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.

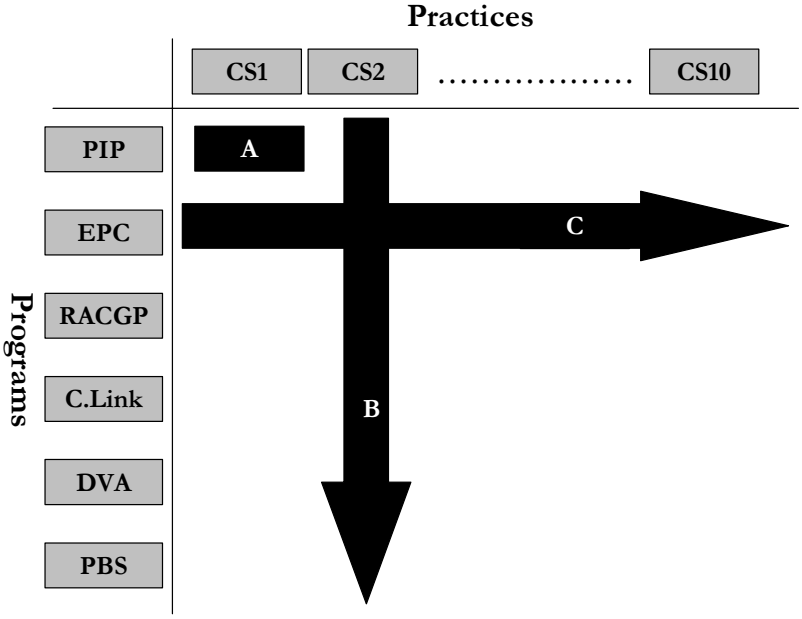
1.5.1 Qualitative data analysis

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

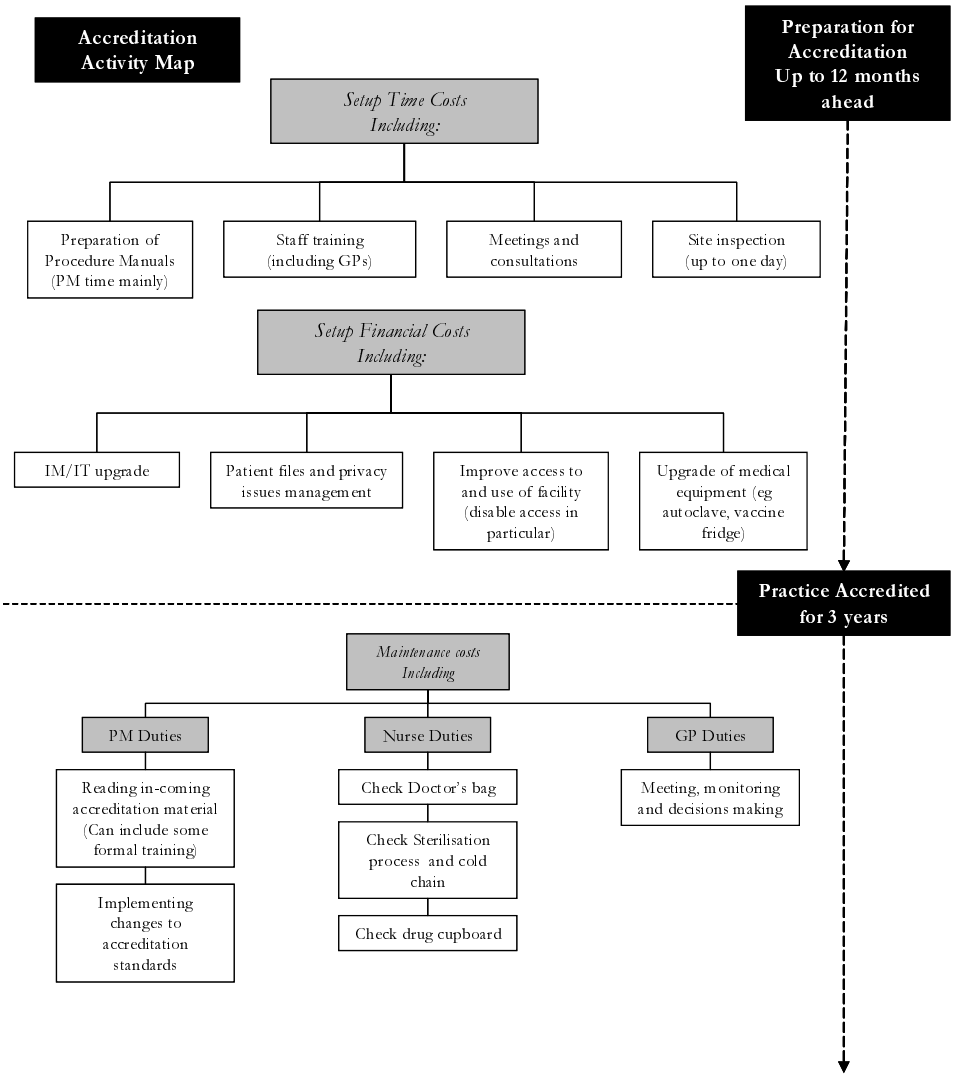
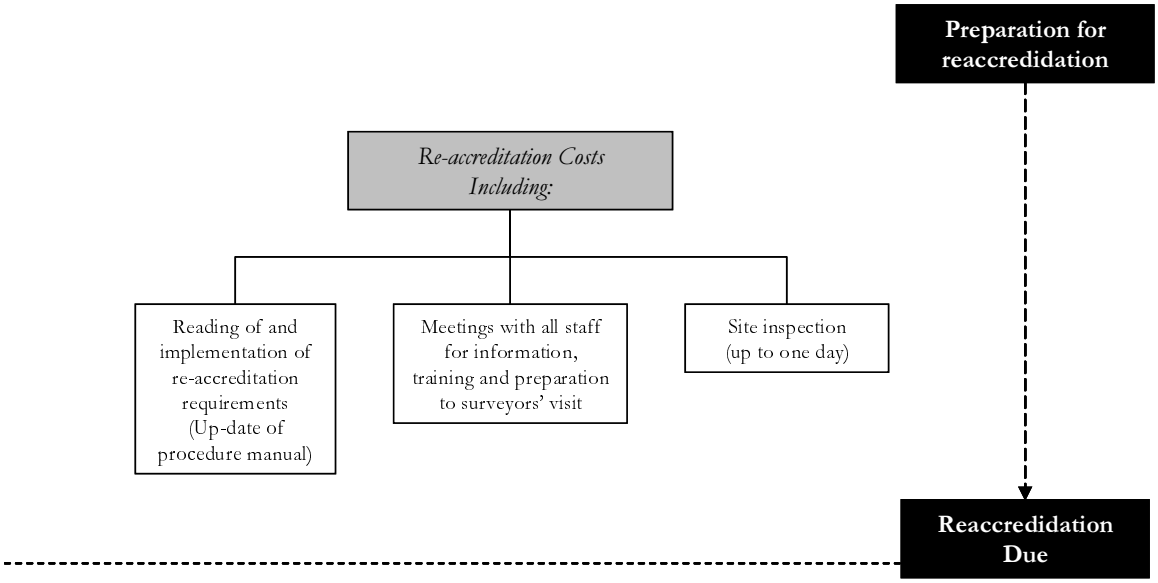


