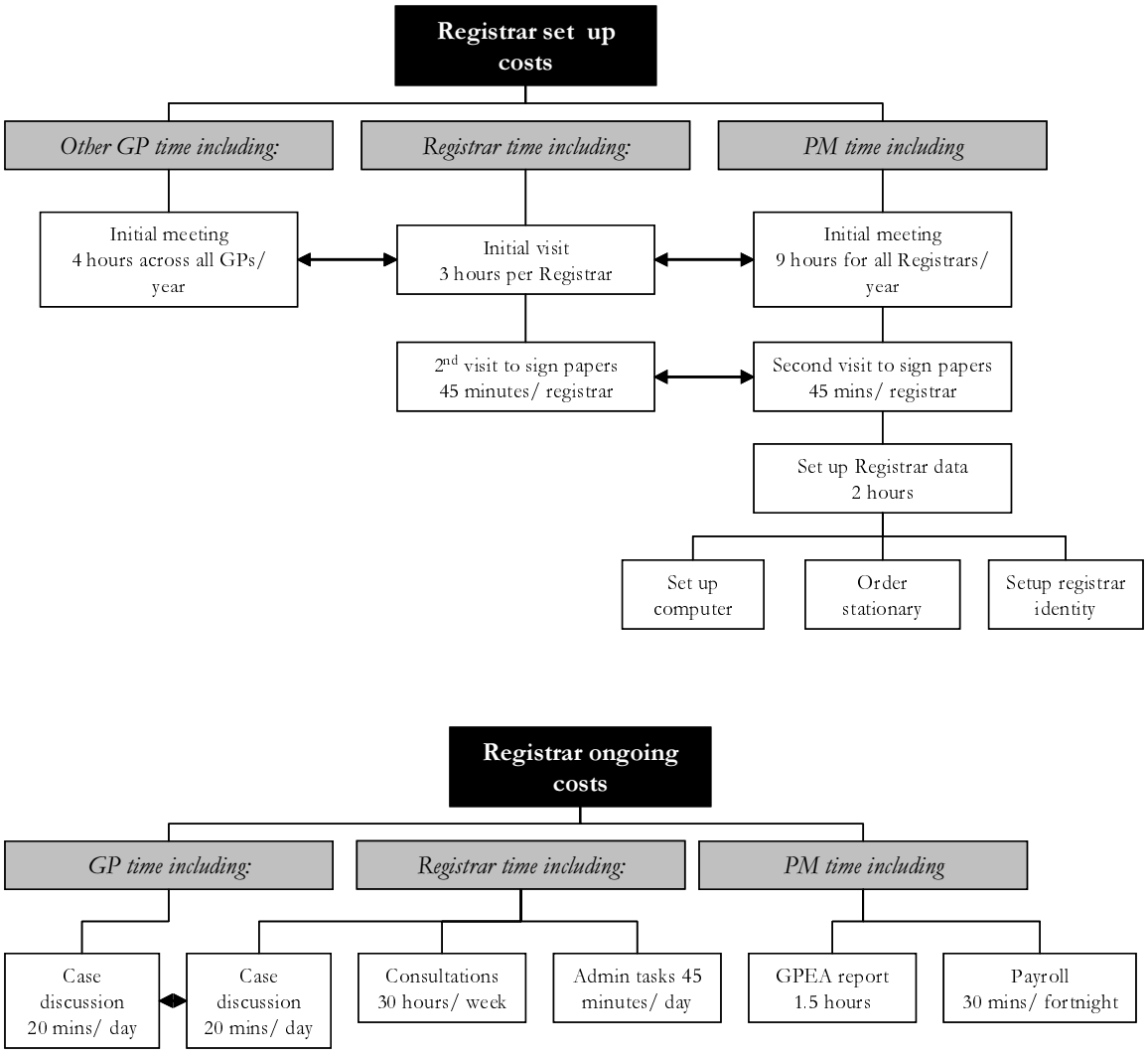
3.5 Teaching

The practice takes a number of students in addition to having two registrars on a regular basis. It is a way for the practice to promote itself and it is part of the long-term recruitment of GPs. Some doctors were also reported to enjoy teaching in itself.

Over the last two months, four students were received for a total of eight weeks full time. This was slightly more than usual, on average each partner would take students for four to eight weeks per year in total.

The consulting time of the doctors during these periods would be reduced to approximately 25% (three patients would be seen instead of four per hour). The practice manager spends around ten minutes for each student in total.

Figure 50: Registrar process map



3.6 NPS program

Dr CS12 does not take part in this program as he is already in full time training as a registrar.

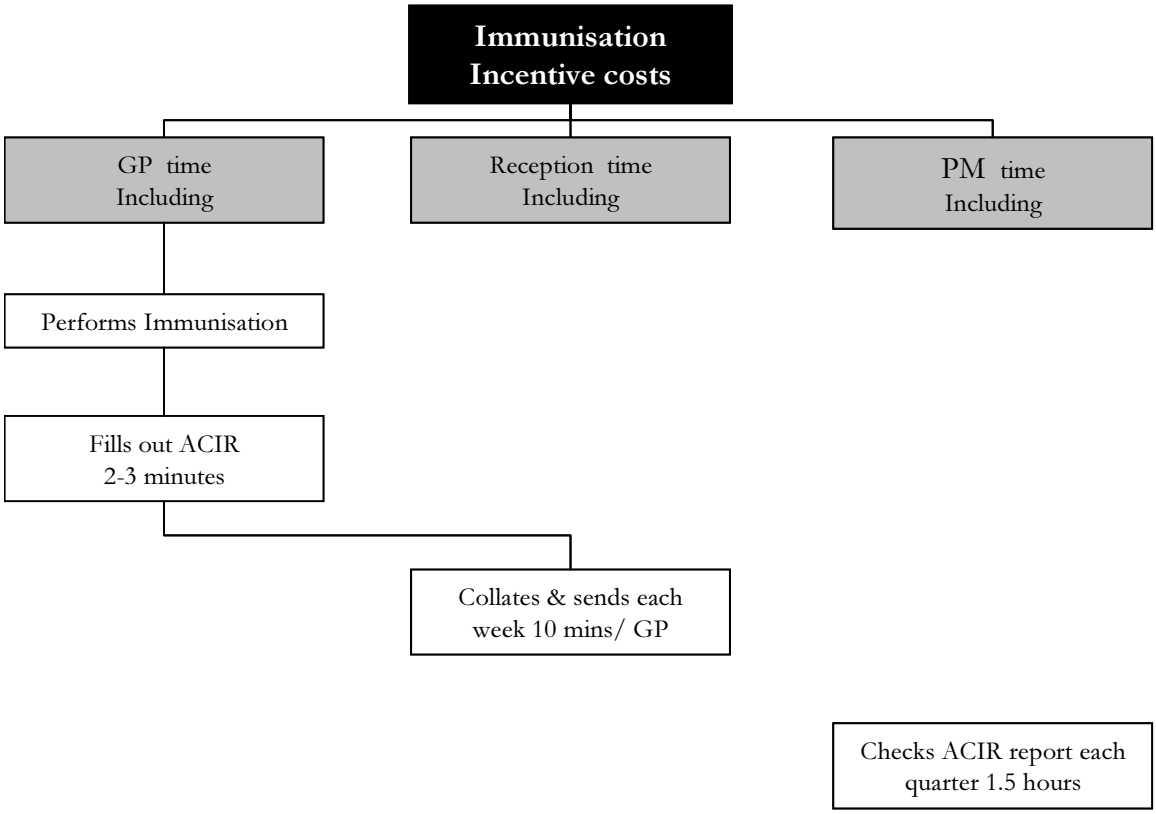
3.7 Immunisation Incentive

Dr CS12 does the immunisations himself most of the time. He does about one immunisation a week (on average each doctor does three immunisations a week). Two to three minutes is required to fill out the ACIIR forms. Dr CS12 then passes the forms onto the receptionists, who sends them to the Register each weekly (this takes about ten minutes per doctor).

