A Conduct of the research study

In this appendix, the Commission outlines the research study process and lists the organisations and individuals that have participated in the study.

The Commission aims to improve the overall performance of the Australian economy. It has regard to the established economic, social, environmental and regional development objectives of governments. The full terms of reference of this study are on page IV.

Following receipt of the terms of reference on 5 July 2002, the Commission released a circular including an issues paper to assist participants in preparing their submissions.

The Commission received 35 submissions before the release of the Progress Report and nine submissions following its release. Those who made submissions are listed in section A.1.

The Commission also held discussions in Canberra, Sydney and Melbourne with the organisations and Commonwealth departments and agencies listed in section A.2.

The Commission set up an advisory committee with representatives of the peak general practitioner and related organisations, and relevant Commonwealth departments and agencies, listed in section A.3. The committee provided advice and feedback to the Commission through two roundtable discussions during the study: in August 2002 and December 2002.

A.1 List of submissions received

The following table lists all submissions received over the course of the research study.

Individual or organisation[a]	*Submission number*
ACT Government	34
Australian Association of Practice Managers	PR39
Australian College of Non VR General Practitioners	28
Australian Divisions of General Practice Ltd	22, PR40
Australian General Practice Accreditation Ltd	25
Australian Medical Association	13, PR36
Begbie, Dr Timothy	2
Boyle, Dr Chris	20
Canning Division of General Practice	11
Castle, Dr Charles	30
Centre for General Practice Integration Studies	16
Dandenong District Division of General Practice	21
Department of Family and Community Services	19, PR37
Department of Health and Ageing	23, PR43
Department of Premier and Cabinet (Tasmania)	18
Eastern Sydney Division of General Practice	4
Far North Queensland Rural Division of General Practice Assn Inc	9
General Practice Computing Group	PR42
Hogan, Dr Chris	33
Hoy, Mavis	35, PR38
Keddie, Dr Peter	15
Kelly, Dr Glynn D	26, 32
McQueen, Dr Linda	29
Medical Board of South Australia	1
Merrington, Dr Dennis	24
North West Melbourne Division of General Practice	6
Northern Rivers Division of General Practice	31
Old Linton Medical Practice	12
Osborne Division of General Practice	8
Ratner, Dr Ruth	7

(Continued next page)

Individual or organisation[a]	*Submission number*
Riverland Division of General Practice	3
Royal Australian College of General Practitioners	PR41
Southern Tasmanian Division of General Practice	PR44
Tasmanian General Practice Divisions	10
The Onlooker Investigative Newsletter *#	14
van Rensberg, Dr Janse	27
Vickers, Dr Alison	17
Winzenberg, Dr Tania	5

[a] An asterisk (*) indicates that the submission contains confidential material not available to the public. A hash (#) indicates that the submission includes attachments.

A.2 List of visits

Informal discussions were held with the following interested parties.

Melbourne

acpm.com.au (formerly Australian Clinical Practice Managers)
Dr Gurdip Aurora — Scoresby Medical Centre
Dr Igor Jakubowicz — Knoxfield Medical Centre
Mavis Hoy
Medical Software Industry Association
Royal Australian College of General Practitioners

Canberra

Australian Divisions of General Practice
Australian Institute of Health and Welfare
Australian Medical Association
Centrelink
Consumers' Health Forum
Department of Family and Community Services
Department of Health and Ageing
Department of Veterans' Affairs
Health Insurance Commission
Rural Doctors Association of Australia

Sydney

Australian Association of Practice Managers

A.3 Organisations represented on the advisory committee

Australian Association of Practice Managers

Australian Divisions of General Practice

Australian Medical Association

Centrelink

Department of Family and Community Services

Department of Health and Ageing

Department of Veterans' Affairs

Health Insurance Commission

Royal Australian College of General Practitioners

Rural Doctors Association of Australia

B Department of Family and Community Services

Seven programs administered by the Department of Family and Community Services (FaCS) create administrative requirements for general practitioners (GPs). These programs can be classified into two broad categories:

- those that provide assistance for people with a disability, illness or injury — the Disability Support Pension (DSP), the Sickness Allowance, the Newstart Allowance, the Youth Allowance and the Mobility Allowance; and
- those that provide assistance for people caring for someone who is frail-aged, ill or has a disability — the Carer Payment and Carer Allowance.

Since September 1997, Centrelink has been responsible for the delivery of income support payments and services on behalf of FaCS.

The Government indirectly remunerates GPs for the time taken to complete FaCS/Centrelink forms through Medicare. Completing a form during a medical consultation (such as when GPs diagnose or treat a patient) attracts a rebate of $25.05 (under item 23B, as is the case for any medical examination). If completing the form results in a longer medical consultation, then GPs may legitimately charge Medicare for a longer consultation (and receive $47.60 under item 36C). If GPs do not bulk bill, they also receive the 'gap' payment from the patient. However, if they complete the form outside a consultation, the time cannot be remunerated through Medicare (DoHA 2003).

Unless otherwise indicated, the information contained in this appendix is sourced from Centrelink's website at http://www.centrelink.gov.au.

B.1 Assistance for people with a disability, illness or injury

Disability Support Pension

Under the DSP program, assistance is provided to people aged 16 years or over who are unable to work full time or train for work for two years or more because of a disability, illness or injury. As at June 2001, 623 926 people received the DSP, two-thirds of whom were aged 45 years or over (FaCS 2001). In 2000-01, FaCS expenditure on the DSP was $6.4 billion (FaCS 2002a).

To be eligible for the DSP, a person must have a disability, illness or injury that attracts an impairment rating of at least 20 points[1] (box B.1), and have a continuing inability to work 30 hours per week at award wages that is likely to last for two years or more.

Impact on medical practitioners

A person seeking to claim the DSP is required to provide Centrelink with current medical information in support of the claim. The most common method of collecting this information is via a DSP Treating Doctor's Report (TDR). The person's medical practitioner (a GP or specialist) is asked to complete the six-page DSP TDR, which provides Centrelink with information on the patient's medical condition (diagnosis, clinical features, symptoms, treatment and stability). In 2001-02, GPs completed 217 384 DSP TDRs (table B.1 and B.2).

In September 2002, FaCS/Centrelink introduced a number of changes to the DSP TDR as part of the Commonwealth Government's 2001-02 Budget package entitled *Australians Working Together — helping people to move forward*.[2] First, the questions contained in the TDR no longer require the GP to assess how the patient's condition would affect ability to work. Figure B.1 contains details of the questions removed from the TDR. The revised form instead asks GPs to provide details about how the diagnosed condition affects the patient's ability to function. When Centrelink is unable to determine whether the claimant is clearly eligible or ineligible for the DSP, based on the information provided by the claimant, Centrelink will refer them for an independent medical assessment (FaCS 2002b).

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1 An impairment rating of 20 points is considered to be the level at which a person's impairment(s) has a significant impact on their ability to work.

2 The *Australian's Working Together* package outlines a number of Commonwealth Government welfare reform initiatives aimed at reducing the number of persons receiving income support payments (such as the DSP).

Box B.1 **Tables for the assessment of work-related impairment for the Disability Support Pension (Impairment Tables)**

The Impairment Tables detail the impairment ratings relating to the severity of the impact of a person's medical condition on normal function as they relate to their work performance. There is a different table for the various body systems — such as psychiatric impairment, upper limb function and neurological function. In determining the degree of impairment resulting from skin disorders, for example, the prime consideration relates to the level of functional loss that impacts on the ability to perform normal daily activities. However, where there is extensive cosmetic or cutaneous involvement, this is also considered.

Skin disorders (table 18)

Impairment rating	*Criteria*
Nil points	Signs and symptoms of skin disorder present and with treatment there is no limitation in the performance of normal daily activities.
10 points	Signs and symptoms of skin disorder present despite optimal treatment and results in some interference with normal daily activities.
20 points	Signs and symptoms of skin disorder present despite optimal treatment and results in significant interference with normal daily activities.
40 points	Very severe symptoms requiring continuous treatment which might include periodic confinement to home or hospital and needs considerable assistance with normal daily activities.

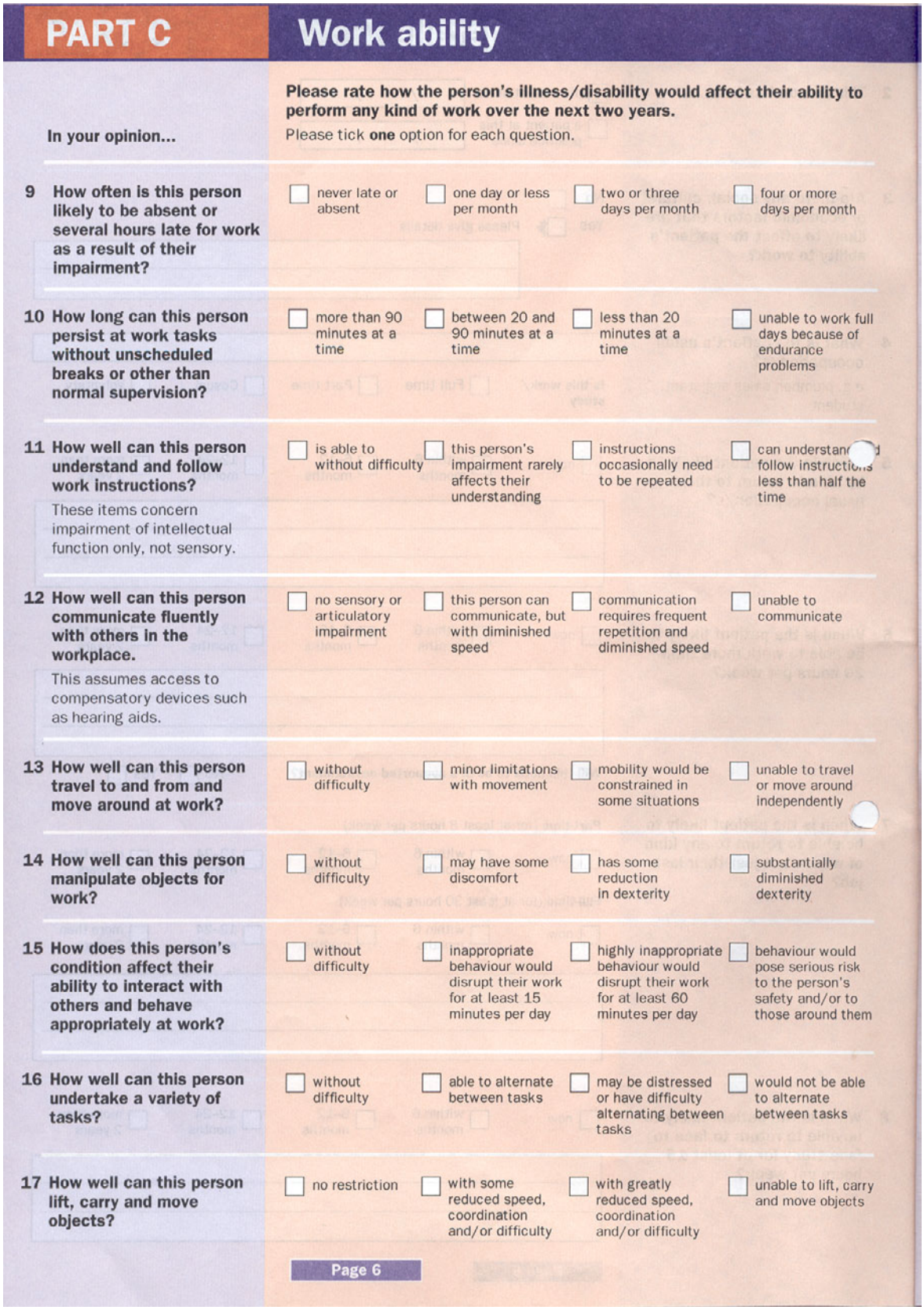
When a person has more than one functional impairment, a separate rating is assigned for each impairment from the relevant table. Then the impairment ratings are summed to generate the total degree of impairment.

Source: Social Security Act 1991 (Schedule 1B).

Second, FaCS/Centrelink changed the format of the TDR, with questions simplified and more space available for information to be provided about the patient's medical diagnosis, clinical features, symptoms, treatment and stability (sub. 19, p. 8).