Figure 4: Accreditation Process Map Continued



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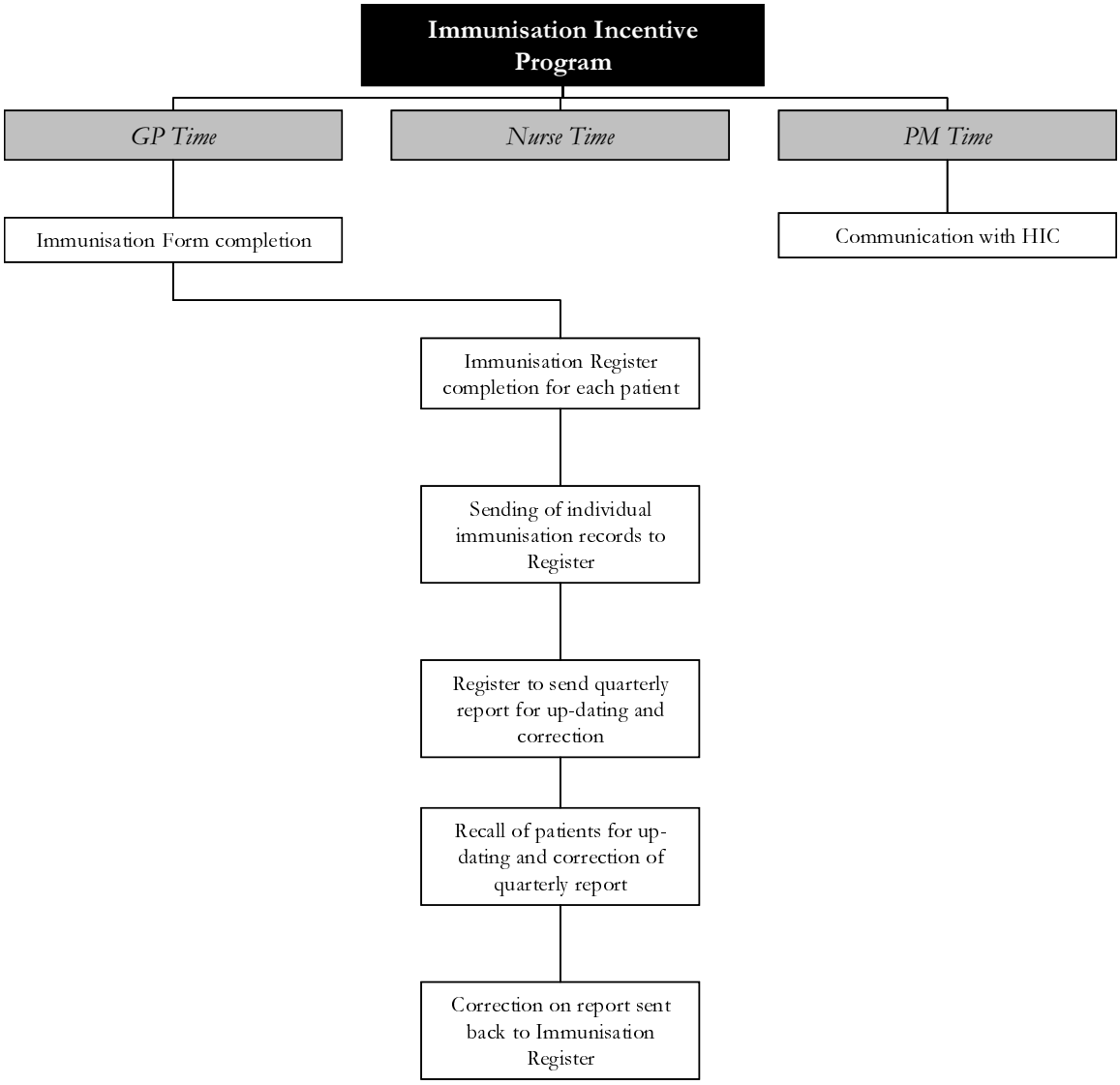
[4] For one case study however, the presence of PIP payments allowed to practice to resume its contract with a locum service, which it could not afford to pay beforehand.

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



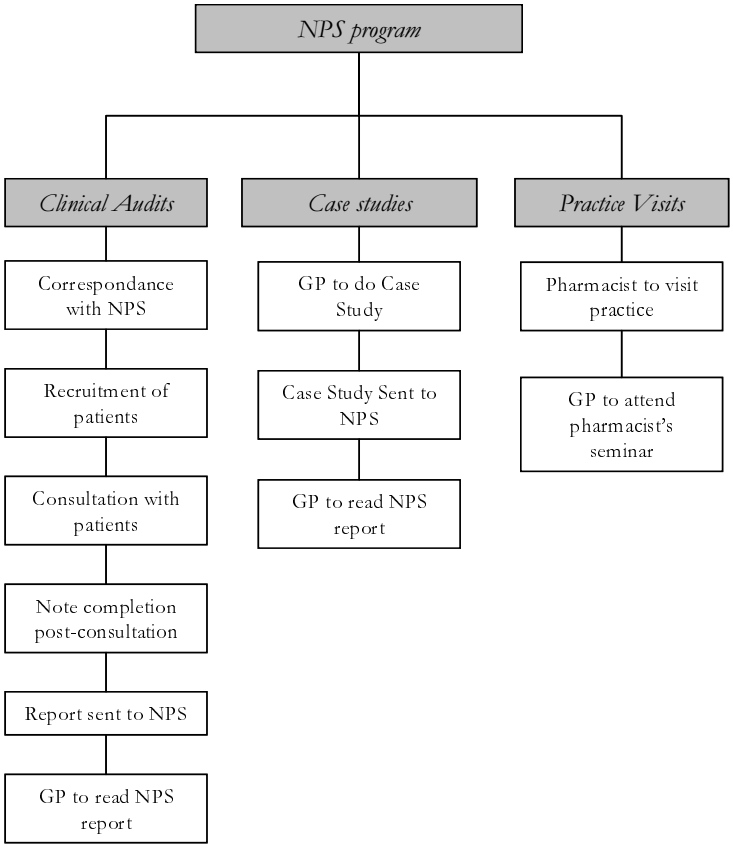
2.3.4 NPS Program (Quality Prescribing Initiative)

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.