Every month, a report is sent back by the Immunisation Register and the reception staff checks any anomaly (10 minutes per month for all immunisation).

Every quarter, the Immunisation Register sends a report, which is checked and corrected by the practice manager supported by a Division staff. This takes 1.5 hours every quarter.

Figure 51: Immunisation Incentive process map



3.8 SIPs

Dr CS12 rarely does any SIPs, although other doctors in the practice do. It takes the practice manager 30 minutes per month to redistribute the SIP payments to each doctor. Additionally, a nurse is employed three days a week to give support when Diabetes SIP and Asthma 3+ visits are undertaken. Cervical Screening SIP is not used because the practice has a recall system to get patients to undertake a PAP smear every two years.

3.9 PIP administration

The practice manager stated that it is impossible to check PIP calculation*: "We have to take what they give us."* Therefore contacts with HIC in relation to PIP administration are rare, and may only involve one 15-minute call every three months.

4. EPC

DR CS12 does not undertake EPC items. The five partners however do undertake them supported each by a practice nurse. The practice manager could not give any indication of the time and resources required to undertake EPC items, as he is not involved in these items.

Dr CS12 stated that EPC items are under-utilised in the practice, and a meeting was held a few weeks ago to discuss ways to undertake more EPC items. This meeting included all the practice doctors and the practice manager. It lasted 2.5 hours in the evening.

4.1 Health Assessment

The practice nurse is paid $45 to 50 per health assessment. About 50 health assessments are undertaken in total. Health assessments are reported to be good preventative measures.

4.2 Care Plan

Around six care plans a month are undertaken. Care plans were reported to represent a formalisation of what was already in place in the practice, and therefore were seen positively.

5. Vocational Registration & RACGP Fellowship

5.1 RACGP Fellowship

Dr CS12 is not yet a member of the RACGP. He will undergo the fellowship examination in 2003, toward the end of his 'mentor' year.

5.2 Vocational Registration

The practice is listed with GPEA. GPEA refers the registrars to the practice, and then one or several members of the practice interview the registrars. Over the last 18 months, the practice had eight registrars, each for a period of six months. This is higher than normally, and the practice would have usually two registrars every six months.

The main reason for taking registrars is that this is the main avenue to recruit GPs. The practice is always in need of more GPs, and the partners see the time spent teaching registrars as a repayment for what they received in the past, and as a way to find potential candidates to replace them upon retirement. Two of the present partners were introduced to the practice as registrars.

The initial contact consisted of a visit to the practice, and an interview with some of the partners. The eight registrars were divided into three groups (One group of two, and two groups of three). The visit to the three practice sites took three hours for each group, and was coordinated by the practice manager. These visits required

- Nine hours of each registrars' time (including three hours of Dr CS12 time);
- 20 minutes of each of the four partners' time spent in discussion with the registrars

Once the initial contact was made, a second visit is required from the registrar to sign all necessary papers before beginning employment. This visit took approximately 45 minutes of Dr CS12's and the practice manager's time.

The practice manager needed to set up the administrative and electronic data required so that the registrar begin can work. This takes about two hours of the practice manager's time for each registrar and includes:

- Set up the computer programs;
- Order stationery and stamps ($30); and
- Set up Registrar identity with pathology companies.

Once employed, Dr CS12 undertook consultations. He received teaching from a practice partner on an informal basis, as required. Dr CS12 estimated that he will spend on average 20 minutes per day discussing cases with one of the partners. Dr CS12 is requires about 45 minutes of administrative time a day. This time includes time spent examining pathology results and referrals, which he does in between patients.

The practice manager undertakes the normal payroll process for the registrars, with takes about 30 minutes every fortnight.

The main administrative task undertaken by the practice manager in relation to the registrar is the writing of a monthly report to GPEA, which describes the type and number of consultations undertaken by Dr CS12, in order to determine the subsidies level. This takes 1.5 hours to complete, and the practice manager thinks this task could simplified and could be undertaken less frequently.

6. Centrelink

6.1 Key Issues

Dr CS12 sees Centrelink forms as the *"necessary evil of the GP profession"*. The forms are said to be too vague and to be impossible to answer for conditions such mental illnesses or chronic illnesses. The forms are better suited for acute conditions.

6.2 Disability allowance

Dr CS12 reported that Disability Allowance forms can take up to 30 minutes if Dr CS12 does not know the patient. Dr CS12 reported that he does about one Disability Allowance form per week.

6.3 Sickness Allowance

Dr CS12 estimated that Sickness Allowance forms can take up to 15 minutes to complete if he does not know the patient. Dr CS12 reported that he would see about one or two of these forms per week.

6.4 New Start/Youth Allowance

Dr CS12 has never filled out a New Start form.

6.5 Carer payment/allowance

Dr CS12 has never filled out a Carer payment/allowance form.

7. DVA

Dr CS12 has never filled out a DVA form.

8. PBS

8.1 Phone authorisation

Dr CS12 estimated that a PBS Phone Authorisation takes about five to seven minutes. Dr CS12 would do about five phone authorisations per week.

8.2 Written authorisation

Dr CS12 reported that he does Written Authorisations very infrequently, as he prefers to use the phone authorisations.

Case Study 13:
Rural Group Practice

1. Contextual Information

1.1.1 Location – SES profile

CS13 is a rural group practice (other rural groups). The practice is located 50 Kilometres out of the capital city. The practice's patient base comprises two distinct groups:

- Middle class families, who were attracted by the high quality lifestyle offered by the area. These patients typically work in the city; and
- Older residents and residents who work in local farming and supporting industries.

Infrastructure developments in the area have lead to a demographic shift towards a younger, professional population. Whereas many of the other Case Studies in this series have involved practices in areas which are medically *underserviced,* the CS13 location is reported to be medically *overserviced,* with a higher than average ratio of GPs per population.

1.1.2 Practice size, number of EFT GPs and other staff

The practice employs five GPs in total. Of these:

- Three GPs are full time partners; and
- One GPs works three sessions a week; and
- Dr CS13, who works .75 EFT.