Third, the DSP policy guidelines have also been revised to recognise specific conditions or situations where other medical evidence might be used instead of a TDR for Centrelink to decide whether the person is eligible for the DSP. An ophthalmologist's report, for example, might be used instead of a TDR for the purpose of assessing whether a blind person is eligible for the DSP (Centrelink, sub. 19, p. 9).

Figure B.1 **Details of questions removed from the Treating Doctor's Report (Part C) — Disability Support Pension**



PART C **Work ability**

Please rate how the person's illness/disability would affect their ability to perform any kind of work over the next two years.

Please tick **one** option for each question.

In your opinion...				
9 How often is this person likely to be absent or several hours late for work as a result of their impairment?	☐ never late or absent	☐ one day or less per month	☐ two or three days per month	☐ four or more days per month
10 How long can this person persist at work tasks without unscheduled breaks or other than normal supervision?	☐ more than 90 minutes at a time	☐ between 20 and 90 minutes at a time	☐ less than 20 minutes at a time	☐ unable to work full days because of endurance problems
11 How well can this person understand and follow work instructions? These items concern impairment of intellectual function only, not sensory.	☐ is able to without difficulty	☐ this person's impairment rarely affects their understanding	☐ instructions occasionally need to be repeated	☐ can understand and follow instructions less than half the time
12 How well can this person communicate fluently with others in the workplace. This assumes access to compensatory devices such as hearing aids.	☐ no sensory or articulatory impairment	☐ this person can communicate, but with diminished speed	☐ communication requires frequent repetition and diminished speed	☐ unable to communicate
13 How well can this person travel to and from and move around at work?	☐ without difficulty	☐ minor limitations with movement	☐ mobility would be constrained in some situations	☐ unable to travel or move around independently
14 How well can this person manipulate objects for work?	☐ without difficulty	☐ may have some discomfort	☐ has some reduction in dexterity	☐ substantially diminished dexterity
15 How does this person's condition affect their ability to interact with others and behave appropriately at work?	☐ without difficulty	☐ inappropriate behaviour would disrupt their work for at least 15 minutes per day	☐ highly inappropriate behaviour would disrupt their work for at least 60 minutes per day	☐ behaviour would pose serious risk to the person's safety and/or to those around them
16 How well can this person undertake a variety of tasks?	☐ without difficulty	☐ able to alternate between tasks	☐ may be distressed or have difficulty alternating between tasks	☐ would not be able to alternate between tasks
17 How well can this person lift, carry and move objects?	☐ no restriction	☐ with some reduced speed, coordination and/or difficulty	☐ with greatly reduced speed, coordination and/or difficulty	☐ unable to lift, carry and move objects

Page 6

DSP claimants have reviews at regular intervals, either on a two- or five-year cycle. Reviews are conducted on the grounds that some medical conditions might improve and consequently some claimants improve their capacity to work over time. However, some claimants are not reviewed at all due to the severity of their impairment (for example, claimants who have a terminal illness).

Some people claiming the DSP are medically reviewed at two- or five-yearly intervals, depending on their medical condition. A review DSP TDR, seeking identical information to the initial TDR, must be lodged with Centrelink.[3] Some claimants with disabilities are not required to undergo reviews if they are permanently incapacitated to work.

Sickness Allowance

Under the Sickness Allowance program, assistance is provided for people aged 21 years or over who are temporarily unable to perform their current work or study because of a disability, illness or injury. The Sickness Allowance can be received for the duration of incapacity determined by the medical practitioner, as stated on the medical certificate. In 2000-01, FaCS expenditure on the Sickness Allowance was $93.7 million (FaCS 2002a).

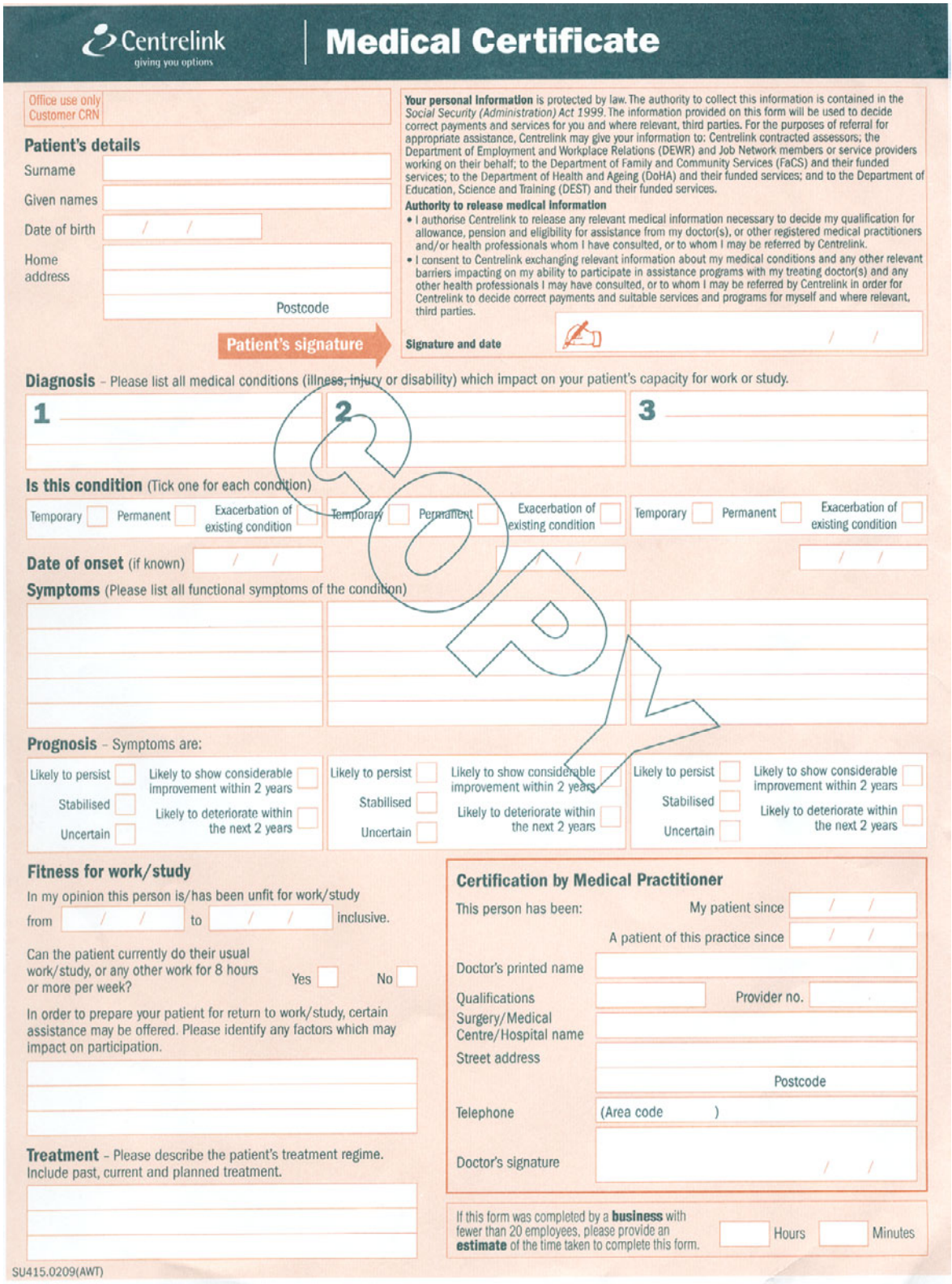
Impact on medical practitioners

A person seeking to claim the Sickness Allowance is required to support the claim with a Medical Certificate. A medical practitioner is consulted to complete the one-page Medical Certificate (figure B.2), which is identical to the certificate lodged by NewStart Allowance and Youth Allowance claimants. Medical Certificates are accepted for periods up to 13 weeks (sub. 19, p. 12). In 2001-02, GPs completed 81 083 medical certificates for Sickness Allowance recipients (table B.1 and B.2).

Similar to the DSP, the Medical Certificate was changed on 20 September 2002. Medical practitioners are now asked to provide more information about the patient's temporary incapacity to work (sub. 19, p. 8). Information is requested on the diagnosis, symptoms and treatment for up to three medical conditions (figure B.2).

[3] Prior to September 2002, a person undergoing a medical review was required to lodge a review TDR with Centrelink within 21 days of receipt.

Figure B.2 **Medical Certificate (post 20 September 2002) — Sickness Allowance, Newstart Allowance and Youth Allowance**



Centrelink
giving you options

Medical Certificate

Office use only
Customer CRN

Your personal information is protected by law. The authority to collect this information is contained in the *Social Security (Administration) Act 1999*. The information provided on this form will be used to decide correct payments and services for you and where relevant, third parties. For the purposes of referral for appropriate assistance, Centrelink may give your information to: Centrelink contracted assessors; the Department of Employment and Workplace Relations (DEWR) and Job Network members or service providers working on their behalf; to the Department of Family and Community Services (FaCS) and their funded services; to the Department of Health and Ageing (DoHA) and their funded services; and to the Department of Education, Science and Training (DEST) and their funded services.

Authority to release medical information

- I authorise Centrelink to release any relevant medical information necessary to decide my qualification for allowance, pension and eligibility for assistance from my doctor(s), or other registered medical practitioners and/or health professionals whom I have consulted, or to whom I may be referred by Centrelink.
- I consent to Centrelink exchanging relevant information about my medical conditions and any other relevant barriers impacting on my ability to participate in assistance programs with my treating doctor(s) and any other health professionals I may have consulted, or to whom I may be referred by Centrelink in order for Centrelink to decide correct payments and suitable services and programs for myself and where relevant, third parties.

Patient's details

Surname

Given names

Date of birth / /

Home address

Postcode

Patient's signature

Signature and date / /

Diagnosis – Please list all medical conditions (illness, injury or disability) which impact on your patient's capacity for work or study.

1	2	3

Is this condition (Tick one for each condition)

Temporary ☐ Permanent ☐ Exacerbation of existing condition ☐	Temporary ☐ Permanent ☐ Exacerbation of existing condition ☐	Temporary ☐ Permanent ☐ Exacerbation of existing condition ☐
Date of onset (if known) / /	/ /	/ /
Symptoms (Please list all functional symptoms of the condition)		

Prognosis – Symptoms are:

Likely to persist ☐ Likely to show considerable improvement within 2 years ☐ Stabilised ☐ Likely to deteriorate within the next 2 years ☐ Uncertain ☐	Likely to persist ☐ Likely to show considerable improvement within 2 years ☐ Stabilised ☐ Likely to deteriorate within the next 2 years ☐ Uncertain ☐	Likely to persist ☐ Likely to show considerable improvement within 2 years ☐ Stabilised ☐ Likely to deteriorate within the next 2 years ☐ Uncertain ☐

Fitness for work/study

In my opinion this person is/has been unfit for work/study from / / to / / inclusive.

Can the patient currently do their usual work/study, or any other work for 8 hours or more per week? Yes ☐ No ☐

In order to prepare your patient for return to work/study, certain assistance may be offered. Please identify any factors which may impact on participation.

Treatment – Please describe the patient's treatment regime. Include past, current and planned treatment.

Certification by Medical Practitioner

This person has been: My patient since / /

A patient of this practice since / /

Doctor's printed name

Qualifications Provider no.

Surgery/Medical Centre/Hospital name

Street address

Postcode

Telephone (Area code)

Doctor's signature / /

If this form was completed by a **business** with fewer than 20 employees, please provide an **estimate** of the time taken to complete this form. Hours Minutes

SU415.0209(AWT)

As the Sickness Allowance is paid in respect of a temporary disability, illness or injury, ongoing eligibility is reviewed at weeks 12, 40, 92 and 120, and then 16 week intervals for subsequent extensions of medical certificates exempting them from work. For each review, a medical practitioner is consulted to complete a three-page review Sickness Allowance TDR, which must be completed by a medical practitioner. The review TDR provides Centrelink with more extensive information about the patient's medical condition and work details (for example, when the patient is likely to be able to return to their usual occupation(s)).

Newstart Allowance

Under the Newstart Allowance program, assistance is provided for people aged 21 years or over who are unemployed. To be eligible for the Newstart Allowance, a person must, among other things, demonstrate that they are actively looking for suitable paid work, unless an exemption from the activity test requirements is granted. To qualify for an activity test exemption on the grounds of incapacity, the claimant must provide a Medical Certificate stating that they are unfit to do at least eight hours of work a week. In 2000-01, FaCS expenditure on the Newstart Allowance was $5.1 billion (FaCS 2002a).