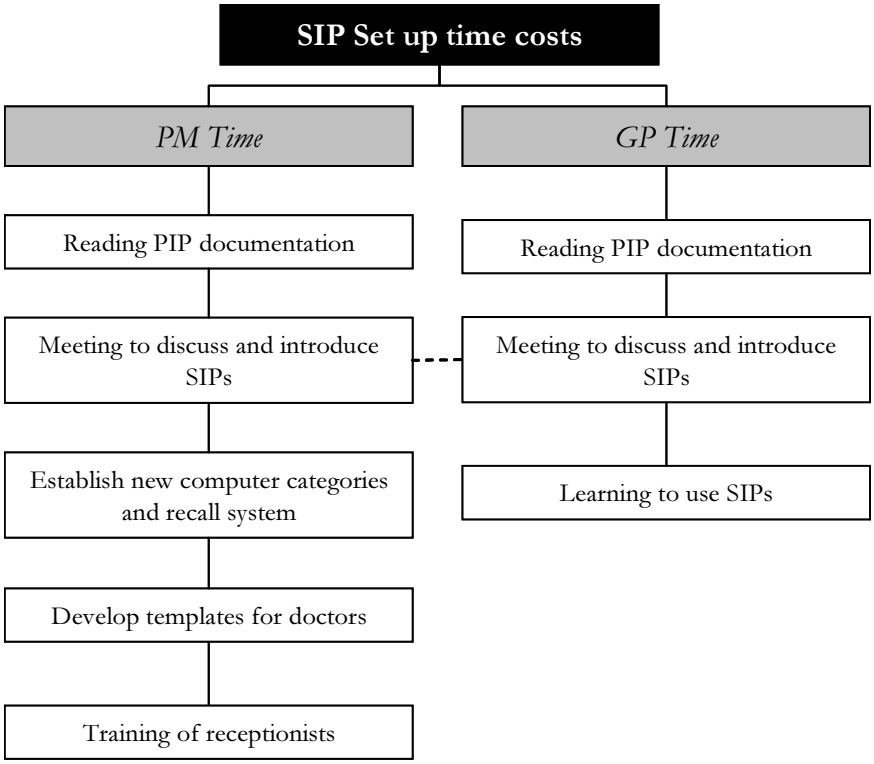
Some GPs disapproved of government initiatives that try to impose or prescribe clinical practices upon GPs. SIP initiatives were seen as overly-prescriptive, because they have a specific framework to which GPs have to conform, even if the framework contradicted their medical knowledge and clinical practice.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

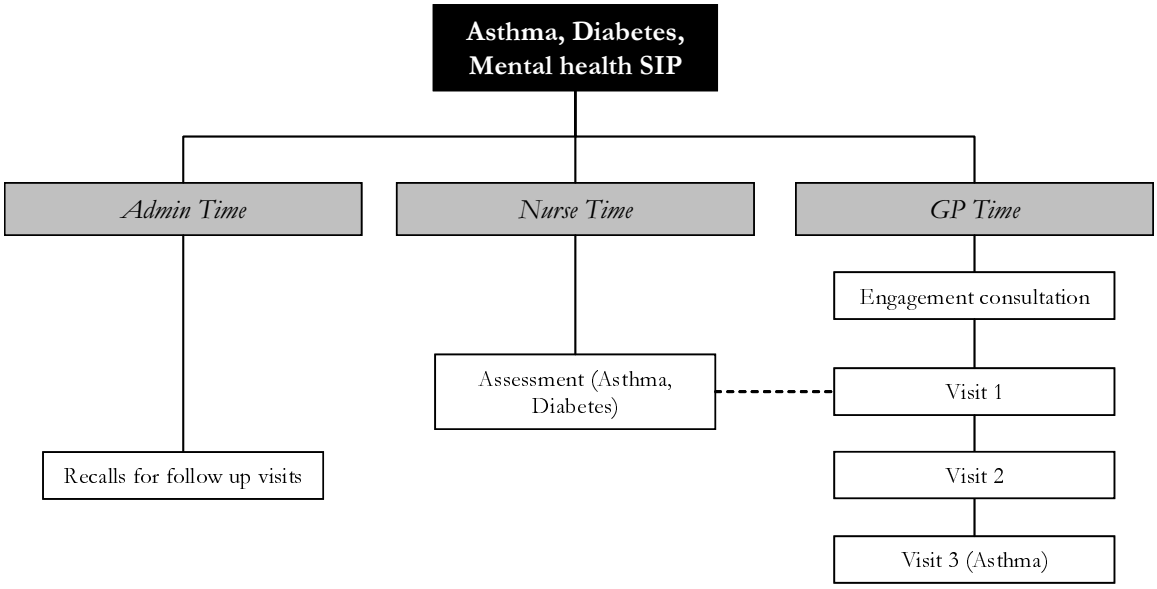
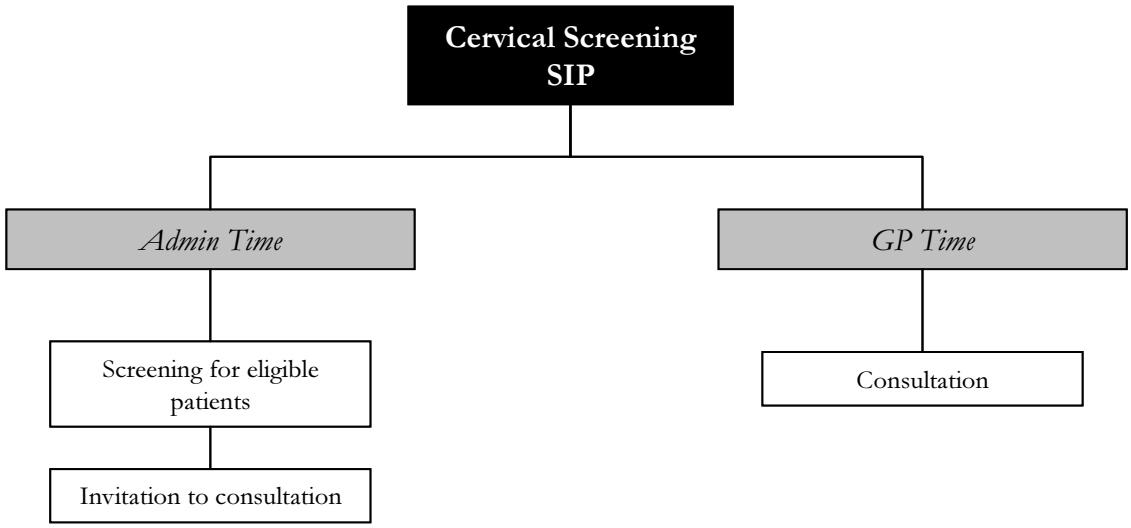