The administrative staff for the practice consists of:

- One practice manager who works full time;
- One practice nurse who works three days per week; and
- Three office staff who work full time.

1.1.3 Participating GP

Dr CS13's working hours vary according to the needs of the practice. Overall, she reported that she works .75 EFT.

Her working hours are:

- Monday: 9.00 am-2.30 pm;
- Tuesday 9.00 am-6.30 pm
- Thursday 9.30 am-5.00 pm
- Friday: 9.00 am-2.30 pm

Dr CS13 graduated in the early 1980s

2. Overall Issues Relating to Program Compliance

Dr CS13 takes part in:

- After hours care;
- Teaching of medical students
- Case Studies;
- Clinical Audits;
- The Immunisation Incentive;
- Diabetes SIPs;
- Asthma SIPs;
- Health Assessments; and
- Care Plans.

3. PIP Program

3.1 Key Issues

Dr CS13 considered that accreditation is a positive process which ensures high standards within practices. She stated that "*ideally we would not need to do it, as (accreditation standards) are the sorts of things that should be done in a practice anyway. It is a good way to ensure that we are conforming to the recommendations".* Dr CS13 also reported that the practice was compliant with most of the accreditation standards it was accredited, but that accreditation also provided the impetus for new initiatives such as a practice newsletter.

Additionally, Dr CS13 reported that the main reason that the CS13 practice applied for accreditation was twofold:

1. To obtain the incentives offered by the government; and
2. That accreditation was likely to become compulsory in the future, as such the GPs in the practice wanted to undergo the process in their own time.

3.2 Accreditation

The CS13 practice was first accredited in 2000. The practice has begun to prepare for re-accreditation, which is due in 2003. The practice manager reported that preparation for re-accreditation was an ongoing process, and actually started when the practice was first accredited. However, an increased amount of time was spent on the process as re-accreditation approached.

3.2.1 Ongoing costs

Dr CS13 reported that the practice had not incurred any ongoing time or financial costs associated with accreditation in the last 18 months. However, in the last month the administrative staff are investing time on accreditation administration, as the practice prepares to be re-accredited. Dr CS13 reported that these costs have not affected her work.

Dr CS13 reported that administrative time included checking that the patient records are *"in order"*. The practice manager reported that this is an ongoing task that involves standardising the patient records such that any staff member could easily access and use the files. She estimated that this would take an administrative staff member about 20 minutes per week.

In addition, the maintenance of accreditation requires the practice nurse to check the dangerous drugs that are stored at the clinic. This takes about five minutes each week.

The practice manager reported that staff at the clinic were required (annually) to attend a first-aid course that was run by the Division. The course took place over two nights, and took three hours per night. The practice nurse and three administrative staff attended the course (four staff times three hours times two nights equals 24 hours in total).

3.2.2 Re-accreditation

The practice held three meetings of two hours duration for all staff. These three meetings have been largely devoted to discussing the requirements for re-accreditation, and reviewing suggestions made by staff at the time of accreditation.

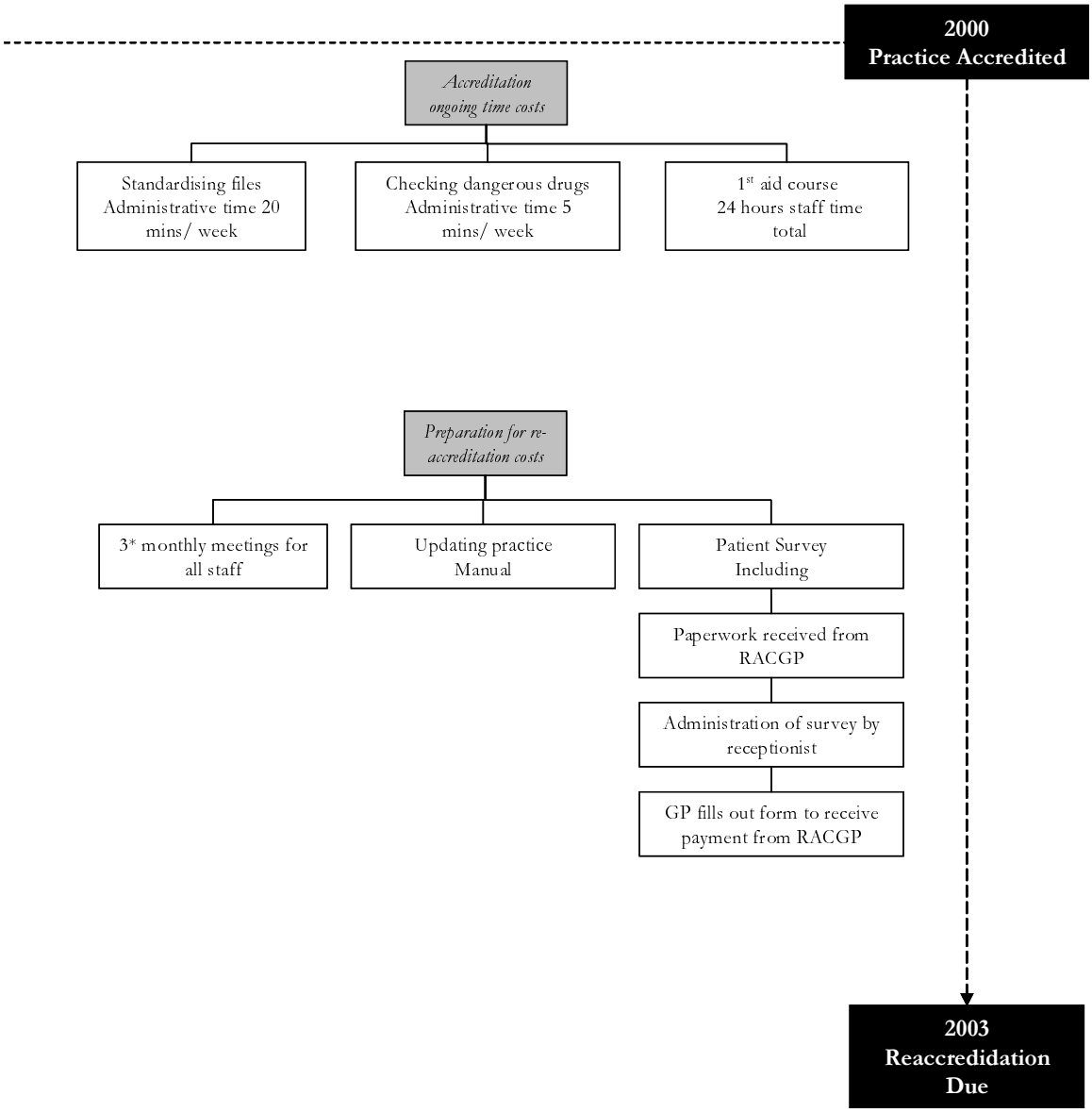
The practice manager reported that the clinic would needs to update the Practice Manual, in order to be re-accredited. This process has yet to begin, and the Practice predicted that it could take a long time.