Impact on medical practitioners

A person seeking a temporary incapacity exemption from the Newstart activity test is required to provide a Medical Certificate. A medical practitioner is consulted to complete the one-page Medical Certificate (figure B.2), which provides Centrelink with the GP's opinion on whether or not the person is unfit to do their usual work, or whether they are able to undertake any suitable work for at least eight hours per week. Individual certificates can be for periods of up to 13 weeks, and consecutive certificates might be accepted. In 2001-02, GPs completed 535 694 Medical Certificates for Newstart Allowance recipients (table B.1 and B.2).

Exempted claimants have their cases reviewed after 16 or 40 weeks. Until recently, a person was reviewed at intervals of 16, 40, 70 and 92 weeks with the 16- and 70-week reviews requiring a medical practitioner to complete a Medical Certificate (figure B.2). The review at weeks 40 and 90 previously required a medical practitioner to complete a more comprehensive review Newstart and Youth Allowance TDR. From 20 September 2002, FaCS/Centrelink abolished the review TDR. Recipients are now required to complete a self-assessment form at review and medical practitioners are no longer involved in this process.

Youth Allowance

Under the Youth Allowance program, assistance is provided for full-time students aged 16 to 24 or unemployed people aged under 21 years. To be eligible for the Youth Allowance, a person must, among other things, demonstrate that they are undertaking an approved training or education program, or that they are actively looking for suitable paid work (unless an activity test exemption is granted). To qualify for an activity test exemption on the grounds of incapacity, the claimant must provide a Medical Certificate stating that they are unfit to study or look for work. In 2000-01, FaCS expenditure on the Youth Allowance was $2.2 billion (FaCS 2002a).

Impact on medical practitioners

A person seeking a temporary incapacity exemption from the Youth Allowance activity test is required to provide a Medical Certificate. A medical practitioner is consulted to complete the one-page Medical Certificate (figure B.2), which provides Centrelink with the GP's opinion on whether or not the person is able to undertake their usual study or look for work, and if not, when they are likely to be able to return to study. Individual certificates can be for periods of up to 13 weeks, and consecutive certificates might be accepted. In 2001-02, GPs completed 67 966 Medical Certificates for Youth Allowance recipients (table B.1 and B.2).

As for the Newstart Allowance, exempted claimants have their cases reviewed after 16 or 40 weeks. Until recently, a person was reviewed at intervals of 16, 40, 70 and 92 weeks with the 16- and 70-week reviews requiring a medical practitioner to complete a Medical Certificate (figure B.2). The review at weeks 40 and 90 previously required a medical practitioner to complete a more comprehensive review Newstart and Youth Allowance TDR. From 20 September 2002, FaCS/Centrelink abolished the review TDR. Recipients are now required to complete a self-assessment form at review and medical practitioners are no longer involved in this process.

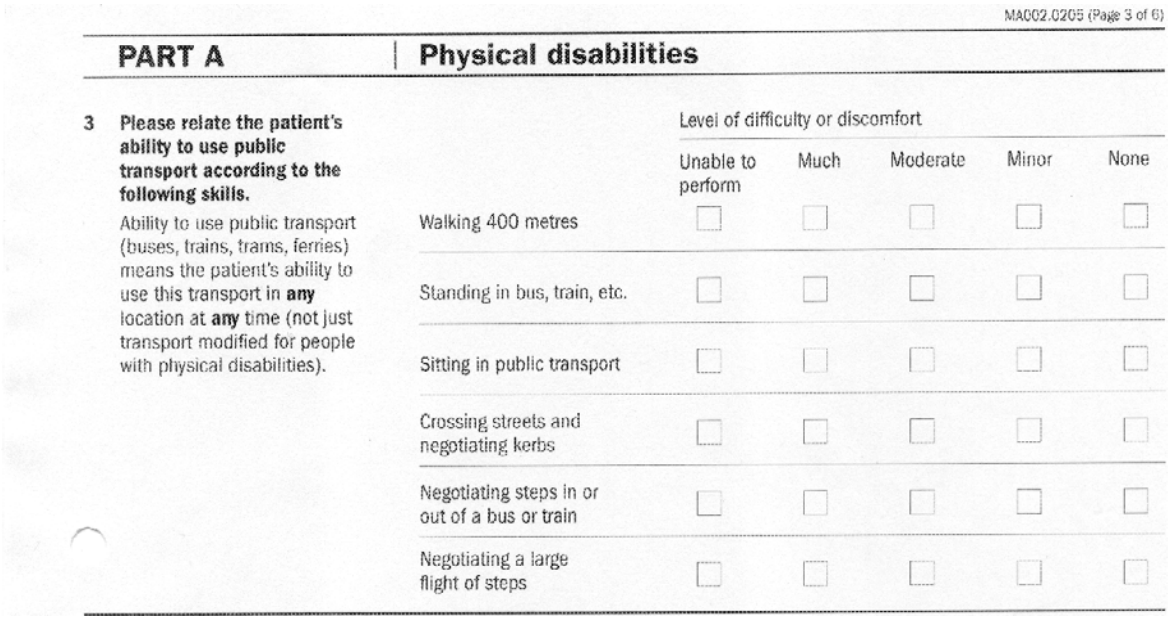
Mobility Allowance

Under the Mobility Allowance program, assistance is provide to people aged 16 years and over who have substantial difficulties using public transport because of a disability. The claimant must be undertaking an approved activity and be required to travel to and from their home for the purpose of undertaking their activity. In 2000-01, FaCS expenditure on the Mobility Allowance was $67.9 million (FaCS 2002a).

Impact on medical practitioners

When a person lodges a claim for the Mobility Allowance, they might already have provided enough information to Centrelink to help determine their claim (such as a recently completed DSP TDR). If more information is required to clearly indicate their inability to use public transport, a medical practitioner is consulted to complete a five-page Mobility Allowance TDR. This form provides Centrelink with information on how the person's physical, psychiatric or intellectual disability impacts on their ability to use public transport (figure B.3). In 2001-02, GPs completed 12 405 Mobility Allowance TDRs (table B.1 and B.2).

Figure B.3 **Part A of the Treating Doctor's Report — Mobility Allowance**



MA002.0205 (Page 3 of 6)

PART A | **Physical disabilities**

3 **Please relate the patient's ability to use public transport according to the following skills.**

Ability to use public transport (buses, trains, trams, ferries) means the patient's ability to use this transport in **any** location at **any** time (not just transport modified for people with physical disabilities).

	Level of difficulty or discomfort				
	Unable to perform	Much	Moderate	Minor	None
Walking 400 metres	☐	☐	☐	☐	☐
Standing in bus, train, etc.	☐	☐	☐	☐	☐
Sitting in public transport	☐	☐	☐	☐	☐
Crossing streets and negotiating kerbs	☐	☐	☐	☐	☐
Negotiating steps in or out of a bus or train	☐	☐	☐	☐	☐
Negotiating a large flight of steps	☐	☐	☐	☐	☐

Medical reviews of the eligibility for assistance are only required if the disability is temporary. In these situations, reviews are scheduled for every 12 months and medical practitioners are requested to complete a two-page review Medical Report.

B.2 Assistance for people caring for someone who is frail-aged, ill or has a disability

Carer Payment

Under the Carer Payment program, assistance is provided to people who are unable to undertake enough paid work to support themselves because of the demands of

their caring role (for a child or an adult). In 2000-01, FaCS expenditure on the Carer Payment was $595.8 million (FaCS 2002a).

Impact on medical practitioners

To claim the Carer Payment, a person must lodge with Centrelink a claim form and either a Medical Report (those caring for a child) or a Health Professional Assessment form (those caring for an adult). Centrelink determines the ability of the person being cared for to function independently based on the information provided in the medical assessment. In 2001-02, GPs completed 60 031 Carer Payment forms (table B.1 and B.2).

The two-page Medical Report (for a child) must be completed by a medical practitioner and provides Centrelink with a description, diagnosis and assessment of the child's disability or medical condition. The GP is requested to assess whether the child's condition is permanent, terminal or temporary, and the length of time of continuous personal care needed.

The six-page, multiple choice Health Professional Assessment (for an adult) can be completed by a range of health-care professionals — such as GPs, specialists, registered nurses, occupational therapists or members of an Aged Care Assessment Team. The health-care professional is requested to assess the person's disability or medical condition.

The medical condition of an adult whose carer is entitled to the Carer Payment (adult) is reviewed every two years, depending on the care recipient's medical condition. However, medical reviews are not conducted if the care recipient's condition is terminal or if the score achieved on the Adult Disability Assessment Tool is 40 or more, and a treating health professional certified that the disability or medical condition is permanent and unlikely to improve. A Health Professional Assessment must be lodged with Centrelink as part of a medical review.

Carer Allowance

Under the Carer Allowance program, assistance is provided to people who provide daily care and attention at home for an adult or child with a disability or chronic medical condition. In 2000-01, FaCS expenditure on the Carer Allowance was $645.7 million (FaCS 2002a).

Impact on medical practitioners

To claim the Carer Allowance, a person is required to lodge a claim form and either a Carer Allowance TDR (for a child) or a Carer Payment and Carer Allowance Health Professional Assessment (for an adult). Centrelink determines the ability of the person being cared for to function independently, based on the information provided in the medical assessment. In 2001-02, GPs completed 121 090 Carer Allowance forms (table B.1 and B.2).

The nine-page, multiple choice TDR (for a child) must be completed by a medical practitioner (a GP or specialist). The medical practitioner is requested to provide an assessment of the child's receptive and expressive language skills, feeding and mealtime skills, hygiene and grooming skills, dressing skills, social and community skills, and mobility skills. The medical practitioner is also requested to tick a series of boxes indicating whether the child has behaviour or special-care needs.

The six-page, multiple choice Health Professional Assessment (for an adult) can be completed by a range of health-care professionals — such as GPs, specialists, registered nurses, occupational therapists or members of an Aged Care Assessment Team. The health-care professional is requested to assess the person's level of disability.

The medical condition of a *child* whose carer is entitled to the Carer Allowance (child) is reviewed at developmental milestones. These milestones are at 3 years 4 months (if the Carer Allowance (child) was granted before the child was 2 years old), 4 years 8 months, 7 years, 10 years and 13 years. When the child is 15 years and 9 months, Centrelink invites the carer to demonstrate the child's eligibility for Carer Allowance (adult). A TDR must be lodged with Centrelink at each review milestone.

The medical condition of an *adult* whose carer is entitled to Carer Allowance (adult) is reviewed every two years, depending on their medical condition. However, medical reviews are not conducted if the care recipient's condition is terminal, or if the score achieved on the Adult Disability Assessment Tool is 40 or more and a treating health professional certifies that the disability or medical condition is permanent and unlikely to improve. A Health Professional Assessment must be lodged with Centrelink as part of its review.

B.3 Employment assistance for people with a disability, illness or injury

Centrelink provides a number of employment services for people with a disability, illness or injury, and who are looking for work. Programs such as the Disability Employment Services, Job Network and Supported Wage System were introduced with the objective of increasing the participation of people with a disability in the labour market.

To be referred or determined eligible to receive one of these employment services, a person is required to have a valid work capacity assessment or a valid recommendation for employment assistance. Centrelink uses information lodged by a claimant related to their disability — in the Professional's Report — in association with the Work Ability Tables to assess the impact of the person's disability on their work ability and to generate the person's work ability profile.

Depending on a person's work ability assessment, Centrelink will refer them either to the Job Network Service or to Disability Employment Services.

Impact on medical practitioners

A person seeking employment assistance is required to undergo a work ability assessment and lodge a Professional's Report with Centrelink. This form was previously called the 'Work Ability Information — Professional's Report'. The five-page report can be completed by any professional able to answer questions about the person's work ability, including a counsellor, social worker, case manager, community health worker, teacher, psychologist and physiotherapist. Since 20 September 2002, FaCS/Centrelink has removed GPs from the list of persons on the front of the form whom it suggests can complete the form; however, GPs might still be asked to complete the form by patients.