Figure 9 Cervical SIP Process Map



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

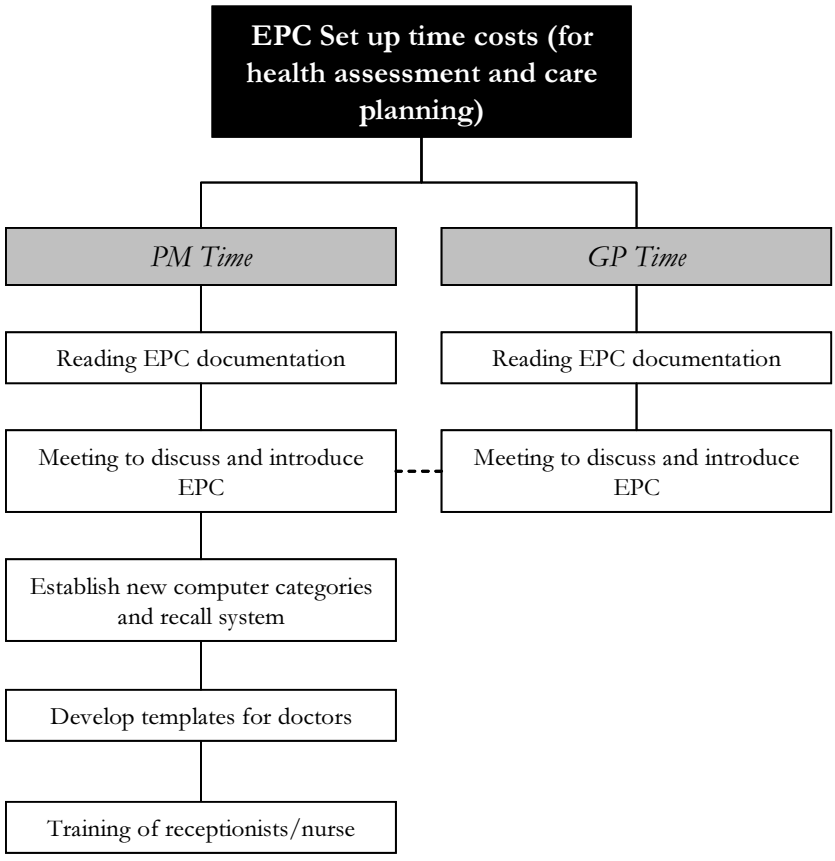


Figure 11: SIP Health Assessment process map

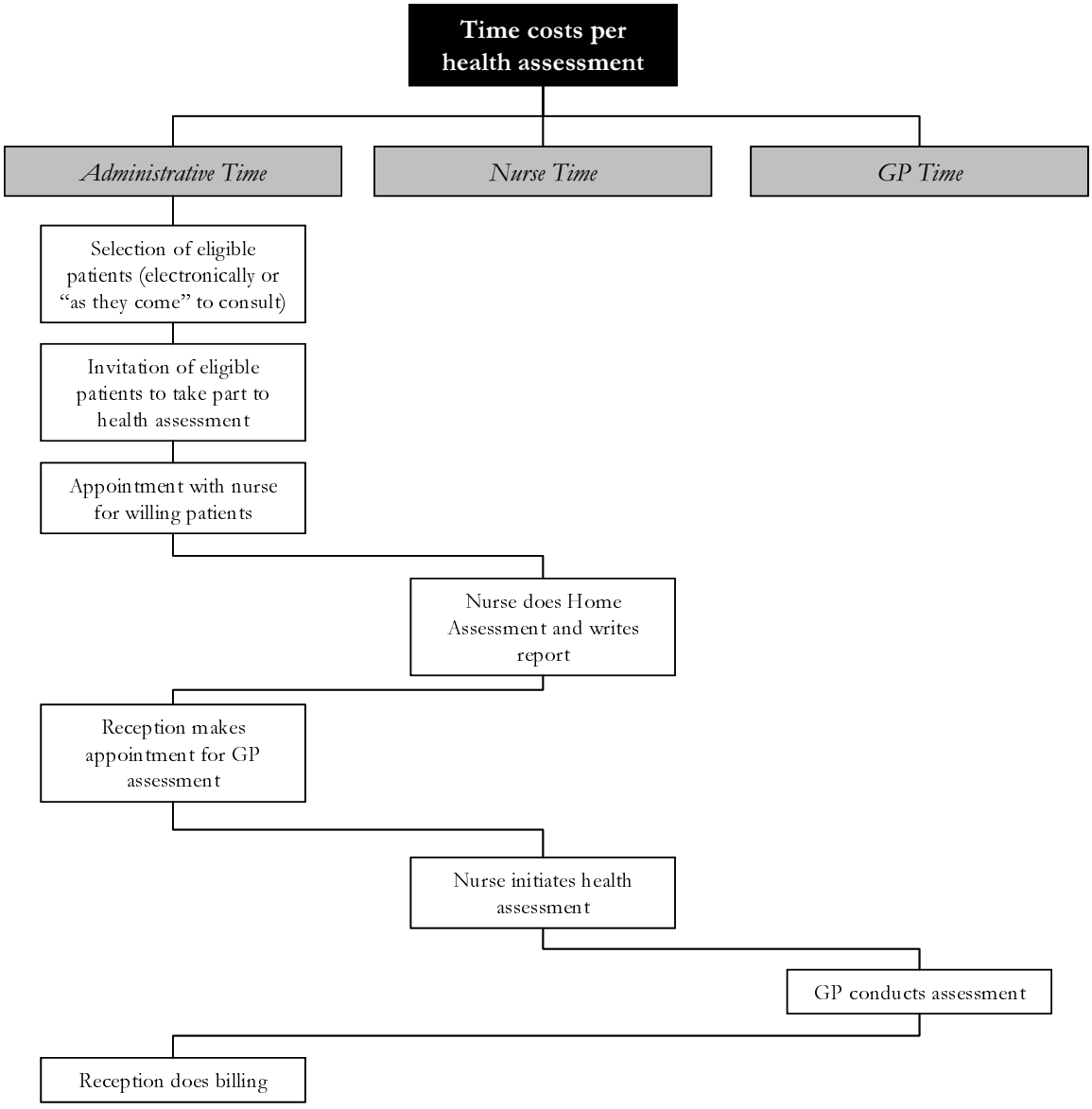


Figure 12: Care Plan process map

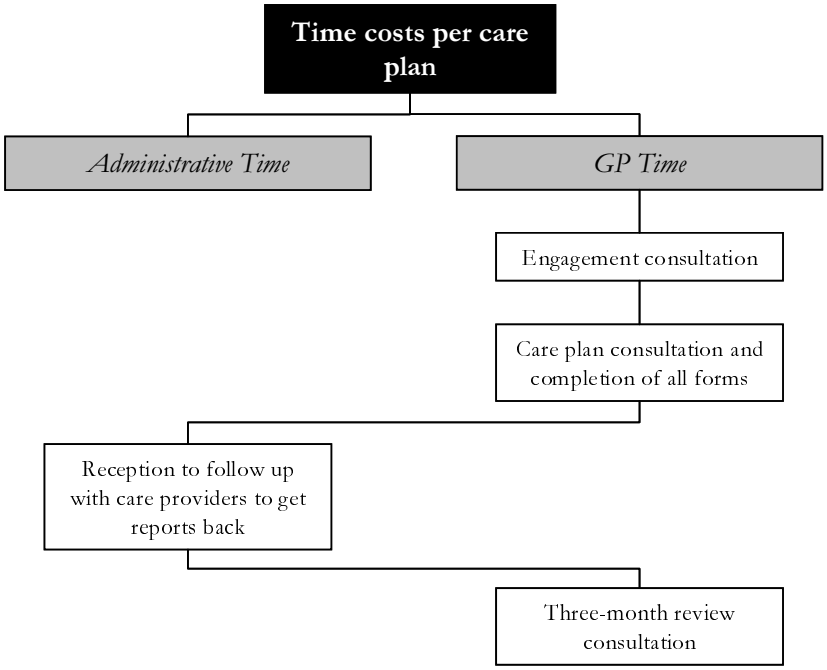
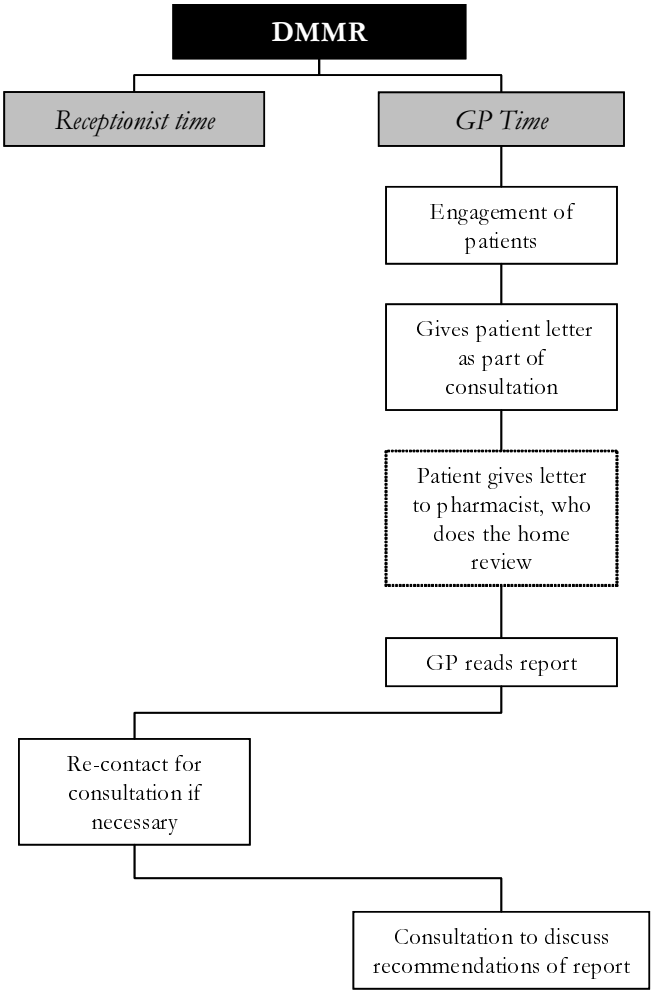