3.2.3 Patient Survey

The CS13 clinic has nearly completed the patient survey, which is required for accreditation. The process of implementing and completing the survey included:

1. The paperwork required for the survey is sent to the practice by the RACGP;
2. The receptionist or other administrative staff administer the survey to the patients. The CS13 practice was required to administer the survey to 250 patients (50 patients per GP) which took about 3 minutes per patient;
3. The GP completes a form for the RACGP once the survey is completed at a cost of $396 for the survey analysis.

Figure 52: Accreditation process map



3.3 IM/IT

Dr CS13 reported that she uses a computerised system for:

- Patient recalls;
- Prescription writing;
- Letter writing for referrals;
- Patient progress notes;
- Dr CS13's patient records;
- Receiving pathology reports; and
- Obtaining pharmaceutical and immunisation information.

Dr CS13 reported that not all GPs in the practice are using the computer system for patient files. This has lead Dr CS13 to stop using the computerised records for patients that see other doctors within the practice, because a combination of computerised and hand-written patient records is *"unwieldy"*.

Dr CS13 stated that this situation is *"frustrating"*, and the issue has been discussed in recent staff meetings. She stated that some GPs are slow to adopt the computerised system because "*most of them don't type*". To address this issue, Dr CS13 recommended that the government offer an incentive to teach Doctors how to type.

Dr CS13 reported that she uses the computer system because it is efficient, and is less concerned with PIP incentives. Her only complaint was a lack of time to *"sit down to play around and explore all of the uses of the computer. I just keep using the things that I'm good at, and don't really develop new skills."*

3.3.1 Ongoing costs

The clinic receives updates for the Medical Director software every three or six months. The cost of these software updates is covered by the yearly subscription cost of about $720.

The practice manager reported that IT problems are dealt with by an IT consultant from the Division. She stated that the Division provides a set amount of support, and that extra support is charged to the practice. Discounts for this support can be obtained, and are calculated on the number of GPs employed at the practice.

3.4 After Hours Care

Dr CS13 also works one Saturday morning in every four, as well as a *"one in six weekend roster"* (either Saturday afternoon or night; or Sunday or afternoon night every six weeks).

The practice manager reported that the clinic is a Tier 2 after-hours provider (providing 15 hours of after-hours care per week). She stated that she was required to provide evidence of the service agreement between the clinic and the after-hours provider to the HIC. There were no costs involved, as the HIC calculates the payment, and sends it to the clinic.

3.5 Teaching

The CS13 practice does some teaching of medical students, but does not have the physical space to accommodate a registrar. In 2001 and 2002, the CS13 practice taught four students per. As such, each of the GPs at the practice sees one student for half a day per week. The practice only sees students during the academic year (about 30 weeks).

Dr CS13 reported that practicing alongside students can sometimes slow down medical consultations. Dr CS13 allows for a slightly longer consultation time when she is seeing students. Dr CS13 builds a half-hour 'buffer' for every six patients in to every session (not just those involving students), to allow for consultations that run over time, or to allow extra time for the students. Technically, Dr CS13 is not paid for this 'buffer time'.

Dr CS13 reported that she needs to write a report for every student that she teaches. This report would take Dr CS13 about 20 minutes.

DR CS13 reported that they take on medical students because *"it is a challenge, and it makes us aware of our practice skills."* Dr CS13 also stated that they teach to obtain the incentives offered by the government, and to earn points required for vocational registration. However, Dr CS13 reported that they taught medical students before these incentives and programs were in place. As such, Dr CS13 sees these rewards as *"added incentives"*.

Dr CS13 also does talks to community groups on topics such as breast-feeding and pregnancy planning. Dr CS13 reported that she does not get paid for this time, and that the talks are not part of a CME program. She reported that she could earn points if she applied to the CME authority. However, Dr CS13 does not need the points, and stated that formalising the process to earn points would be *"a lot of work, with little gain"*. Dr CS13 reported that she does the talks because she "*enjoys helping out in the community, an because it is good experience"*

3.6 NPS program

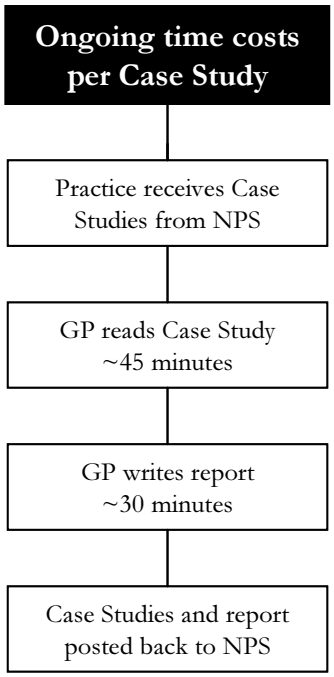
3.6.1 Case studies

Dr CS13 takes part in Case Studies as part of the NPS program. She reported that the process for completing the Case Studies involves:

- The NPS send the Case studies to the practice;
- The GP reads the Case Studies (about 45 minutes of the GPs time);
- The GP writes a report based on the Case Study (about half an hour of the GPs time); and
- The Case Studies are sent back to the NPS.

Dr CS13 generally undertakes Case Studies in her own time. Dr CS13 reported that she had done six Case Studies in the last 18 months, or roughly one per quarter.

Figure 53: Case Study process map



3.6.2 Practice visit

Dr CS13 has not had a practice visit at the clinic.

3.6.3 Clinical audit

Dr CS13 has taken part in a diabetes audit and a blood pressure audit; she is about to take part in Asthma SIP. She reported that these audits are quite time consuming.

Dr CS13 reported that an audit involves:

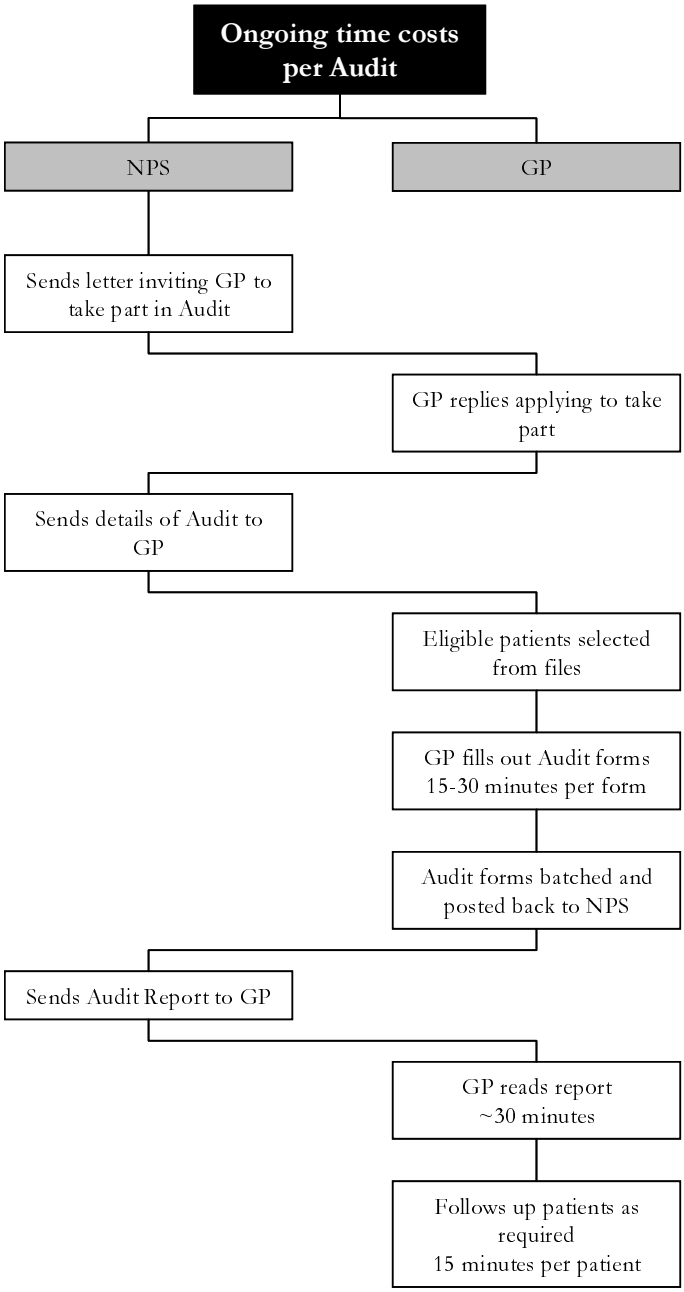
1. A letter is sent by the NPS to the GP informing them of the audit;
2. The GP writes back to the NPS, and applies to take part in the audit (20 minutes);
3. A package arrives from the NPS with information on the audit which the GP reads (this takes about half an hour);
4. Patients are selected for the audit, either *"as they come in"* or from the computerised patient files. Dr CS13 reported that this is not a time consuming process *if* the GP maintains computerised patient files, as the GP can simply 'screen' the computerised files for eligible patients by diagnosis or prescription type (30 minutes). GPs who still use handwritten files would need to manually search through the files for eligible patients.
5. The GP fills out an audit form based on the information from the patient files. Dr CS13 reported that one audit takes 15 minutes for a simple audit such as diabetes, or 30 minutes for more complicated audits such as cholesterol. Each audit comprises 20 patient files.
6. The audit forms are then batched and posted back to the NPS by CS13. This takes about 15 minutes.
7. The NPS then sends a report back to the GP based on the audit forms. Reading the report takes Dr CS13 about half an hour.
8. The NPS encourages GPs to follow up on the audit by taking steps to improve the management of the patients examined. Dr CS13 identified five patients that would benefit from such follow-up the last time that she did a time diabetes audit. This follow-up took about 15 minutes per patient.

Dr CS13 reported that she undertook these audits because she finds them useful. She reported that *"the audits either makes me see that I am doing things properly, or show me where I can make improvements."* For example, Dr CS13 reported that she able to identify a patient whose blood pressure was not being treated as aggressively as it should.

Dr CS13 stated that conducting such audits at home raises issues regarding computerised patient files. She stated that working with computerised files away from the clinic can be cumbersome as print-outs are required. This is also an issue for other situations when a GP needs to transport patient files such as house calls. Transporting patient files also raises confidentiality concerns for the clinic. Dr CS13 stated that she tends to take work home more often than other GPs due to the fact that she is works time, and does not always work for a full day. As such, these issues are particularly salient to her work.

To address these issues, the clinic has looked into buying a laptop computer or setting up remote access to patient files via a modem, but the issue has not been resolved.

Figure 54: Clinical Audit process map



3.7 Immunisation Incentive

Dr CS13 reported that the clinic is *"very active in the Immunisation Program"*. Dr CS13 reported that the process for the program involves:

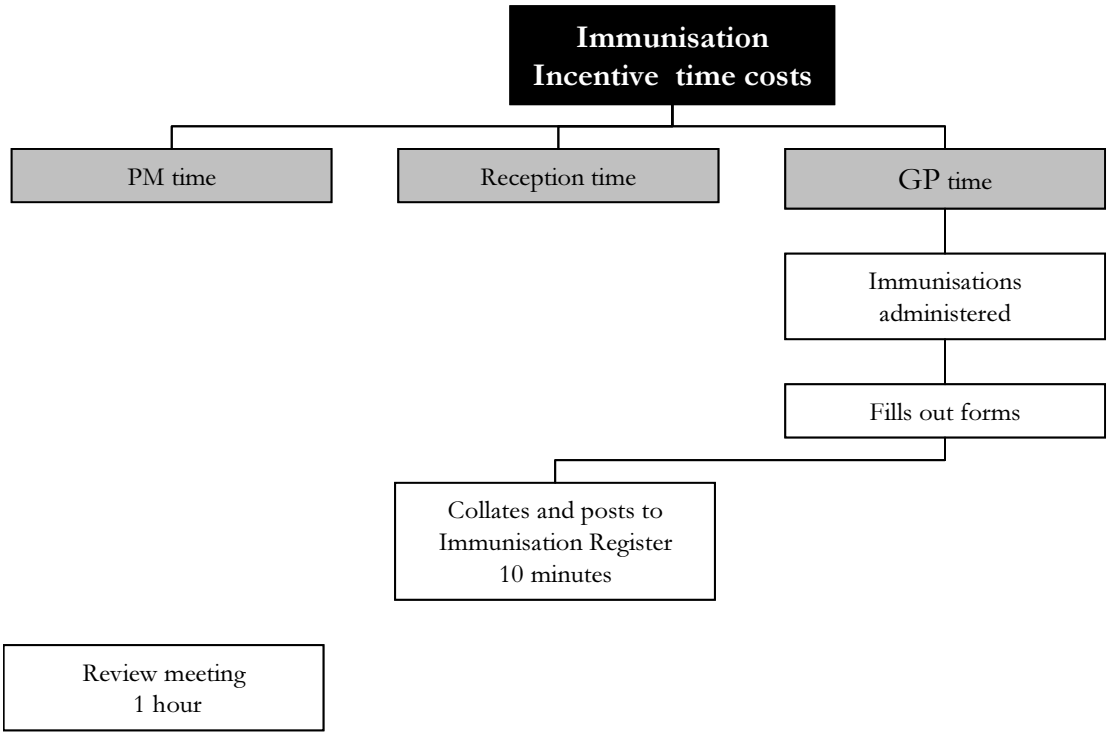
1. The patient presents at the clinic and receives the necessary immunisations.
2. A form is given to reception detailing the immunisations that were administered.
3. The receptionist collates and posts the form to the Immunisation Program (this takes about 10 minutes).

Dr CS13 reported that she has very little to do with this administrative process, as it is mostly dealt with by the administrative staff. She stated that the only time that she would have contact with the process is when she had forgotten to keep the immunisation forms up to date. In which case she has to re-issue the form.

The practice manager reported that the CS13 clinic does about 10 to 15 immunisations per week across all GPs, approximately 3 per GP per week. Reporting takes about 5 minutes for the ACIIR.