FaCS/Centrelink are currently working with the Department of Employment and Work Relations to develop a new process that focuses on an individual's support needs in gaining and maintaining employment. Under the new approach, the departments will not require medical practitioners to provide medical information. Instead, the departments will require an appropriate professional to report on the job seeker's support needs in relation to their disability, illness or injury.

B.4 Data

Table B.1 **FaCS/Centrelink forms completed by GPs by region, 1999-2000 to 2001-02[a]**

	Carer Allowance	*Carer Payment*	*Disability Support Pension*[b]	*Mobility Allowance*	*Newstart Allowance*	*Sickness Allowance*	*Youth Allowance*
				1999-2000			
Unknown RRMA	22	5	107 419[c]	3	25	12	1
Inner capital city	34 431	16 694	23 992	3 599	181 599	32 996	17 818
Outer capital city	22 191	10 689	14 805	2 020	91 837	21 281	12 308
Other metropolitan	9 291	4 939	6 906	909	35 287	6 797	4 750
Large rural centre	6 814	4 043	5 672	886	26 654	6 376	4 556
Small rural centre	8 068	4 590	6 220	832	27 415	5 716	4 351
Other rural area	13 224	8 003	11 210	1 137	49 519	11 433	6 560
Remote	1 512	1 040	1 893	115	8 456	1 951	1 094
Total	**95 553**	**50 003**	**178 117**	**9 501**	**420 792**	**86 562**	**51 438**
				2000-01			
Unknown RRMA	19	7	118 527[d]	2	60	12	1
Inner capital city	43 639	17 115	25 502	4 156	220 696	33 384	23 317
Outer capital city	29 393	11 090	16 250	2 253	115 378	22 012	16 154
Other metropolitan	12 104	4 979	7 436	988	44 520	6 819	6 201
Large rural centre	8 733	3 869	5 574	946	31 567	6 255	5 719
Small rural centre	10 074	4 394	6 468	848	32 685	5 859	5 633
Other rural area	16 606	7 604	11 425	1 297	59 359	12 222	8 079
Remote	1 948	1 039	1 929	106	9 964	1 867	1 308
Total	**122 516**	**50 097**	**193 111**	**10 596**	**514 229**	**88 430**	**66 412**
				2001-02			
Unknown RRMA	23	7	640	2	110	21	8
Inner capital city	43 376	20 256	75 327	4 864	229 637	30 571	23 379
Outer capital city	28 598	13 042	48 831	2 626	123 685	19 862	17 209
Other metropolitan	11 871	5 946	21 241	1 159	45 856	6 374	6 385
Large rural centre	8 633	4 754	15 409	1 037	32 721	5 642	5 814
Small rural centre	10 087	5 398	18 250	1 046	32 808	5 778	5 498
Other rural area	16 581	9 381	32 254	1 539	60 772	10 987	8 352
Remote	1 921	1 247	5 432	132	10 105	1 848	1 321
Total	**121 090**	**60 031**	**217 384**	**12 405**	**535 694**	**81 083**	**67 966**

a Regions based on DoHA's Rural, Remote and Metropolitan Areas (RRMA) classification. This classification normally has seven categories — two metropolitan (capital city and other metropolitan areas), three rural (large rural centres, small rural centres and other rural areas) and two remote (remote centres and other remote areas). The Commission disaggregated capital city into two areas (inner and outer) and grouped all remote into one category. **b** Includes data for initial and review TDRs completed by non-GPs, which is estimated to be approximately 3 per cent of total forms. **c** Includes 107 398 review TDR forms not provided by RRMA. **d** Includes 118 516 review TDR forms not provided by RRMA.

Source: Centrelink (pers. comm., 14 December 2002 and 20 March 2003).

Table B.2 **FaCS/Centrelink forms completed by GPs by socio-economic area, 1999-2000 to 2001-02[a]**

	Carer Allowance	*Carer Payment*	*Disability Support Pension*[b]	*Mobility Allowance*	*Newstart Allowance*	*Sickness Allowance*	*Youth Allowance*
				1999-2000			
Unknown SEIFA	832	340	108 036[c]	71	3 226	718	398
Most disadvan.	10 466	6 646	8 815	877	50 354	7 803	5 524
-4	13 142	7 791	10 003	1 110	57 471	10 563	6 917
-3	10 504	6 063	8 258	933	44 346	8 037	5 425
-2	8 209	4 575	6 703	819	34 767	7 299	4 746
-1	8 346	4 424	6 651	883	38 012	7 669	4 880
0	9 184	4 798	6 866	955	38 654	8 717	5 247
1	7 794	3 909	5 607	842	35 119	7 562	4 237
2	6 699	3 261	4 734	760	30 748	6 831	4 082
3	7 450	3 505	5 078	807	33 874	8 068	3 871
4	7 331	2 973	4 437	812	31 680	7 905	3 770
Least disadvan.	5 596	1 718	2 929	632	22 541	5 390	2 341
Total	**95 553**	**50 003**	**178 117**	**9 501**	**420 792**	**86 562**	**51 438**
				2000-01			
Unknown SEIFA	1 086	395	119 230[d]	61	4 355	837	594
Most disadvan.	13 171	6 309	8 775	979	62 204	7 973	7 271
-4	17 197	7 632	10 891	1 316	71 026	10 920	8 784
-3	13 465	6 104	8 541	983	54 192	8 420	7 097
-2	10 314	4 542	6 618	857	41 415	7 355	5 929
-1	10 785	4 522	7 129	952	46 581	8 207	6 357
0	12 066	4 805	7 140	1 108	48 053	8 825	6 759
1	9 890	3 985	6 054	938	41 846	7 690	5 391
2	8 822	3 486	5 291	870	38 228	7 079	5 140
3	9 286	3 388	5 339	897	41 381	7 592	5 094
4	9 404	3 110	4 881	916	38 493	7 981	4 949
Least disadvan.	7 030	1 819	3 222	719	26 455	5 551	3 047
Total	**122 516**	**50 097**	**193 111**	**10 596**	**514 229**	**88 430**	**66 412**
				2001-02			
Unknown SEIFA	1 064	438	2 941	99	4 780	823	576
Most disadvan.	13 137	7 787	25 583	1 240	65 455	7 302	7 426
-4	16 830	9 258	30 699	1 565	73 764	9 810	9 365
-3	13 310	7 295	23 982	1 217	56 677	7 811	7 342
-2	10 296	5 470	18 657	1 023	41 943	6 667	5 960
-1	10 619	5 361	20 552	1 148	48 358	7 475	6 686
0	11 786	5 759	20 763	1 166	48 671	7 892	6 739
1	9 825	4 731	17 940	1 086	43 378	6 846	5 464
2	8 607	4 035	15 447	879	40 271	6 854	5 312
3	9 306	4 140	15 675	1 039	43 065	7 265	5 116
4	9 293	3 641	15 189	1 121	41 276	7 353	5 007
Least disadvan.	7 018	2 116	9 956	822	28 056	4 985	2 973
Total	**121 090**	**60 031**	**217 384**	**12 405**	**535 694**	**81 083**	**67 966**

a Based on the ABS's 1996 Index of Relative Disadvantage, which is an index derived from attributes such as low income, low education attainment, high unemployment and jobs in relatively unskilled occupations (using data from the 1996 Census). Eleven Socio-Economic Indexes for Areas (SEIFA) categories were derived by DoHA by sorting postcodes into ascending order according to the value of the SEIFA index. Postcodes were then assigned into 11 groups, each with equal numbers. The lowest classification corresponds to areas that are the most disadvantaged, and the highest to the least disadvantaged. **b** Includes data for initial and review TDRs completed by non-GPs, which is estimated to be approximately 3 per cent of total forms. **c** Includes 107 398 review TDR forms not provided by SEIFA. **d** Includes 118 516 review TDR forms not provided by SEIFA.

Source: Centrelink (pers. comm., 14 December 2002 and 20 March 2003).

C Department of Veterans' Affairs

The Repatriation Commission and the Department of Veterans' Affairs (DVA) develop and implement government policies and programs relating to war veterans, members of the Australian Defence Force and their dependants as part of the Veterans' Affairs portfolio (Repatriation Commission 2001). The Repatriation Commission has decision-making powers for pensions, allowances and other benefits to veterans (and other entitled people). DVA provides support to the Repatriation Commission, and staff for discharging the Commission's responsibilities.

Programs operated by the Repatriation Commission that place administrative requirements on general practitioners can be classified into four broad categories:

- health-care services;
- disability compensation;
- income support; and
- military compensation scheme.

In 2001-02, DVA's expenditure on health programs was $3.3 billion, disability compensation and income support programs $5.5 billion and military compensation $10.4 million (Repatriation Commission 2002).

DVA often requires a claimant to undergo a medical examination by a general practitioner (GP) as part of its assessment of the eligibility of the claimant. Other medical reports might also be required. In many instances, the Government directly remunerates GPs for the time taken to complete DVA forms. GPs can receive payment for the medical consultation in which they see the veteran, per page of forms completed and for providing clinical notes.

Unless otherwise indicated, the information contained in this appendix has been sourced from DVA's website (http://www.dva.gov.au).

C.1 Health-care services

DVA's health-care services are aimed at increasing the health and well-being of eligible veterans, their war widows/widowers and dependants. The veterans are provided with acute hospital care through the Repatriation Private Patient Scheme and receive integrated care from many GPs through the Repatriation Comprehensive Care Scheme (RCCS).

Repatriation Comprehensive Care Scheme

The RCCS is designed to provide coordinated health care to veterans.

To access health-care services under the scheme, a veteran must possess a repatriation health card. The type of repatriation health card (gold, white or orange) determines the medical conditions for which veterans can receive treatment funded by DVA (box C.1).

The RCCS operates in accordance with a Memorandum of Understanding between the Repatriation Commission and the Australian Medical Association (AMA). The Memorandum of Understanding sets out the guidelines for the care and treatment of veterans and other eligible persons. GPs who wish to provide services to veterans under the RCCS need to be registered as a Local Medical Officer (LMO) by DVA. Currently there are about 16 000 LMOs (approximately two thirds of all GPs practising in Australia).

LMOs enter into a contractual arrangement with DVA. They agree to carry out certain administrative activities, such as making arrangements for a veteran's transport to and from the consultation. In return, LMOs are eligible to receive higher payments for the services they provide to eligible veterans. LMOs are paid a higher percentage of the fees in the Medicare Benefits Schedule (MBS) — 100 per cent (or 110 per cent if they are in certain rural areas), instead of 85 per cent, but are not allowed to charge veterans a co-payment.

Impact on medical practitioners

To become a LMO, a GP must lodge an application form (Application to be a Local Medical Officer) with DVA. In 2001-02, 918 applications were accepted (table C.2 in section C.5). Once DVA accepts a GP's application to become an LMO, the GP is given a provider number for use on all departmental correspondence.

Box C.1 **DVA Repatriation cards**

Repatriation cards are issued to veterans and dependants who are eligible under the *Veterans' Entitlements Act 1996*, for medical treatment funded by DVA. There are three types of Repatriation cards.

Repatriation Health Card — for all conditions (Gold Card)

A Gold Card enables the holder to access the full range of health-care services funded by DVA, whether the medical conditions are related to war service or not.

Australian veterans who are entitled to receive a Gold Card include: all veterans who have qualifying service from a conflict and are aged 70 years or over; veterans receiving the disability pension at or above 100 per cent of the general rate; veterans receiving the disability pension at or above 50 per cent of the general rate plus any amount of service pension; service pensioners who satisfy the treatments plus benefits eligibility test; and former prisoners of war. Certain dependants of Australian veterans might also be eligible for a Gold Card.

Repatriation Health Card — for specific conditions (White Card)

A White Card enables the holder to access the full range of health-care services funded by DVA for their medical conditions, which DVA accept as being war-caused or service-related.

White cards are issued to Australian veterans who have medical conditions attributed to war or other service activities. Veterans from countries who have reciprocal arrangements with the Australian Government might also be issued with a White card.

Repatriation Pharmaceutical Benefits Card (Orange Card)

Introduced in January 2002, the Orange Card is available to British Commonwealth and Allied veterans who have been residents of Australia for at least ten years. These veterans must have qualifying service from World War I or World War II, and be aged 70 years and over. It gives these veterans access to Repatriation Pharmaceutical Benefits Scheme (RPBS) pharmaceutical items at the concessional rate.