Figure 13: DMMR process map



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.

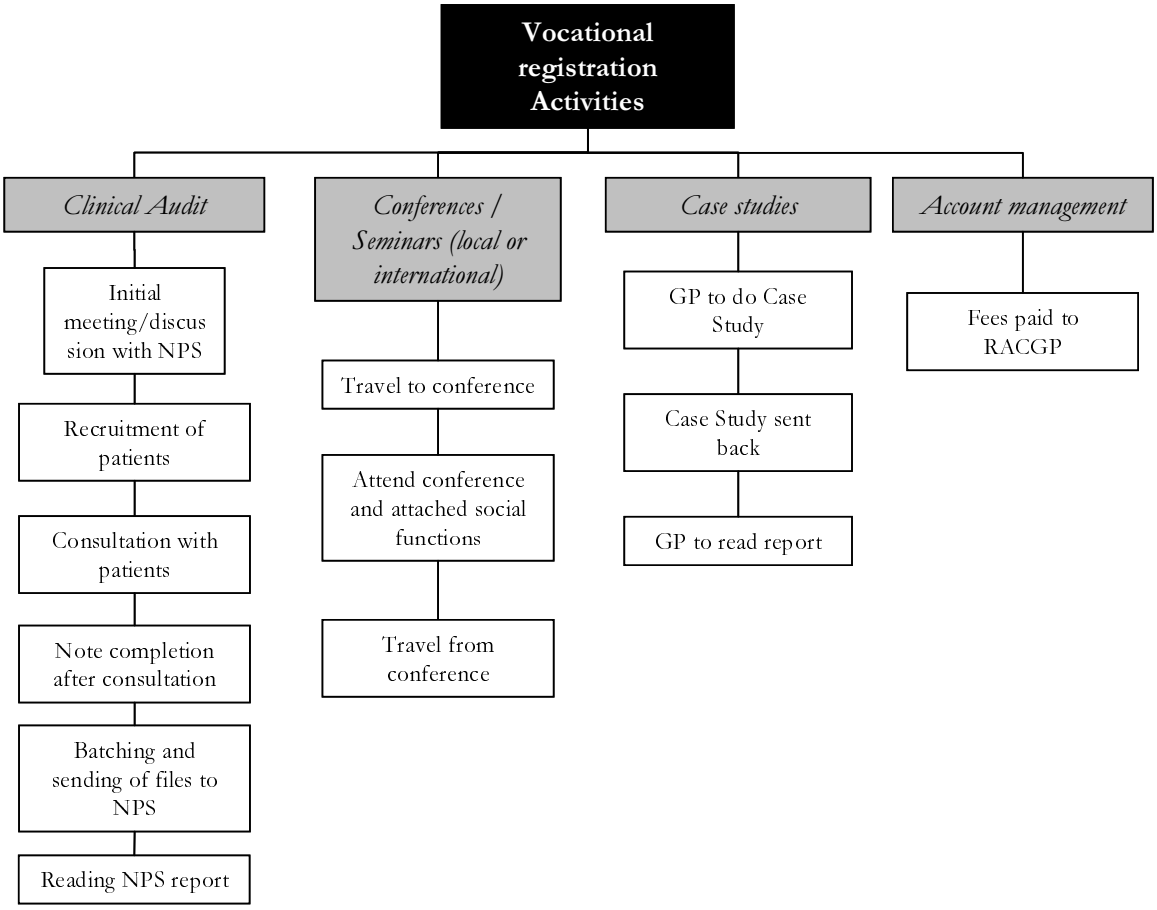
Most GPs acknowledged the benefits associated with these activities in terms of maintaining a current, up-to date knowledge base. On this basis, GPs generally indicated that they would participate in CPD activities, irrespective of Vocational Registration requirements.

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

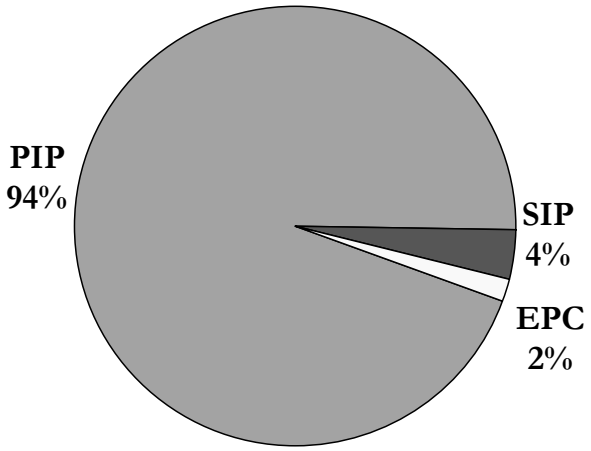
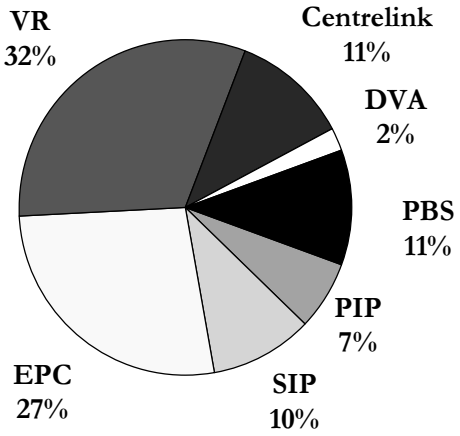


Figure 16: GP-related compliance costs by program



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

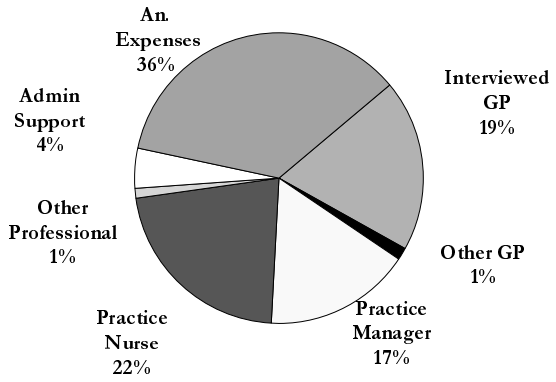
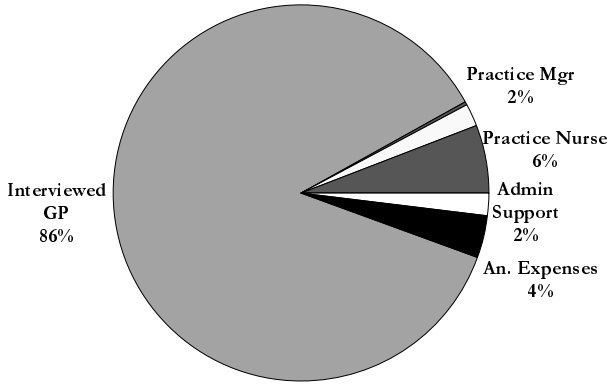