The practice manager meets with Division staff to review the clinic's immunisation records. This meeting lasts about one hour per quarter.

Figure 55: Immunisation Incentive process map



3.8 SIP

Dr CS13 takes part in all of the SIP programs, but considered the programs to be "*pretty lousy, cumbersome and regimented.*" She reported that the practice frequently misses out on the payments, as many of the patients involved in the programs only attend two out of the three visits required to receive the incentive. She also stated that she frequently forgets to charge a particular visit to the SIP program, and finds that keeping track of the numerous item numbers associated with the program cumbersome.

Dr CS13 stated that the practice takes part in the program in order to receive the Government incentive. However, she also stated that the incentive was not worth the trouble of completing the administrative aspects of the program.

Dr CS13 was also conscious of the fact that *"many patients do not fit in to a pigeonhole"*, and did not easily 'slot into' a SIP program.

3.8.1 Diabetes Assessments

The practice undertook Diabetes Assessments before the SIP program was implemented. As such, Dr CS13 reported that it was easy to adapt the processes in that they were already in place to suit the Diabetes SIP.

The diabetic assessments are structured as a series of three monthly visits. The practice was already undertaking these three monthly reviews, and easily qualified for the SIP payments. Dr CS13 has undertaken 8 Diabetes SIP in total, each patient taking 15 minutes including paperwork.

3.8.2 Cervical Screening SIP

Dr CS13 reported that Cervical Screening SIPs are useful, as they encourage GPs to keep their patient's smears up to date. However, she also stated that the program had little effect on her patients, as she already had an effective system for keeping her patient's smears up to date. Dr CS13 reported that she would have only undertaken three Cervical Smear SIPs in the last year, which is not enough to qualify for SIP payments. These also take about 15 minutes.

3.8.3 Asthma SIPs

Dr CS13 does take part in the Asthma SIP 3+ program, and stated that they are useful. The 3+ program involves three consultations with the asthmatic patient. The process involves:

1. The practice nurse constructs a list of patients who would benefit from an Asthma SIP, either following a regular consultation, or from the patient files. This would take the nurse about two hours.
2. The list of 20 was given to the GP, who selects the patients to be contacted for the assessment. This would take Dr CS13 about 15 minutes.
3. The list is given to the reception staff. The administrative staff contact the each patient, first with a letter (5 minutes), and then with a telephone call (5 minutes).
4. The practice nurse sees the patient for the first visit to administer spirometry tests to assess the patient's wellbeing (25 minutes). The GP might spend a small amount of time with the patient during these visits if required, and to discuss the spirometry results. At this stage, the GP is also involved in formulating an asthma plan (10 minutes).
5. This process is repeated in a second consultation;
6. The GP then follows up with a third in-depth consultation. This consultation includes a medication review, a review of the spirometry results, and a review of the asthma plan that was formulated in the first visit. This is structured as a standard consultation, and lasts for about 20 minutes.

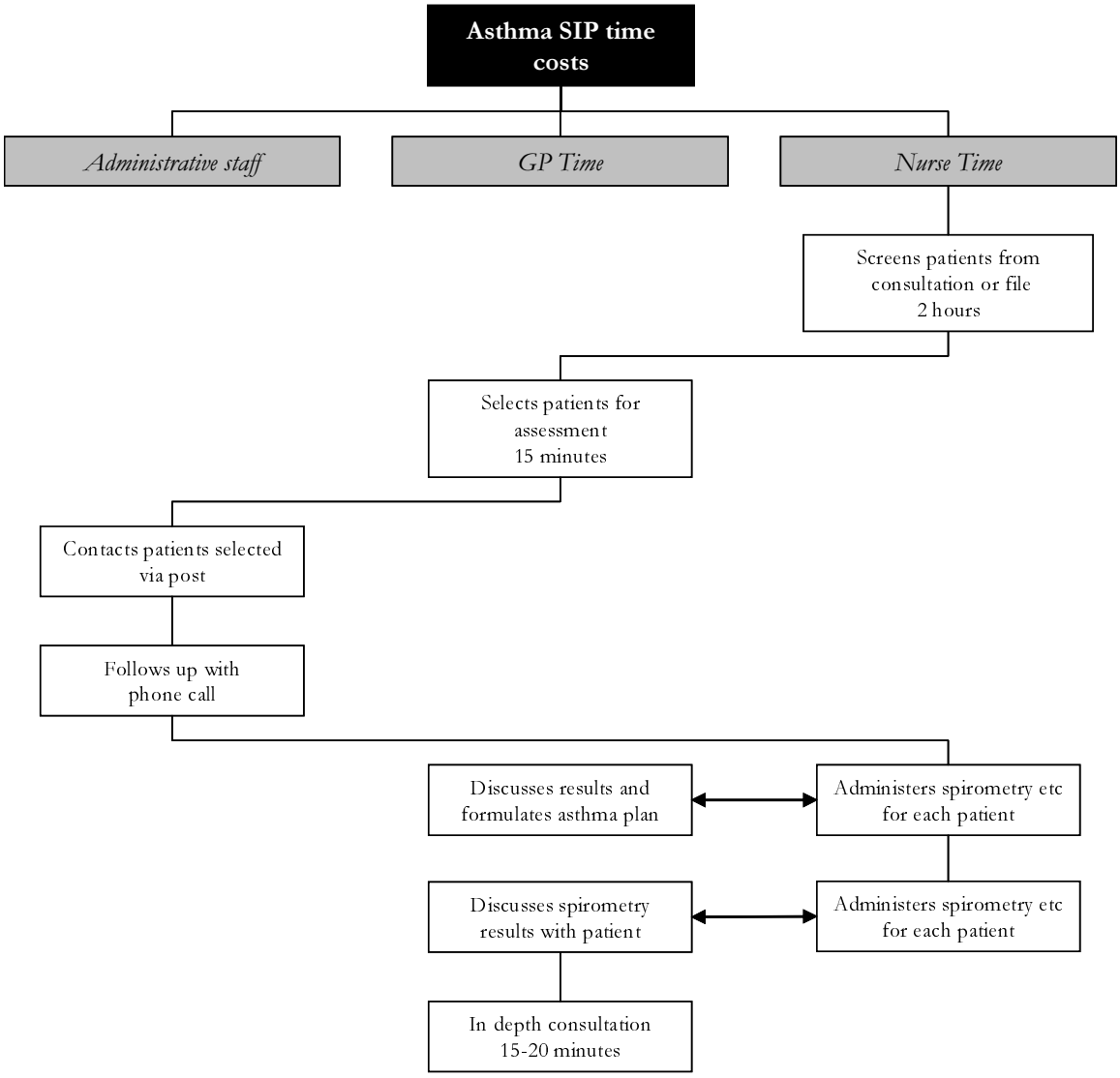
Dr CS13 reported that she has taken part in six Asthma SIPs.

3.8.4 Mental Health Assessments

Dr CS13 has not charged any item numbers for the Mental Health Assessments, even though she frequently sees patients with mental health issues. She finds it hard to conform to the rigid criteria involved in the program.