LMOs are responsible for coordinating all of the health services that are provided to a veteran.[1] An operational principle of the RCCS is that treatment should only be provided where there is a clinical need. Both the administrative and practical framework for providing health services are standardised, through treatment guidelines for LMOs.

GPs must complete a number of forms associated with different consultations and medical procedures. The GP must, for example, see the veteran's Repatriation

[1] Veterans do not have to go to a LMO, but by doing so they receive certain benefits such as letters of referral for specialist practitioners that are willing to accept DVA fee arrangements (so that co-payments can be avoided at every level).

Health Card and record its number, to determine eligibility for treatment. For some treatments, the GP might require prior approval from DVA — for instance, to prescribe certain drugs or to admit a veteran into some private hospitals.

In some instances, DVA remunerates LMOs for completing departmental requirements (for example, completing a medical diagnosis and an LMO's report on behalf of the veteran). Other activities are not remunerated (for example, arranging and certifying the need for a taxi if other transport options, paid for under the Repatriation Transport Scheme, are not suitable).

Prescriber Intervention Feedback Program

The Prescriber Intervention Feedback Program is aimed at identifying those veterans who, because of their medical condition or the combination of drugs they are taking, might be at risk of medication misadventure.

According to DVA, safe and effective drug therapy in the veteran population remains a major challenge. Each quarter, DVA highlights one clinical issue related to the quality use of medicine, such as benzodiazepine use, polypharmacy, drug interactions or drugs with high risk for the elderly (box C.2). Patients at risk of drug injury related to these issues are identified in a retrospective analysis of Repatriation Pharmaceutical Benefit Schedule claims data and the principal prescribing LMO is alerted to the situation.

Box C.2 Prescriber Intervention Feedback Program in practice: review of the use of benzodiazepines

In June 2000, benzodiazepines were selected as the clinical issue. Drugs of this type can have depressant effects on the central nervous system. As part of the Prescriber Intervention Feedback Program, 16 749 patients were identified for LMO intervention due to their use of long acting benzodiazepines (diazepam, nitrazepam and flunitrazepam).

After 12 months, a survey was taken of 9581 patients whose LMOs had received prescriber feedback. Of these, 2023 patients (21 per cent) were no longer using the same benzodiazepine. Just over two-thirds of these patients had discontinued use of all benzodiazepines, while more than a quarter had switched to a shorter acting benzodiazepine. The remaining 96 patients had switched to another long acting benzodiazepine.

Source: Killer (2002).

Following the advice, a LMO might consider that the patient requires a medication review. Medication reviews can be performed by a LMO or by an accredited pharmacist registered with DVA upon referral by a LMO. Gold Card holders are eligible for a medication review, while White Card holders are eligible where the review relates to an accepted disability or other conditions for which DVA has accepted a treatment claim.

Generally, reviews are only conducted once in a 12-month period, although approval might be sought in clinically justified circumstances. During 2001-02, 4527 medication reviews were performed (DVA, pers. comm., 16 August 2002). Of these, over 60 per cent were performed in rural or remote areas.

DVA pays LMOs for undertaking medication reviews. If the review is in the LMO's surgery, the fee is $81.10. If it is undertaken at the patient's home, or at an institution, the fee is $107.20.

Claiming

To claim payment for services provided to veterans, LMOs must complete a Claim for Treatment Services form or a Treatment Services Voucher form where multiple claims are being made (figure C.1). Treatment Service Vouchers are to be used for all MBS items, and are supplied in a carbonised format for use in an imprinter. Veterans sign the Treatment Services Voucher before leaving the LMOs' surgery. All claims are processed by the Health Insurance Commission for DVA.

Figure C.1 **Claim for treatment services form**


PROVIDER DETAILS

NAME

ADDRESS

PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN

Provider number if imprinter not used

IMPORTANT Payment will be made through the Service Provider Number if this section is not completed.

Payee's Provider Number

Print Name of Payee Provider

I authorise the Department of Veterans' Affairs to make payment in respect of the attached vouchers, to the Payee Provider at or from whose practice the services were rendered.

D1217 (Designed 05/97) – Duplicate – Claimant copy

Commonwealth Department of Veterans' Affairs

22

Claim for Treatment Services

DATE OF CLAIM (DD / MM / YY)

Pathology Inpatient Box

CLAIM NUMBER

W 7671

NUMBER OF VOUCHERS

TOTAL AMOUNT CLAIMED

$

I claim payment for all professional services specified in the attached vouchers and certify:

- that the services were rendered by me or on my behalf and to the best of my knowledge and belief all information in this claim is true
- that none of the amounts claimed is for a service which is not payable by the Department of Veterans' Affairs
- that no charge was or will be levied against the patient/s for the service/s
- that a copy of the Service Voucher was given to the patient.

Signature of provider who rendered the service

C.2 Disability compensation

Disability Pension

DVA is responsible for administering disability pensions, which are provided to veterans who experience injuries or diseases caused or aggravated by serving the country. There are 46 300 claims per annum for the disability pension (DVA, pers. comm., 5 August 2002).

Veterans are eligible to receive a disability pension if they have incurred an illness, injury or disease as a result of eligible service.

The level of the pension reflects, among other things, the assessed level of impairment. Veterans might receive an additional payment if they have specific disabilities that are service related, such as the amputation of a limb or blindness in one eye.

Typically, once a veteran qualifies for a disability pension, there is no regular review of their disability. If, however, the veteran wishes to obtain an increase in their pension, their disability must be reviewed. Veterans eligible for disability compensation also qualify for the DVA health program.

Impact on medical practitioners

To claim a disability pension, the veteran must lodge a disability pension claim form with DVA (figure C.2). The GP (frequently an LMO) or treating specialist is required to provide either a provisional or final diagnosis of the condition for which the veteran is seeking compensation. The pension claim form does not require the GP or treating specialist to make an assessment of the veteran's ability to function, or to provide details of past and present treatments for the diagnosed conditions. DVA might also ask the LMO to provide clinical notes giving an explanation of the diagnosis for the condition, a medical history of the condition, and/or clinical notes such as x-ray or pathology reports. This process is described in figure C.3.

Similar requirements are made in circumstances where a veteran applies to increase their disability pension. The GP is required to document each condition, or change in condition, for which the veteran is claiming.

In assessing the condition of a veteran, the LMO should take into consideration both the medical impairment caused by the disability and its effect on the veteran's lifestyle. This assessment is carried out using the *Guide to the Assessment of Rates of Veterans' Pensions* (GARP) and forms the basis for the pension rate that a veteran receives. A simplified illustration of this is presented in box C.3. The GARP is a legislative instrument, which has been passed by the Parliament. Between 2 July 2001 and 30 August 2002, DVA paid LMOs around $6.8 million for completing GARP examinations and forms (DVA, pers. comm., 23 September 2002).

LMOs usually send the completed form to DVA, which in turn provides the information to the Repatriation Commission to determine the veteran's disability rating. Veterans have the option to request the LMO to provide a specific disability rating using the GARP. In these situations, the LMO might be requested to justify the rating if it is not in accordance with the facts contained in the form or the attached medical reports.

Following the submission of the disability pension claim form, DVA might then provide the GP with additional forms requesting additional detail on some of the conditions that are being claimed. These additional forms include (for various conditions):

- Medical Impairment forms;
- Diagnostic Report forms; and
- Medical Report forms.

DVA pays LMOs for undertaking medical examinations of veterans for pension assessment purposes. The fee for examinations using the GARP is the appropriate MBS fee for the consultation plus $11.25 per page of forms. DVA also has a fee schedule for LMOs providing clinical notes — these currently range from $23.80 for basic notes through to $128.75 for notes that have been researched extensively (DVA 2002).

Figure C.2 **Application form for the disability pension**

Details of the NEW disabilities you are now claiming as war or defence caused

If you are not claiming for acceptance of new disabilities ***go straight to question 23.***

This column is to be filled in by the **Veteran**

This column is to be filled in by a **Medical Practitioner**

18. List the disabilities you are now claiming and describe the signs and symptoms.

Please provide the diagnosis of the disability, if you know what it is. If you don't know what the diagnosis is, please describe as fully as you can the signs and symptoms that make you notice the disability (for example, pain in lower back, shortness of breath, loss of range of movement in arm).

Do not include any injury or disease already accepted as war or defence caused.
You are requested to ask your doctor to fill in the Medical Practitioner column next to this section before lodging your claim.

For each disability that the veteran is claiming, provide a diagnosis indicating whether the diagnosis is final or provisional. A final diagnosis is preferred. **Please supply a brief summary of the basis for each diagnosis.** Please attach any reports you have that confirms the diagnosis/es.
The Department will pay you for this service according to *The Schedule of Fees.* **Note:** An account must be lodged before payment can be made.

Disability 1

Signs and symptoms

Medical Diagnosis

Diagnosis

Basis for diagnosis

How do you believe your service caused, contributed to, or aggravated this disability?

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? *(approx. date if known)*

When did the veteran first consult you for this condition?

Box C.3 Tables for assessing impairment using the Guide to the Assessment of Rates of Veterans' Pensions

The tables for assessing the extent of incapacity from war-caused or defence-caused injury or disease are designed to assess impairment to normal function. They consist of system-based tables that assign ratings in proportion to the severity or impact of a person's medical condition.

The tables provide ratings for over 100 medical conditions ranging from psychiatric impairment, spinal function, upper limb function, miscellaneous eye conditions and neurological function. For example, a person with reduced spinal function that imposes no or only minor effects on their range of movement, attracts an impairment rating of nil. In contrast, a person with stiffening and fixation (ankylosis) of the middle and lower spine in an unfavourable position might be given an impairment rating of up to 50 for this condition — depending on whether the impairment is partially or completely due to a war-caused injury.

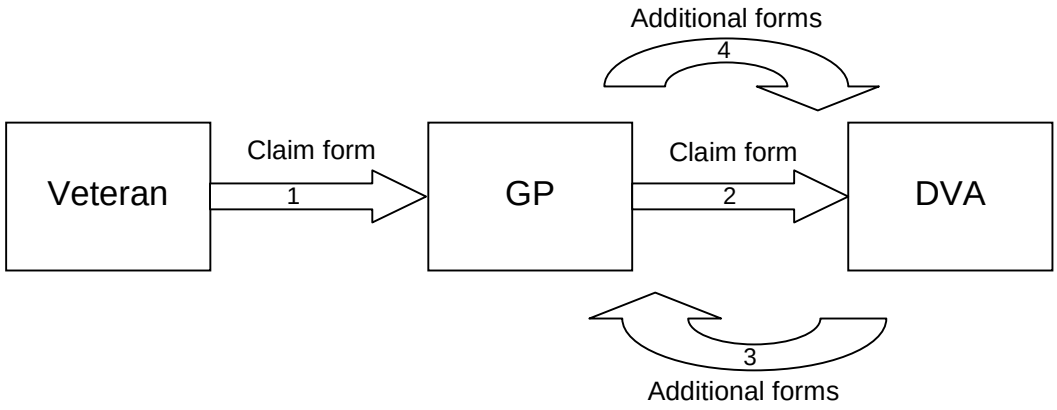
Loss of musculoskeletal function: spinal movement

	Criteria	
Impairment rating	Neck (cervical spine)	Middle and lower spine (thoraco-lumbar spine)
Nil points	Normal or nearly normal range of movement.	Normal or nearly normal range of movement.
5 points	Loss of about one-quarter of normal range of movement.	
10 points	Loss of about half of normal range of movement.	Loss of about one-quarter of normal range of movement.
15 points	Loss of about three-quarters of normal range of movement.	
20 points	Loss of all movement, or complete ankylosis in position of function.	Loss of about half of normal range of movement.
30 points	Ankylosis in an unfavourable position.	Loss of about three-quarters of normal range of movement.
40 points		Loss of all movement or complete ankylosis in position of function.
50 points		Ankylosis in an unfavourable position.

When a person has more than one functional impairment, separate ratings are assigned from the relevant tables to each impairment and these values are combined using a formula to obtain the person's total degree of incapacity.

Source: Based on DVA (1998).

Figure C.3 **The disability pension application process**



Disability allowances

Disability allowances are paid to veterans to assist them in covering expenses incurred as a result of injuries and diseases arising from performing their service duties. These allowances are for specific purposes, such as the loss of income a veteran might incur whilst undergoing medical treatment for a disability. There are four disability allowances, and medical certification is required for three of these allowances — the attendant allowance, the loss of earnings allowance, and the temporary incapacity allowance. In 2002, 490, 200 and 160 of these forms were completed, respectively (DVA, pers. comm., 5 August 2002).