Figure 18: GP-related compliance costs by cost category



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

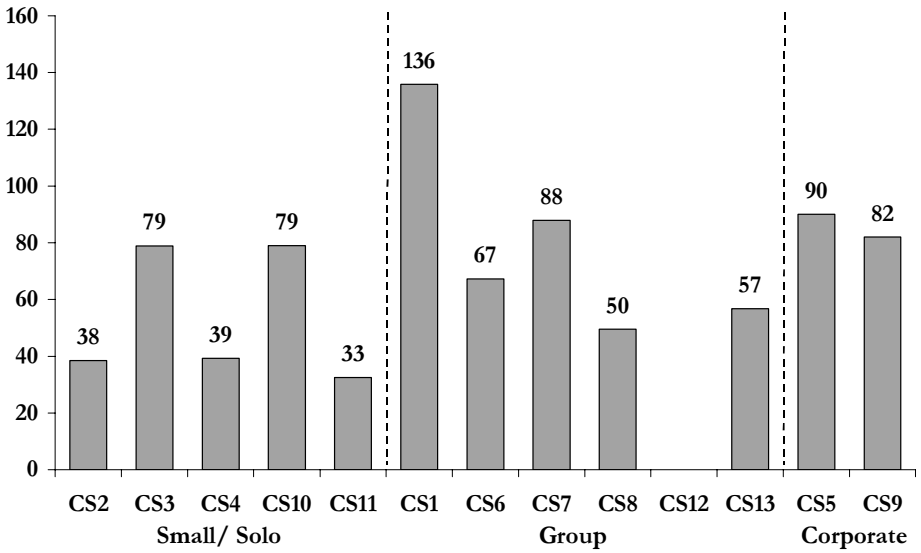
	GP-related cost	Practice–based cost
PIP	100%	63%
EPC	100%	94%
VR	98%	100%
SIP	90%	65%
Centrelink	100%	-
DVA	100%	-
PBS	100%	-

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 ($)

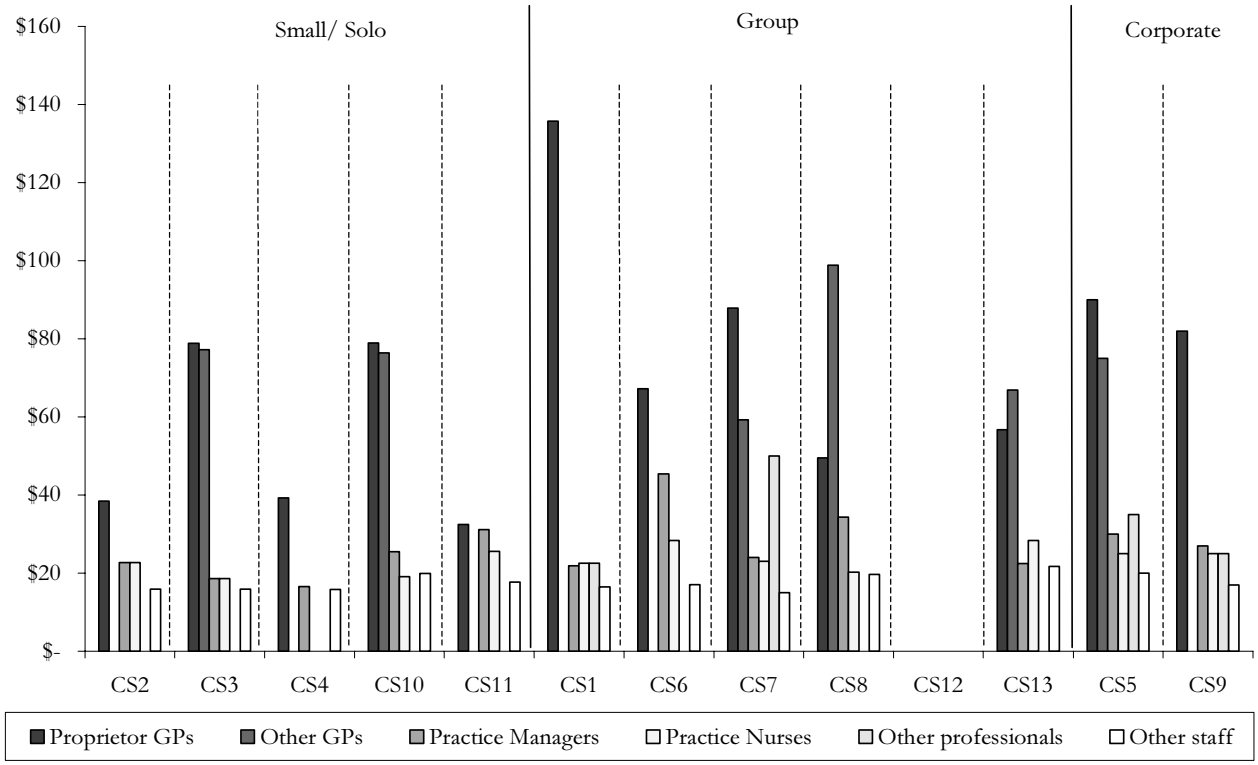


The hourly rates reported or derived for the GPs indicate significant variability. They range from a low of $32.50 per hour to $135.79 per hour; over $100 per hour difference. The median hourly rate is estimated to be $73 per hour across all case studies.