Dr CS13 reported that she had attended a nine-hour training course in preparation for the Mental Health SIPs. The course was mandatory if she wanted to undertake Mental Health SIPs. However, she stated that the course contained only basic information that she already knew. She reported that the course did not change the way that she practiced. She stated "*at the end of the day, I wish I hadn't bothered*".

Figure 56: Asthma SIP process map



3.9 Other Administrative Costs

The CS13 practice receives their PIP payments every quarter. Every quarter, the practice manager reviews the calculations used for the payment, and the payment received in relation to each GP at the practice. This takes between two to three hours.

4. EPC

Dr CS13 reported that she first joined the EPC program when it first started a few years ago.

4.1 Health Assessment

Dr CS13 reported that she undertakes Health Assessments for all of her eligible patients. This equates to about 30 to 40 Health Assessments per year.

Dr CS13 reported that the practice now employs a practice nurse who conducts Health Assessments once or twice a week. This process includes:

1. The practice nurse calls the patient to invite them to take part in the assessment (often this call is technically a recall, as the patient would have taken part in an assessment in the previous year) – 5 mins per patient;
2. The nurse conducts a home visit to assess environmental influences on patients' health (the GP used to accompany the nurse of these visits, but this turned out to be too cumbersome and time consuming). This takes about 1.5 hours per patient, more if the patient lives a fair distance away.
3. The home visits are then followed up with a consultation with the GP to discuss the findings of the home visit – 20 minutes per patient.

This process is repeated and reviewed on a yearly basis.

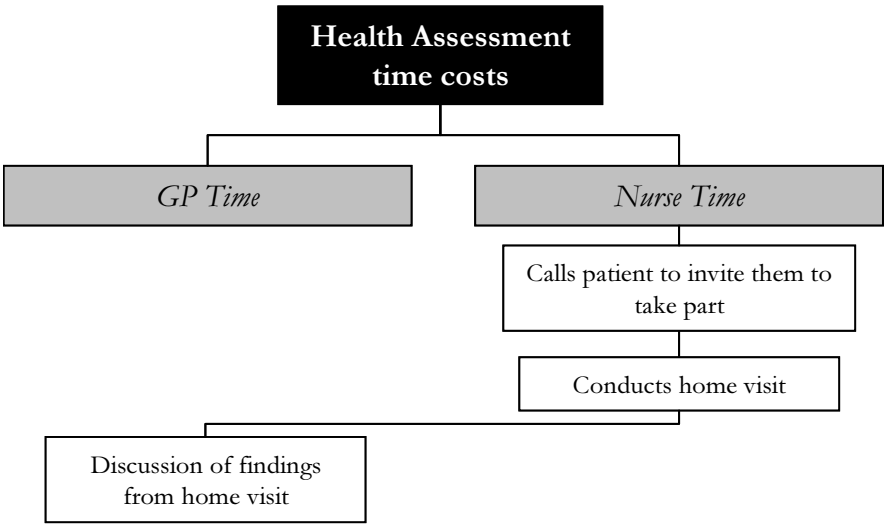
Dr CS13 stated that the Health Assessment program is useful in theory. However in practice, the assessments are not as useful as she would have hoped. Of the dimensions of health examined in the assessments, Dr CS13 reported that:

- The safety aspects are useful;
- Urinary and incontinence analysis can be useful; but
- The dietary aspects are not as useful.

Dr CS13 stated that the assessments can be a good summary of the patient's wellbeing. Seeing the patient alone in the context of the home can be particularly useful, as this can uncover medical issues that do not necessarily arise in the course of a regular consultation. She stated that the assessments can sometimes result in minor, but sometimes important improvements to the patients' health. She stated that the medical issues detected are generally "*subtle, rather than stunningly obvious and useful*".

Dr CS13 estimated that she would do about a similar number of Health Assessments as the full time GPs in the practice, even though she only works part time. She attributes this to the high number of elderly older patients that she sees.

Figure 57: Health Assessment process map



4.2 Care Plan

Dr CS13 stated that Care Plans are time consuming, and that three-monthly contact with Care Providers is unnecessary, as there are few changes to the patients' condition during this time. Dr CS13 also reported that a lot of time is required to 'chase up' the paperwork and the other parties involved in the Care Plan to get all of the information involved. Dr CS13 stated that often she *"just gives up, as there is too much effort"*. As such, Dr CS13 does not often claim for Care Plans. She stated *"a GP who has nothing better to do than chase paper can do very well financially. But a GP who is busy and does not have time to do the paperwork doesn't get rewarded"*.

Dr CS13 stated that Care Plans act as an incentive to undertake the good practices that she is already doing, but does not reward her for it because she does not have time to do the paperwork.

In addition to the Diabetes SIP program mentioned above, the practice organises a yearly a diabetic clinic. The clinics are run as multi-disciplinary review of the patient's treatment schedule. These clinics involve a diabetic educator, a podiatrist, a dietician, and the treating GP. Patients who have attended the three-monthly visits are invited to attend these clinics.

Dr CS13 is unsure about the distinction between claiming these clinics as a SIP item, and claiming them as a Care Plan EPC item.

Dr CS13 also conducts Care Plans for elderly patients who see a number of medical specialists. Dr CS13 estimated that she would have done about 20 Care Plans in the last 18 months. This takes 30 minutes per plan.

4.3 Case Conference

Dr CS13 undertakes some Case Conferences for her diabetic patients. She reported that she does eight Case Conferences per year. This involves two mornings per year at the diabetic clinic with four patients at each.

Dr CS13 stated that *"diabetes is the perfect disease to have a Case Conference about, because it requires a multiple number of health care providers"*.

5. Vocational Registration & RACGP Fellowship

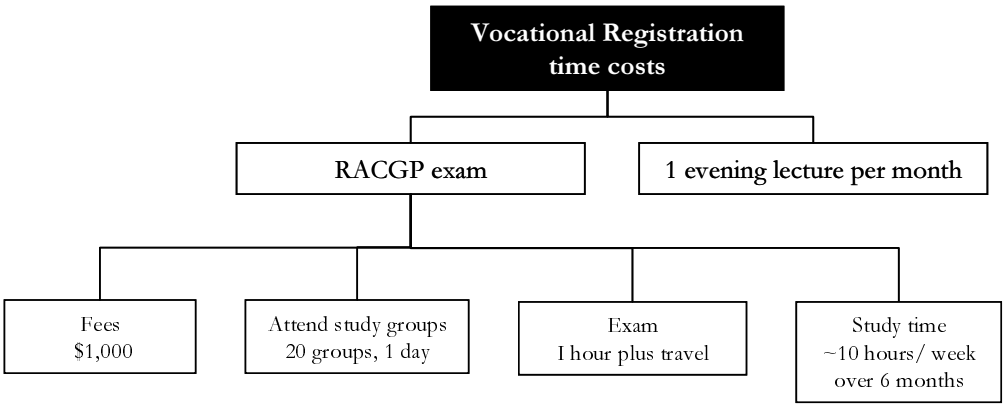
Dr CS13 first graduated in 1981. She was granted vocational registration under the 'Grandfather Clause' based on her experience in General Practice. She considers herself *"very lucky"* to have obtained her registration so easily, given that she was only working part time.