Attendant allowance

An attendant allowance is paid to the veteran to assist in meeting the costs of having an attendant who assists with daily activities (such as feeding, bathing and dressing) if the veteran's ability to undertake such tasks is impeded by injuries or diseases related to war or defence activities. Each application for an attendant allowance must include a medical report completed by a GP, outlining the veteran's ability to care for themselves.

Loss of earnings allowance

The loss of earnings allowance compensates veterans for salary, wages or earnings they lose while attending appointments required to investigate a claim for a disability pension or while receiving treatment. The allowance might also be paid where another person loses salary, wages or earnings because they are helping a

veteran to pursue a claim for a disability pension. The loss of earnings allowance is usually paid for a short period of time, and the claimant must outline the treatment they have received and dates on which they were absent from work on the application.

GPs are required to complete a section of this form outlining the nature of the treatment and the dates on which it was provided.

Temporary incapacity allowance

A temporary incapacity allowance might be paid to veterans who cannot work during or after hospitalisation while being treated for a war-caused or defence-caused injury or disease. GPs must complete a section in the application form for this allowance detailing the veteran's treatment and associated period of incapacitation.

C.3 Income support

Service pension

DVA provides income support for veterans who have limited means. A veteran who is permanently incapacitated for work might be granted the service pension at any age. A service pension can be paid to veterans on the grounds of age or invalidity. Eligible partners, widows and widowers might also be paid in some circumstances.

Impact on medical practitioners

DVA might request a LMO to conduct medical examinations and completed reports on the claimant to assist in its investigation of applications for a service pension lodged on the grounds of invalidity.

LMO services can range from providing a diagnosis on a Service Pension Claim form (Invalidity Details), through to the completion of a GARP examination and Work Test Questionnaire. Between 1 January 2000 and 30 June 2002, there were estimated to be 2041 claims nationally. It is likely that all of these required a medical prognosis and completion of the Work Test Questionnaire (DVA, pers. comm., 17 September 2002).

DVA pays LMOs who provide these services. The fee for a medical diagnosis on a pension application form is $23.80 (excluding GST) or $49.10 (excluding GST) if GPs also provide specialist reports and/or test results. GPs are paid $11.25 per page for completing GARP forms and the Work Test Questionnaire, in addition to the standard MBS fee for the consultation.

C.4 Military Compensation Scheme

The Military Compensation Scheme provides Australian Defence Force members with workers' compensation and rehabilitation services. DVA provides claims management and rehabilitation case management through the Military Compensation and Rehabilitation Service. Policy and safety management issues are the responsibility of the Department of Defence. In 2001-02, the Military Compensation and Rehabilitation Service received 6471 claims.

Defence force medical officers and specialists provide the majority of the medical information used to assess these compensation claims. A GP might provide medical evidence for a claimant by supplying a letter or report (a specific form is not used). DVA estimates that GPs provide medical evidence in about 1300 instances annually (DVA, pers. comm., 28 August 2002).

C.5 Data

Health-care services

Table C.1 **LMO services, 2001-02**

	Department data[a]		*Adjusted values*[b]	
Activity	*Services*	*Payments to GPs*	*Services*	*Payments to GPs*
	no.	$	no.	$
Care plan	19 767	3 076 626	26 356	4 102 168
Case conference	1 318	167 802	1 757	223 736
Health assessment	33 658	5 832 451	44 877	7 776 601
Medication review	4 085	341 670	5 447	455 560
Referral	83 444	..	111 259	..

[a] Data provided for July 2001 to March 2002. [b] Estimates for 2001-02 were derived by multipling department data on number of services and total payments by 4/3. .. Not applicable.

Source: Productivity Commission estimates based on DVA data (pers. comm., 12 September 2002).

Table C.2 **LMO application forms, 1999-2000 to 2001-02**

	Total forms
1999-2000	1 195
2000-01	1 778
2001-02	918

Source: DVA (pers. comm., 10 September 2002).

Table C.3 **Country Taxi Voucher Scheme by region, 2001-02**

RRMA classification	*GPs*	*Voucher books*[a]	*Estimate of vouchers*[b]
Unknown RRMA	1	1	200
Inner capital city	0	0	0
Outer capital city	98	132	26 400
Other metropolitan areas	52	67	13 400
Large rural centre	28	36	7 200
Small rural centre	72	98	19 600
Other rural areas	64	81	16 200
Remote	0	0	0
Total	**315**	**415**	**83 000**

a Voucher books distributed to GPs over a three-month period. **b** Yearly estimates were derived by multiplying the number of voucher books by four and 50 (because there are 50 vouchers per book).

Source: Productivity Commission estimates based on DVA data (pers. comm., 22 August 2002).

Table C.4 **Country Taxi Voucher Scheme by socio-economic area, 2001-02**

SEIFA classification	*GPs*	*Services*[a]	*Estimate of vouchers*[b]
Unknown SEIFA	4	4	800
Most disadvantaged	17	24	4 800
-4	65	90	18 000
-3	56	77	15 400
-2	79	101	20 200
-1	20	29	5 800
0	15	19	3 800
1	6	6	1 200
2	30	39	7 800
3	0	0	0
4	19	21	4 200
Least disadvantaged	4	5	1 000
Total	**315**	**415**	**83 000**

a Voucher books distributed to GPs over a three-month period. **b** Yearly estimates were derived by multiplying the number of voucher books by four and 50 (because there are 50 vouchers per book).

Source: Productivity Commission estimates based on DVA data (pers. comm., 22 August 2002).

Table C.5 **Prescriber Intervention Feedback Program, 2001-02**

Survey	*LMOs targeted in program and sent a survey letter*	*Response rate*	*Number of respondents*
	no.	%	no.
CHF	3 816	12	458
Cox 2	10 114	15	1 517
Tricyclics	5 669	16	907
Polypharmacy 2001	8 309	12	997

Source: DVA data (pers. comm., 3 March 2003).

Disability compensation

Table C.6 **Disability compensation services, 2001-02**

			Adjusted data		
Activity	*Services*	*Total payments*[a]	*Total payments*[b]	*Payment per service*	*Services*[c]
		$	$	$	no.
Allowances[d]	Pages of forms	27 533	24 274	11.25	2 158
Medical consultations	Consultation	3 424 214	3 018 933	54.60	55 292
GARP assessment	Pages of forms	3 337 752	2 942 704	11.25	261 574
Medical Diagnosis report	Pages of forms	723 067	637 487	11.25	56 665
Pension claim form	Forms	83 645	73 745	22.05	3 344
Workability assessment	Forms	147 159	129 741	56.25	2 307

a Total compensation payments from 12 July 2001 to 30 August 2002. **b** Derived by multiplying department data on total payments by 365/414 to convert to yearly data. **c** Derived by dividing Commission estimates of total payments by per unit charge. **d** Consultations and form completion relating to Allowance claims.

Source: Productivity Commission estimates based on DVA data (pers. comm., 23 September 2002).

Income support

Table C.7 **Claims for income support services, 2001-02**

	Claims[a]	*Forms completed per service*	*Adjusted claims*[b]
Invalidity details form	2 041	1	816.4
Work test questionnaire	2 041	3	2 449.2
GARP form	2 041	3	979.7

a Total number of income support claims from 1 January 2000 to 30 June 2002. **b** Derived by multiplying the department data by 0.4 to convert from 30 month data to 12 month data. This is then multiplied by the number of forms completed per service. The total for GARP forms is multiplied by 0.4 because GPs complete 40 per cent of total GARP forms.

Source: Productivity Commission estimates based on DVA data (pers. comm., 9 September 2002).

D Department of Health and Ageing

The Department of Health and Ageing (DoHA) has a number of programs and initiatives (generally referred to in this report as programs) that impact on general practitioners (GPs). These programs have been classified under three broad categories (table D.1):

- programs to influence the quality and availability of general practice services (section D.1);
- programs to promote population health (section D.2); and
- programs relating to providing information to departments and others (section D.3).

Table D.1 **Department of Health and Ageing programs**

List of programs
Programs to influence the quality and availability of general practice services
Practice Incentives Program
Quality Innovation Funding
Enhanced Primary Care
Domiciliary Medication Management Reviews
GP access to Medicare
Rural Retention Program
General Practice Registrars Rural Incentives Program
Rural Women's GP Service
Rural and Remote General Practice Program
Aboriginal Community Controlled Health Services
Doctors for Outer Metropolitan Areas Measure
Programs to promote population health
Australian Childhood Immunisation Register
General Practice Immunisation Incentives Scheme
Programs relating to providing information to departments and others
Pharmaceutical Benefits Scheme
Commonwealth Hearing Services
Private health insurance regulations

The Health Insurance Commission (HIC) is responsible for administering many of DoHA's programs and for making payments to GPs. Rural Workforce Agencies (RWAs) are also involved in administering some of DoHA's rural programs.

Most DoHA programs are voluntary and the department provides incentive payments to encourage GPs to participate. Nevertheless, under private health insurance legislation it is mandatory, under some circumstances, for GPs with hospital admitting rights to provide information to private health insurance funds or members.

Unless otherwise indicated, the information contained in this appendix was sourced from DoHA's website (http://www.health.gov.au), the HIC's website (http://www.hic.gov.au) and information provided directly to the Commission by DoHA and the HIC.

All financial and other data provided in relation to DoHA programs, for 2001-02, is supplied on an estimates basis. Where provided, total Government expenditure on a program (for example, Practice Incentives Program (PIP)) is an estimate composed of direct payments plus internal departmental costs of program management and HIC processing costs (DoHA, pers. comm., 7 March 2003).

D.1 Programs to influence the quality and availability of general practice services

Practice Incentives Program

The objective of PIP is to reward general practices that provide comprehensive and quality care. To meet this objective, PIP was designed to:

- encourage general practices to become accredited and put in place certain practice arrangements (practice incentive elements); and
- encourage individual GPs in PIP practices to provide prescribed clinical services to treat certain diseases (service incentive elements).

There are many practice incentive elements (some of the elements have several tiers) covering a range of practice arrangements, including information management and technology, after-hours care, and quality prescribing (table D.2). Practices can enrol in one or more of these elements. To encourage practices to participate in specific elements, practices are paid incentive payments (table D.2).

There are four disease-specific service incentive elements that target asthma, diabetes, cervical cancer and mental health. To encourage GPs to provide these specific service incentives, GPs are paid each time they provide particular services (table D.2).

Practices generally need to be accredited to qualify for any PIP payments. The exceptions to this are practices that first enrolled in PIP after 1 January 2001. However, these practices have to be accredited within 12 months of PIP enrolment.

GPs and practices also undertake a range of activities and tasks in order to qualify for payments, in relation to different PIP practice and service incentive elements (table D.2).

In 2001-02, there was an average of 4829 general practices enrolled in PIP (this is about 76 per cent of all general practices). Each practice received, on average, $39 000 funding through PIP for that year (about $189 million in total for Australia).

Between November 2001 and July 2002, GPs in PIP practices provided 134 070 services to patients with asthma, diabetes or who were at 'high risk' of having undiagnosed cervical cancer. GPs received about $4.2 million for providing such services between November 2001 and May 2002.

In 2001-02, total Government expenditure on PIP was $195.3 million.