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

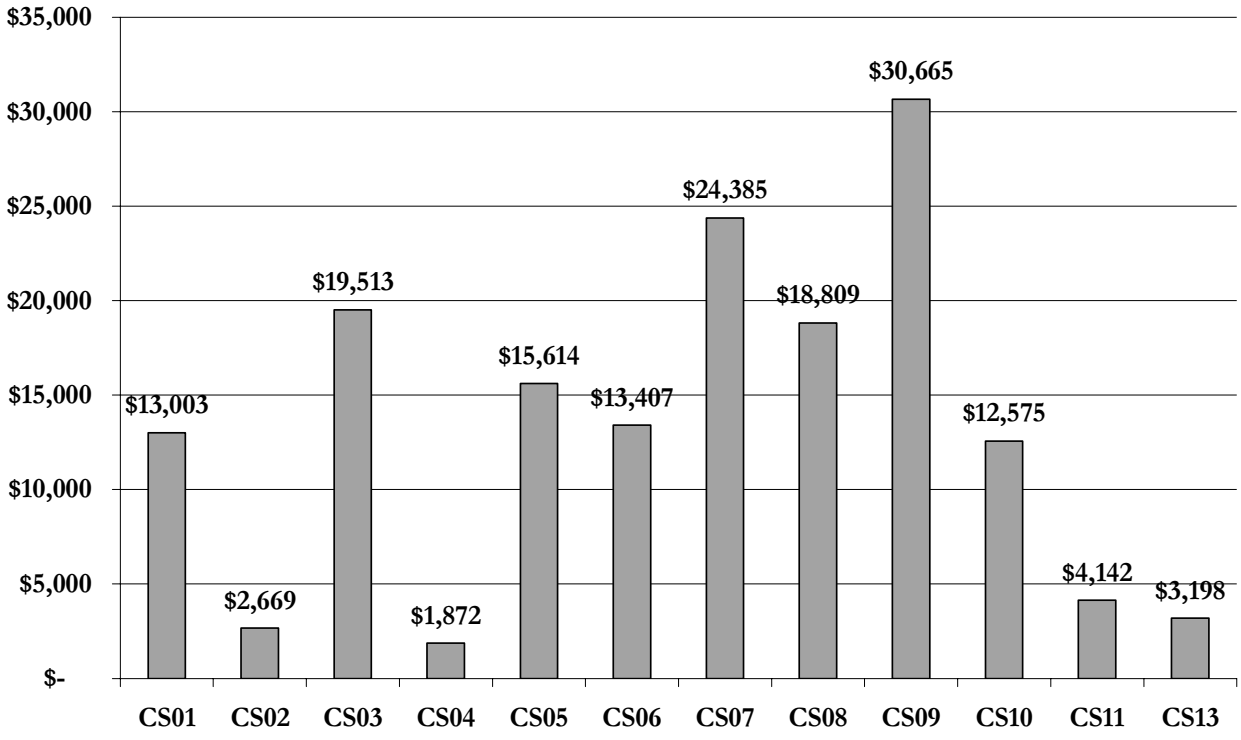
	Mean	Median	Minimum	Maximum	Range	Incurred
PIP	$2,033	$1,069	$309	$7,365	$7,056	9
SIP	$3,525	$1,796	$28	$12,316	$12,288	8
EPC	$9,449	$6,411	$813	$36,661	$35,848	8
VR	$7,395	$5,734	$762	$19,623	$18,861	12
Centrelink	$3,160	$2,582	$543	$8,340	$7,797	10
DVA	$648	$335	$25	$2,212	$2,187	10
PBS	$2,569	$1,938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

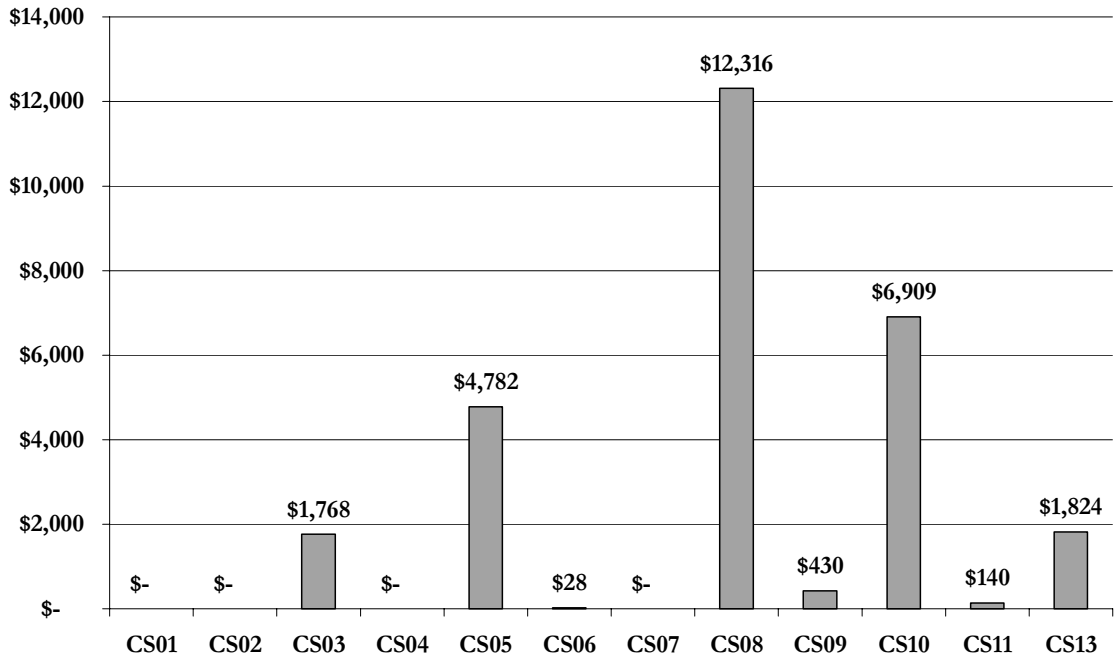
The overall reported practice-based compliance costs for SIP is $34,372. 82% of this cost is GP-related. The provision of GP-related SIP has also been variable across practices for reasons identified in Section 2.3. There are reported costs in eight of the twelve practices. Reported costs ranged from 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