Despite the fact that she received her registration automatically, she has recently undertaken the RACGP examination. This was a major task and gave her *"hundreds of CME points"*. It involved:

- Paying exam registration fees: $1,000.
- Starting 6 months prior to the exam, studying 2 hours for 3-4 days per week
- Attending about 20 study groups of a full day duration in the capital city (plus 30 minutes travel time)
- Sitting for the exam: 4 hours plus one hour travel time.

Since then, she has been attending one evening lecture every month, which involves 4 hours of her time including travel (around 18 lectures over the 18 last months).

Figure 58: Vocational registration process map



6. Centrelink

6.1 Key Issues

Dr CS13 stated that she *"does not have a problem with Centrelink forms, they are a necessary evil"*. She stated that they are a difficult thing to document, as they need to address a wide variety of medical problems. She also stated that she can usually complete the forms quite quickly.

6.2 Disability Allowance

Dr CS13 reported that she would complete about twelve Disability Allowance forms per year. Each form takes about 20 minutes.

Dr CS13 reported that she photocopies each of the Centrelink forms so that she can copy the information across to the new form should the case come up for review. Dr CS13 stated that these reviews are unnecessary as the patient's conditions have not changed, and thus a new history is not required.

Dr CS13 stated that the Centrelink staff are quite helpful, and acknowledged that *"they have an awful job to do"*.

6.3 Carer Payment

Dr CS13 is critical of the points system used for the Carer Payments program. She stated that *"try as I might, I can not get enough points to make my patients eligible. Unless the patients are demented and incontinent, the families are expected to do a huge amount of work, and do not get any payment for it"*.

Dr CS13 estimated that she would do about four Carer Payment forms per year. Each form takes about 20 minutes. Dr CS13 is unsure about the difference between a Carer Payment, and a Carer Allowance forms.

6.4 Sickness Allowance

Dr CS13 does a lot of Sickness Allowance forms, she reported that *"patients let them lapse, and then come in wanting another one"*. She stated that there should be some sort of incentive to the patient to keep them up to date. She stated that *"this is probably a problem relating to the style of patient, and not Centrelink itself"*. Dr CS13 reported that these forms can be complicated in these situations as the forms need to be backdated.

Dr CS13 reported that the number of Sickness Allowance forms she does per week varies, but is typically about one per week. The forms take between five and ten minutes to fill out.

6.5 New Start/ Youth Allowance

Dr CS13 had heard about these forms from her patients, but had not filled one out.

6.6 Mobility Allowance

Dr CS13 has not heard of Mobility Allowance forms.

7. DVA

Dr CS13 reported that she has never initiated the DVA form process, but rather takes on existing DVA patients.

She reported that she has about twelve DVA patients, and has *"only written a report for one or two of them"*. She could not clearly remember how much time she had spent on the reported. Dr CS13 does not consider the DVA forms to be an issue. She stated that the *"patients do not hassle me like the Centrelink patients, and the DVA does not try to re-do the forms unnecessarily"*.

8. PBS

8.1 Phone Authorisation

Dr CS13 estimated would make about four PBS Phone Authorisations every day. Each of these would take Dr CS13 about five minutes. She reported that these authorisations are a *"pain in the ****, because these calls are often for double quantities of a normal medication such as blood pressure medication. If a patient needs twice the regular amount of a drug, I should be able to write the scrips, and shouldn't have to get permission for it. I have no problem with authorisations for very expensive drugs, but for every day medications, I just find it irritating."*

8.2 Written authorisation

Dr CS13 reported that she would only seek written authorisations for increased quantities for a patient's narcotic or analgesic medication. Dr CS13 estimated that she would do about one written authorisation per month. Each authorisation would take about ten minutes.

9. Cost Estimates

The cost estimates of compliance for CS13 are based on the times and other related costs identified during the interview with the GP and the staff of the practice. These have been summarised as:

- Costs for programs that entail compliance by the entire practice (Table 1). These costs include PIP [including accreditation], IM/IT strategies and SIP.
- Costs where there is a requirement for compliance on the individual GP (Table 2). These costs include vocational registration, Centrelink, DVA and PBS where the costs are GP based. Some PIP costs (including NPS), SIP and EPC are based on the GP.

The practice based costs for CS13 was $3,255. This represents 0.6% of the gross operating cost (GOC) of the practice. This was almost entirely attributed to PIP, with few practice-based costs for SIP and none for EPC.

A quarter (26.2%) of the practice based compliance costs for CS13 was attributed to annualised expenses associated with accreditation. General administrative staff accounted for one third (30.4%) of the costs while another one third was distributed between other GPs (16.5%), the practice manager (11.0%) and the practice nurse (12.5%). The interviewed GP did not incur substantial practice based compliance costs.

Table 28: Practice Related Compliance Cost

Program	Practice Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$113	$535	$358	$350	-	$989	$852	$3,198	98.3%
SIP	-	-	-	$57	-	-	-	$57	1.7%
EPC	-	-	-	-	-	-	-	-	0.0%
Total	$113	$535	$358	$407	-	$989	$852	$3,255	100.0%
% of Compliance Costs	3.5%	16.5%	11.0%	12.5%	0.0%	30.4%	26.2%	100.0%	

The total GP related compliance costs for the GP interviewed was $17,562 (Table 2). PBS accounted for nearly one third (26.9%) of the compliance costs while PIP, EPC and VR each comprised close to one fifth of that GP's compliance costs. No time was spent on Centrelink and little on DVA programs.

GP compliance costs were primarily due to the GP's time with 79.1% being attributed to the GP interviewed. The reported GP related costs are for one of the GPs at the practice. The compliance costs for the GP interviewed represents approximately 12.0% of a single GP's 'share' of the practice GOC[16].

[16] The GP "share" of gross operating costs has been *estimated* by dividing the gross operating costs by the number of EFT GPs in the practice.

Table 29: GP Related Compliance Cost

Program	GP Cost							Total	% of Compliance Costs
	Labour						Annualised Expenses		
	Prime GP	Other GP	Practice manager	Practice nurse	Other Prof.	Admin			
PIP	$2,759	-	-	-	-	$522	-	$3,281	18.7%
SIP	$1,247	-	-	$142	-	$435	-	$1,824	10.4%
EPC	$1,492	-	-	$1,573	-	-	-	$3,065	17.5%
VR	$2,722	-	-	-	-	-	$1,000	$3,722	21.2%
Centrelink	-	-	-	-	-	-	-	-	0.0%
DVA	$643	-	-	-	-	-	-	$643	3.7%
PBS	$5,027	-	-	-	-	-	-	$5,027	28.6%
Total	$13,891	-	-	$1,715	-	$957	$1,000	$17,562	100.0%
% of Compliance Costs	79.1%	0.0%	0.0%	9.8%	0.0%	5.4%	5.7%	100.0%	