Table D.2 **PIP activities and payments**

Description	*Practice or GP activities*	*Annual payment*[a]
Practice incentive elements		
Information Management and Information Technology (IM and IT)		
Tier 1 — Provide data to the Commonwealth	Practice completes a PIP application form and the HIC's biennial confirmation statement (to ensure HIC records on the practice are correct).	$3.00 per SWPE
Tier 2 — Electronic prescribing	Practice uses approved electronic prescribing software to generate the majority of their prescriptions.	$2.00 per SWPE
Tier 3 — Capacity for electronic data transfer	Practice uses a computer connected to a modem to send/or receive clinical information.	$2.00 per SWPE
After hours care[b]		
Tier 1 — Patient access to 24-hours care	Practice ensures patients have access to comprehensive after-hours care.[c] This might be, for example, through arrangements with other practices or a medical deputising service.	$2.00 per SWPE
Tier 2 — 15 hours plus after-hours care	Practice provides at least 15 hours per week of after-hours care from within the practice.	$2.00 per SWPE
Tier 3 — 24 hours plus after-hours care	Practice provides all after-hours care from within the practice.	$2.00 per SWPE
Care planning	Practice provides care plans or case conferences for a target percentage of its patients with chronic conditions and multidisciplinary care needs (this element ceased in November 2002).	$10.00 per WPE aged 65 and over[d]
Teaching	Practice hosts at least one university medical student and provides appropriate training sessions.	$50.00 per teaching session
Quality prescribing initiative	Practice participates in three activities per full-time equivalent GP that are recognised or provided by the National Prescribing Service (at least one of these activities must be a clinical audit).	$1.00 per SWPE
Rurality	Practice's main location is outside metropolitan areas.	15 per cent to 50 per cent loading of total payment
Diabetes — sign on component (patient register and recall/reminder system)	Practice agrees to participate in the diabetes incentive and has established a diabetes patient register and recall system.	$1.00 per SWPE (one-off payment)

(Continued next page)

Table D.2 (continued)

Description	*Practice or GP activities*	*Annual payment*[a]
Asthma — sign on component	Practice agrees to participate in the asthma incentive.	$0.25 per SWPE (once off)
Cervical screening — sign on component	Practice agrees to participate in the cervical screening incentive and to consider strategies to improve the level and quality of participation in the National Cervical Screening Program.	$0.25 per SPWE (once off)
Mental health — sign on component	GPs obtain appropriate training that provides them with accredited mental health skills.	$150.00 per eligible GP
Diabetes — outcome payments	Practice reaches target levels of care for their patients with diabetes.	$20.00 per diabetes patient
Cervical screening — outcome payments	Practice reaches target levels of cervical screening for their female patients aged 20 to 69 years.	$2.00 per female WPE (aged 20 to 69 years)
Additional practice nurses (rural and other areas of need)	Practice is in an eligible location and employs a practice nurse for a minimum number of sessions per week.	$7.00–8.00 per SWPE
Service incentive elements[e]		
Diabetes	GPs complete an annual diabetes program of care for a patient of the practice. Minimum requirements of care are set out in the Medicare Benefits Schedule.	$40.00 per patient for an annual cycle of care
Asthma	GPs complete an Asthma 3+ Visit Plan for a patient with moderate to severe asthma. Minimum requirements of care are set out in the Medicare Benefits Schedule.	$100.00 per patient for a completed Asthma 3+ Visit Plan
Cervical screening	GPs screen women aged between 20 and 69 years who have not had a cervical smear within the last four years.	$35.00 per patient screened
Mental health	GPs complete the required three step mental health process for their patients.	$150.00 per patient. Payment is capped at $10 050 per GP

a For most of the elements, the level of practice incentive payments made to practices depends on the practice's number of Standard Whole Patient Equivalent (SWPE). SWPE is an indicator of the practice's patient load that adjusts the weighting for each patient serviced by the practice to take into account that some patients have greater care needs than other, and that some patients go to more than one practice. **b** After hours is the time outside of the hours of 8am–6pm weekdays and 8am-12pm Saturday. **c** Comprehensive after-hours care includes after-hours visits (for example, to the patient's nursing home), where appropriate. **d** Whole patient equivalent (WPE) is an indicator of the practice patient load that adjusts the weighting for each patient serviced by the practice to take into account that some patients go to more than one practice. **e** GPs inform the HIC they have completed activities associated with each service incentive element by billing Medicare using a specific item number.

Source: DoHA (sub. 23).

Quality Innovation Funding

The objective of the Quality Innovation Funding program for medical deputising services — practices that only provide after-hours primary care services, such as on evenings and public holidays — is to improve the provision of after-hours primary medical care in Australia.

Under the program, medical deputising services apply for funding in order to implement specific quality improvements, such as improving the service's security arrangements or information technology infrastructure. Successful medical deputising services receive up to $80 000 per year. Those offering clinic-based care can apply for an additional $20 000 per year, per clinic.

To apply, medical deputising services must be accredited to the Royal Australian College of General Practitioners (RACGP) standards for medical deputising services. The deputising service pays a fee, $1200 per full-time equivalent GP, to the accreditation agency undertaking the accreditation survey (DoHA, pers. comm., 11 September 2002). The service also need to complete the application form, and be willing to enter an agreement with the Commonwealth Government regarding how they will spend the funding. In the agreement, they also agree to certain reporting arrangements and to participate in the program's evaluation process.

In 2002, three medical deputising services participated in the program, and total Government expenditure was about $258 000.

Enhanced Primary Care

The objective of the Enhanced Primary Care (EPC) program is to facilitate the provision of preventative care for older Australians and the better coordination of care between GPs and other professionals providing care to people with chronic conditions and complex care needs.

Under the EPC program, GPs can claim specific Medicare payments (accessed by billing a particular item number) associated with preventative care and care coordination. There are 28 EPC items in the Medicare Benefits Schedule. These items cover:

- health assessments;
- multidisciplinary care plans; and
- multidisciplinary case conferences.

In 2001-02, total Government expenditure on the EPC program was about $62.8 million.

Program description

Health assessments

Health assessments are in-depth assessments of the health of older patients — 75 years of age and over for a general community patient, and 55 years of age and over for an Aboriginal or Torres Strait Islander patient.

Four different Medicare item numbers apply to health assessments. The item numbers differ in terms of whether or not the patient is Aboriginal or Torres Strait Islander, and whether the health assessment is undertaken wholly in consulting rooms or includes a component undertaken in the patient's home.

GPs undertake certain activities before conducting a health assessment. These activities include checking a patient's eligibility, discussing with the patient the benefits of the assessment and obtaining the patient's consent.

The GP (possibly with assistance from a practice nurse) examines a patient's medical, physical, psychological and social function in a health assessment. Patients must then be offered a written report about their health assessment, with recommendations about matters covered by this assessment.

In 2001-02, GPs conducted around 165 000 health assessments, generating Medicare benefits payments of approximately $25 million.

Multidisciplinary care plans

EPC care plans are comprehensive longitudinal plans for patients with one or more chronic conditions and complex needs requiring care from a multidisciplinary team. They are written documents describing a patient's care needs and related management goals, the kinds of treatment and services a patient needs to meet these goals, and the arrangements made to access these services. They also include arrangements for a review of the plan. A minimum of three multidisciplinary providers — health- or other- care — need to be involved in the development and management of a care plan, including the patient's GP.

Six different Medicare item numbers apply to care plan activities. The item numbers differ in terms of whether the care plan is prepared for a community patient, a hospital discharge patient or a resident of an aged care facility, and if the GP is preparing, reviewing or contributing to the plan.

GPs undertake certain activities before undertaking a care plan, including checking a patient's eligibility, obtaining the patient's consent, and informing the patient of the need to discuss their medical history with other care providers and any costs the patient will incur.

To develop a written care plan, a GP collaborates with the other team members in identifying a patient's care needs, establishing goals and a plan to meet these needs, and identifying and contacting other providers who can assist in meeting these needs. When recruiting other professionals to assist with the plan, the GP needs to obtain and record their agreement to provide services. GPs must offer a copy of the plan to the patient and give copies of relevant parts of the plan to the other team members and other providers identified in the plan.

GPs can also review, or contribute to, a care plan. When reviewing a care plan, GPs obtain the patient's consent, consult with the other members of the team, discuss the review with the patient and, if necessary, revise the plan. When only contributing to a care plan, GPs are required to obtain the patient's consent and to communicate with the professional organising the plan. GPs should request a copy of the completed plan, or an extract relating to their contribution, for the patient's medical record.

In 2001-02, GPs' provided about 275 000 care planning services generating Medicare benefit payments of approximately $37 million.

Multidisciplinary case conferences

Case conferences are meetings of health-care and other-care providers to plan care for patients with chronic conditions and multidisciplinary care needs. Health-care and other-care providers can conduct these meetings face-to-face, via telephone or videoconference link, or a combination of these. Case conferences are used where more immediate solutions are needed to treat a patient's condition, and where the management of a patient's care needs can be improved through sharing information and clearly defining the contribution to be made by each provider.

Case conferences can be conducted for patients who are in the community, in an aged-care residential facility or who are being discharged from hospital. There are 18 different Medicare item numbers that apply to case conferences. These numbers

differ in terms of the duration of the case conference, the category of the patient involved, and if the GP organises and coordinates or only participates in the case conference. The GP needs to obtain the patient's consent for the provision of a case conference service.

To conduct a case conference, a GP needs to ensure the minimum three members of the multidisciplinary case conference team are present for the whole case conference. In the course of a case conference, the providers have to discuss various aspects of the patient's history and care needs, and how each provider can contribute to managing these needs. In this process the providers agree to, and allocate tasks, amongst themselves, in line with each provider's skills. The GP discusses the outcomes of the case conference with the patient and offers them a written summary. The GP also provides a written summary to the other providers.

GPs can also contribute to another health professional's case conference. When only contributing to a case conference, GPs are required to participate in the case conference, ensure the organiser of the conference has followed the correct procedure and record details of the conference in the patient's file.

In 2001-02, GPs provided around 11 000 case conference services generating Medicare benefits payments of approximately $880 000. DoHA also introduced, as part of the EPC package, the sharing health care initiative to train GPs on how to help their chronically ill patients to be more active in their health-care management (box D.1).

Box D.1 **Sharing health care initiative**

The objective of the sharing health care initiative is to enhance the health-related quality of life for people with chronic diseases by improving their use of the health-care system and encouraging them to work together with health-care professionals to better self-manage their medical condition.

The main component of the initiative is the implementation of 12 demonstration projects (including four community focused Indigenous projects) that test a range of chronic condition self-management models. Education and training sessions for GPs are a significant component of the initiative. These sessions include clinical audits and short training courses. In 2001-02, 48 GPs participated in these training and education sessions.

Source: DoHA (pers. comm., 10 September 2002); Wooldridge (2001).

Domiciliary Medication Management Reviews

The principal objective of Domiciliary Medication Management Reviews (DMMR) (also known as Home Medicines Reviews) is to achieve safe, effective and appropriate use of medicines by detecting and addressing potential medication-related problems that interfere with desired patient outcomes.

A DMMR is a review of a patient's medication management. They are for patients living in a community setting and for whom the quality use of medicines and the risk of medication misadventure might be an issue. GPs claim payments for completing tasks associated with a patient's DMMR through a Medicare billing item.

Before initiating a review, a GP needs to inform the patient about the review and any costs that they might incur, and obtain the patient's consent. The GP refers a patient to the patient's preferred community pharmacy, which organises for a pharmacist to review the patient's medication regime in a home visit. In referring the patient to the pharmacist, the GP provides the patient's details and any relevant clinical information.

After completing a review, the pharmacist discusses the findings with the GP. The GP then reaches an agreement with the patient on any changes the patient needs to make to their current medication regime and develops a written medication management plan. The GP has to offer a copy of the plan to the patient and provide a copy to the pharmacist.

In 2000-01, GPs conducted around 6500 DMMRs, generating Medicare benefits payments of about $658 000 for these reviews. In 2001-02, total Government expenditure on the DMMR program was about $907 000.

GP access to Medicare

Payments to GPs are tied to Medicare billing items. GPs have to meet certain requirements before any services they provide can attract a Medicare benefit. In addition, higher rebates are available for those GPs who satisfy certain vocational registration requirements or who are fellows of the RACGP. GPs not in this category (but are otherwise eligible to bill Medicare) can receive higher rebates if they meet other legislative requirements.

The Medicare access requirements for which GPs undertake administrative activities are:

- vocational registration;
- RACGP fellowship;
- section 3GA placements; and
- other programs.

In 2001-02, total Government expenditure on Medicare was about $8.05 billion. Of this, $2.74 billion were payments made to GPs for non-referred attendances.

Vocational registration

The HIC recognises GPs as vocationally registered if the RACGP certified them as eligible for vocational registration before 24 December 1996 (that is, GPs who had already completed five years of clinical practice at this date) (DoHA, pers. comm., 7 March 2003).

GPs apply to be included on the HIC's vocational register by completing an Application for Certification of Eligibility for Vocational Registration form.