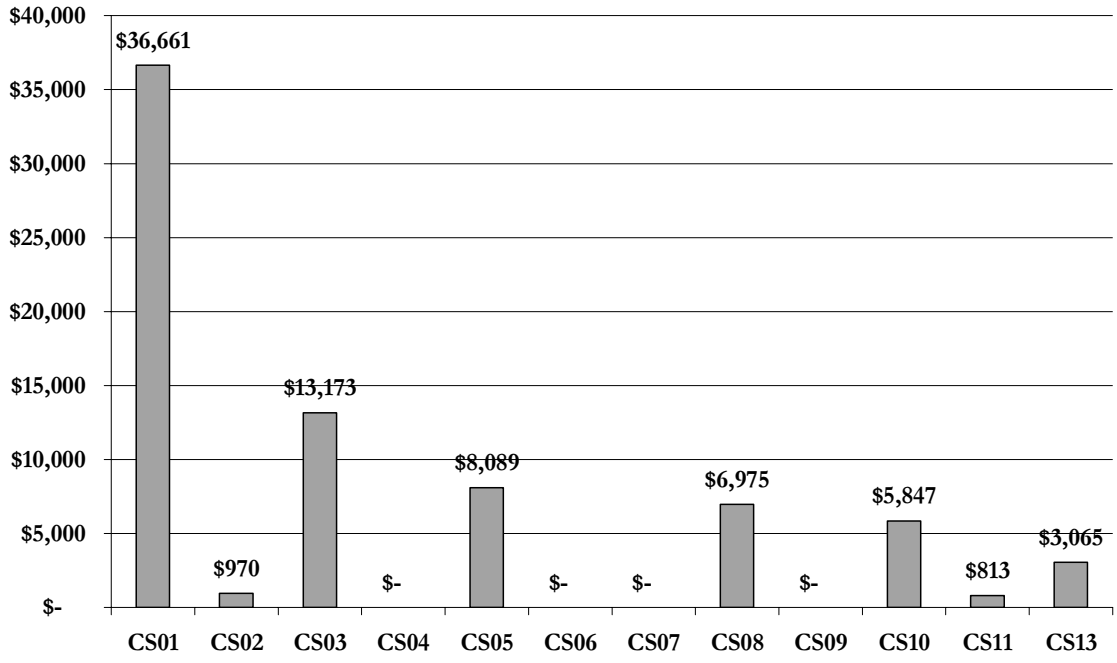
3.5.3 EPC

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



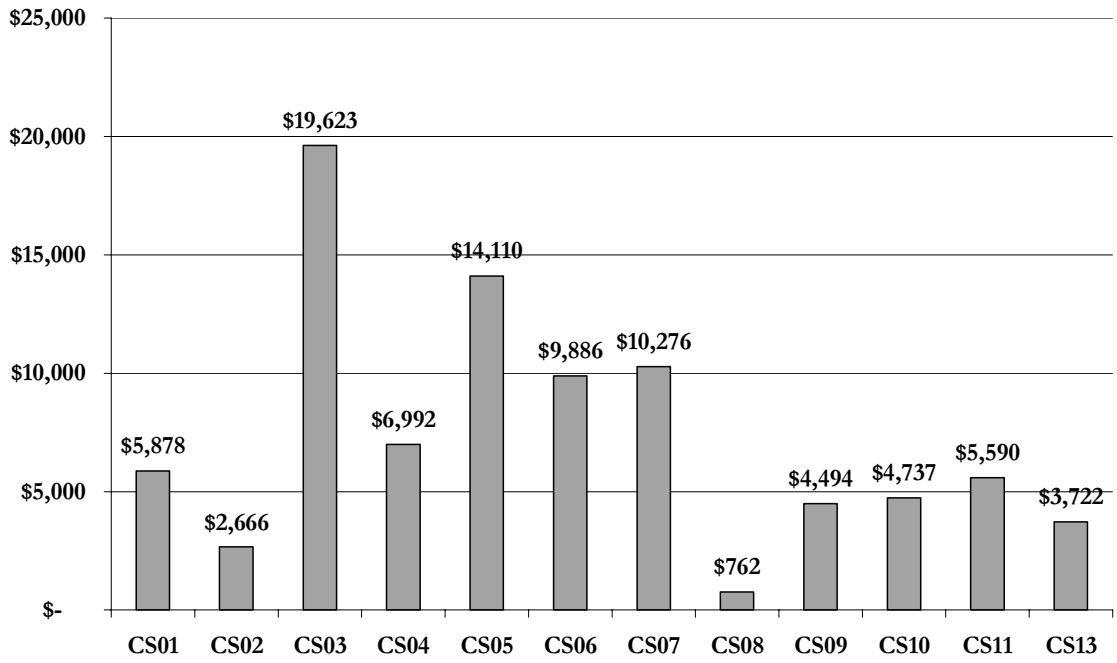
3.5.4 Vocational Registration

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

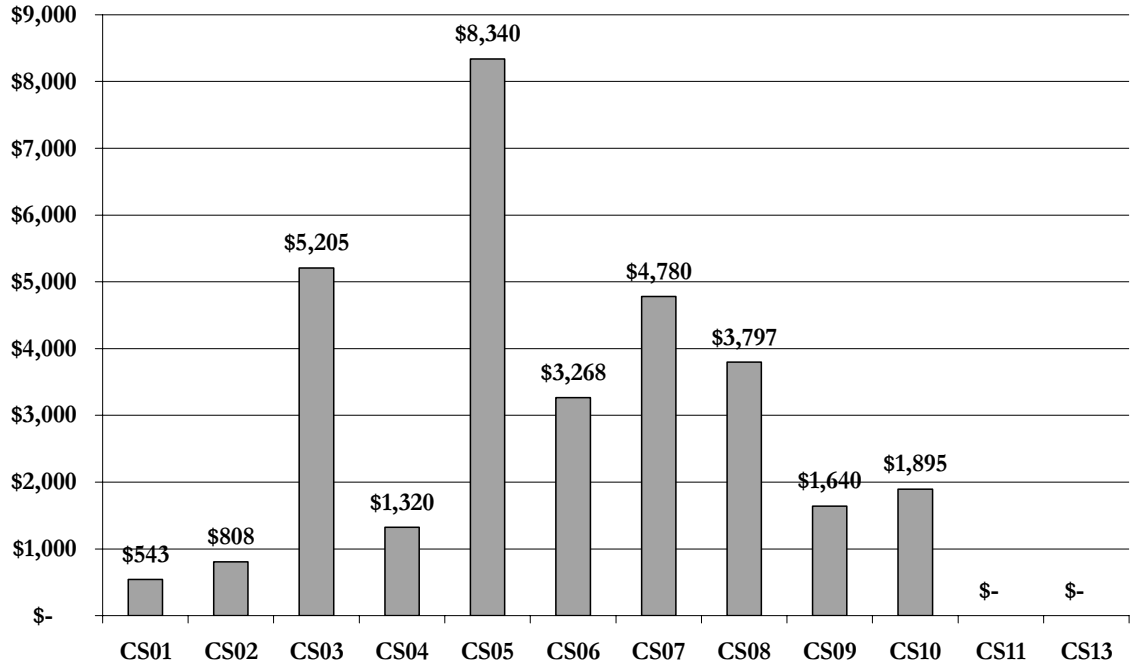


3.5.5 Centrelink

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

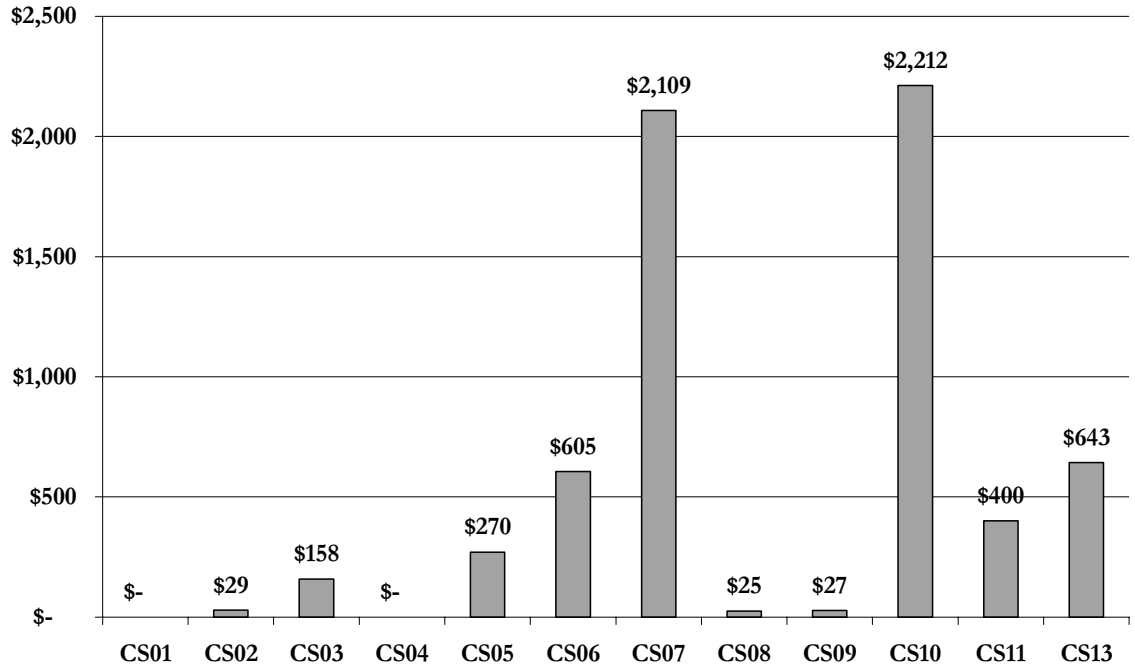


3.5.6 DVA

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