To remain on the register, GPs have to practise predominantly in general practice and continue to participate in RACGP Quality Assurance (QA) and Continuing Professional Development (CPD) programs. Over a three-year period, to meet this criterion, GPs need to have a minimum of 130 QA and CPD points. GPs receive QA and CPD points when they participate in a range of activities that are part of QA and CPD programs. At least 30 points have to come from Group 1 activities, which include clinical audits, supervised clinical attachments or participation in educational activities with approved providers. The remainder come from Group 2 activities, which include attendance at conferences or teaching community groups.

GPs pay an annual administration fee (which varies for members and non-members of the College) to the RACGP to administer their QA and CPD points. The RACGP keeps a record of the number of points gained by each GP and advises the HIC if a GP does not receive enough points. GPs can ask the HIC to remove them from the register. To reapply for listing on the register, GPs complete an Application for Readmission to the Register of Recognised General Practitioner's form.

In 2000-01, 13 324 GPs were on the HIC vocational register (55 per cent of all GPs).

RACGP fellowship

The HIC recognises GPs as RACGP fellows if they have:

- completed a vocational training program and passed the RACGP examination;
- completed a specified time in general practice, and passed the RACGP assessment process; or
- met RACGP requirements for fellowship via other education or qualification arrangements.

The HIC cannot register GPs on both the fellows list and the vocational register. GPs who are eligible for both choose the program under which they want to be recognised. In contrast to GPs on the vocational register, GPs on the fellows list do not have to be predominantly in general practice.

GPs apply to the HIC's RACGP fellows list by completing an Application for Recognition as a General Practitioner form. To remain on the fellows list, GPs have to participate in the RACGP QA and CPD program (discussed earlier). GPs can ask the HIC to remove them from the fellows list. To reapply for listing on the fellows list, GPs complete an Application for Readmission to the Register of Recognised General Practitioners (fellows list) form.

In 2001-02, 5698 RACGP fellows were registered with the HIC (23 per cent of all GPs).

Section 3GA placements

The objective of the 3GA placements program is to enable GPs, subject to Medicare restrictions, to gain temporary access to Medicare when working in approved placements. These approved placements encourage GPs to either achieve further education and training, or to locate in areas of 'workforce need', such as rural and remote areas. There are also other DoHA programs that seek to encourage GPs to locate in areas of workforce shortages, for example, the More Doctors for Outer Metropolitan Areas Measure and the Rural Retention Program (RRP).

The HIC is required to establish and maintain a Register of Approved Placements of GPs. In 2001-02, the programs with the largest numbers of GPs involved were the Rural Locum Relief program and vocational training programs (table D.3).

For each of the three general practice vocational training programs — General Practice Education and Training registrars, RACGP registrars and Pilot Remote Vocational Training registrars — GPs have to apply to the program, complete the

training component and pass the RACGP assessment process. On completion of these programs, registrars can become RACGP fellows.

GPs in the Temporary Resident Other Medical Practitioner program have to complete their RACGP fellowship within a period of five years.

For the remaining three programs, activities are undertaken both by individual GPs who seek access to Medicare, and the practice for which they will be working. In the Rural Locum Relief and the Rural and Remote Area Placements programs, for example, the GP who is seeking a placement and the potential general practice principal need to complete an application form. In addition, the principal of the general practice needs to ensure an adequate level of supervision is available for the GP during the period of placement.

Table D.3 **Types of section 3GA placements, 2001-02**

GP type	*Description*	*Number of GPs*
General Practice Education and Training registrars	Medical practitioners who are in a recognised postgraduate GP training placement with General Practice Education and Training.	445
RACGP registrars	Medical practitioners who are in a recognised postgraduate GP training placement with GP Education Australia (the RACGP's education and training company).	978
Pilot Remote Vocational Training registrars	Medical practitioners who are in a recognised postgraduate GP training placement through the Pilot Remote Vocational Training stream.	11
Approved medical deputising service	Medical practitioners who are in an approved medical deputising service, providing after-hours home visits.	74
Rural Locum Relief	Medical practitioners who are in an approved placement as part of specified rural locum arrangements.	1 307
Rural and Remote Area Placement	Medical practitioners who are in a rural general practice setting for a term of ten to thirteen weeks. This program applies to hospital interns in year 1 to 3 of postgraduate training.	45
Temporary Resident Other Medical Practitioners	Medical practitioners who were temporary resident prior to 1997, who have a period of five years to gain RACGP fellowship. They are also encouraged to practise in areas of workforce need such as rural and remote areas.	74
Total 3GA placements		2 934

Source: DoHA (pers. comm., 7 March 2003); HIC (pers. comm., 10 September 2002).

Other programs

Medical practitioners are able to access either Medicare or certain types of payments through three other programs: the Rural Other Medical Practitioner program; section 19AB exemptions; and the Remote Area Exemption program.

The Rural Other Medical Practitioner program enables medical practitioners, who are otherwise only eligible to access Medicare for Group A2 attendance items, to access the Group A1 attendance items, which provide a higher rebate. These practitioners access the program by applying to the HIC, practising in an approved rural location and agreeing to undertake an alternative pathway to vocational registration. In 2001-02, there were 1430 of these practitioners.

Under section 19AB of the *Health Insurance Act 1973*, overseas trained doctors and former overseas medical students are ineligible for a period of 10 years to provide services that attract Medicare benefits. However, they can obtain an exemption to this restriction by committing to work in a district of workforce shortage, commonly a rural or remote area. These exemptions are time and location specific.

The Remote Area Exemptions program enables GPs in remote areas undertaking R-type diagnostic imaging services, to render these services without a referral from a specialist of diagnostic radiology. To access the program, GPs need to apply (and reapply every three years) and participate in RACGP QA and CPD programs.

Rural and Remote General Practice program

The objective of the Rural and Remote General Practice program is to target the shortage of GPs in rural and remote Australia, and to improve access to quality GP services. The program provides a framework for the delivery of incentives and support strategies for the attraction, recruitment and retention of GPs and their families in rural and remote areas.

The program is administered by the State- and Northern Territory-based RWAs. The RWAs are responsible for identifying areas where there is an under-supply of GPs and for developing strategies to improve access to general practice services. As part of this role, the RWAs are required to maintain a Workforce and Skills Minimum Data Set, which contains GP workforce information, including GP workforce skills and participation in CPD. To collect this information, the RWAs often conduct surveys of GPs (sub 23, pp. 36–37). The RWAs, in turn, provide assistance to GPs through various incentive schemes.

GPs can participate in RWAs' surveys. GPs also need to complete some forms to receive financial incentives and benefits from the RWAs.

In 2001-02, total Government expenditure on the Rural and Remote General Practice program was $17.2 million.

Rural Retention Program

The objective of the RRP is to encourage GPs to stay longer in rural and remote areas, in order to improve the local community's access to health-care services in these areas.

The RRP is a funding program that provides payments to GPs who practise for at least one year in eligible rural and remote areas. The RRP has two payment components. The major component is the central payments system and the other component is the flexible payments system.

GPs become eligible for central payments when they meet the qualifying period of continuous active service in their location. The HIC uses GPs' Medicare billing records to determine their eligibility.

Once a GP qualifies, the size of the annual payments depends on the GP's location and level of service (determined from their Medicare billing records). To receive payments, GPs are required to complete (on a once-off basis) an Authority for Electronic Funds Transfer form.

The flexible payments system is designed to provide assistance to non-Medicare billing GPs or those for whom Medicare billing records are relatively ineffective in ensuring GPs receive adequate retention payments. These circumstances include where a GP had a period of maternity leave or was located in a very isolated community where the Medicare billing rate does not reflect her workload.

The flexible payments system operates within the same broad framework as the central payments system. That is, the same qualifying periods and maximum annual payment rates apply. To receive flexible payments, GPs are required to complete a Rural Retention Program Flexible Payments System Application form, providing information on their personal details, medical practising history and why they are applying for flexible payments.

The main difference between central and flexible payments is that eligibility for, and the level of, payments are calculated by the RWAs, based on both the GP's Medicare billing records and additional information the GP provides in an application form.

In 2001-02, 2010 GPs received central payments under the RRP (data on flexible payments are not available). Each GP received, on average, about $7200 in payments through the RRP (around $14.6 million total for Australia). In 2001-02, total Government expenditure on RRP was about $14.8 million.

General Practice Registrars Rural Incentive Payments scheme

The objective of the General Practice Registrars Rural Incentive Payments scheme is to encourage GP registrars to train in rural and remote areas and to improve the local community's access to health-care services in these areas. GP registrars have to be registered in the Rural Training Pathway of the Australian General Practice Training Program and be undertaking the majority of their training in a rural and remote area (other than a large rural centre).

To enrol in the program, GP registrars complete a registration form. Then, after an appropriate period of service (minimum of 6 months), the registrars complete a Claim for Payment form that provides the HIC with their service details, including the location of the training practice and any leaves of absence. This form also has to be signed by their supervisor. They complete this Claim for Payment form every six months.

Since 2001, 494 GP registrars have claimed General Practice Registrars Rural Incentive Payments scheme payments. In 2001-02, total payments to GPs under this scheme were about $3.8 million. In the same year, total Government expenditure on the scheme was about $4.1 million.

Rural Women's GP Service

The objective of the Rural Women's GP Service program is to improve access to health services for women in rural Australia by providing greater access to female GPs. DoHA contracts the Royal Flying Doctor Service to provide regular female GP clinics to communities that currently have little or no access to a female GP. In these clinics, female GPs provide mostly female-specific services including, cervical cancer screening, breast and skin examinations, and other preventive health care. In addition, the GPs identify and provide necessary intervention for other conditions, such as cardiovascular disease.

The female GPs involved in this program are required to travel to designated locations to conduct clinical sessions and are also asked to provide a statistical report to the Royal Flying Doctor Service. GPs are encouraged to attend Royal

Flying Doctor Service in-service sessions. These sessions involve discussions about the program and educational lectures on relevant topics.

GPs are paid for their involvement in the program (including for educational sessions). Each Royal Flying Doctor Service has its own payment arrangements. In 2001-02, there were 69 GPs involved in the Rural Women's GP Service. These GPs conducted 624 clinics in 99 location. In 2001-02, total Government expenditure on the Rural Women's GP Service program was about $2.1 million.

Arrangement for Aboriginal Community Controlled Health Services to access Medicare funding

The objective of the arrangement under which Aboriginal Community Controlled Health Services (ACCHS) access Medicare funding for services provided by their GP employees is to improve the access of the Aboriginal and Torres Strait Islander communities to primary health-care services. DoHA approves ACCHS access to Medicare on the condition that these funds are used for additional primary health-care services.

ACCHS gain access to Medicare payments for services provided by their employed GPs by applying for an exemption from sub-section 19(2) of the *Health Insurance Act 1973*. In their application, the ACCHS provide details of their status as an autonomous Aboriginal and Torres Strait Islander community controlled health service. Once approved, ACCHS do not need to re-apply again.

To facilitate ACCHS Medicare access, GPs provide written authority to the HIC allowing it to pay Medicare benefits directly to the services. ACCHS also provide the HIC with written endorsement of the arrangement, their GPs' Medicare provider number and the service's bank account details.

Twice a year, all ACCHS with these arrangements are required to report to HIC on the ACCHS and the GPs practising within them.

In 2002, 108 ACCHS were eligible for this program, involving 400 GPs. About one ACCHS applies for access to Medicare payments each year. In 2001-02, total Government expenditure on the ACCHS program was $224.2 million.

More Doctors for Outer Metropolitan Areas Measure

The objective of the More Doctors for Outer Metropolitan Areas Measure is to increase the supply of doctors working in outer metropolitan areas of the six State capital cities experiencing shortages of medical practitioners.

There are two programs under the measure that impact on GPs. The Outer Metropolitan Other Medical Practitioners program allows non-vocationally recognised GPs access to higher Medicare rebates, if they agree to work in a outer metropolitan area of workforce shortage and are prepared to participate in a vocational recognition program. This program commenced on 9 January 2003.

The second program is the Outer Metropolitan Registrars program. This requires GP registrars who are enrolled in the General Training Pathway of the Australian General Practice Training Program undertake a supervised placement in an outer metropolitan area of workforce shortage. This program commenced with the 2003 intake of registrars.

In 2001-02, total Government expenditure on the Doctors for Outer Metropolitan Areas Measure was about $140 000.

D.2 Programs to promote population health

Australian Childhood Immunisation Register

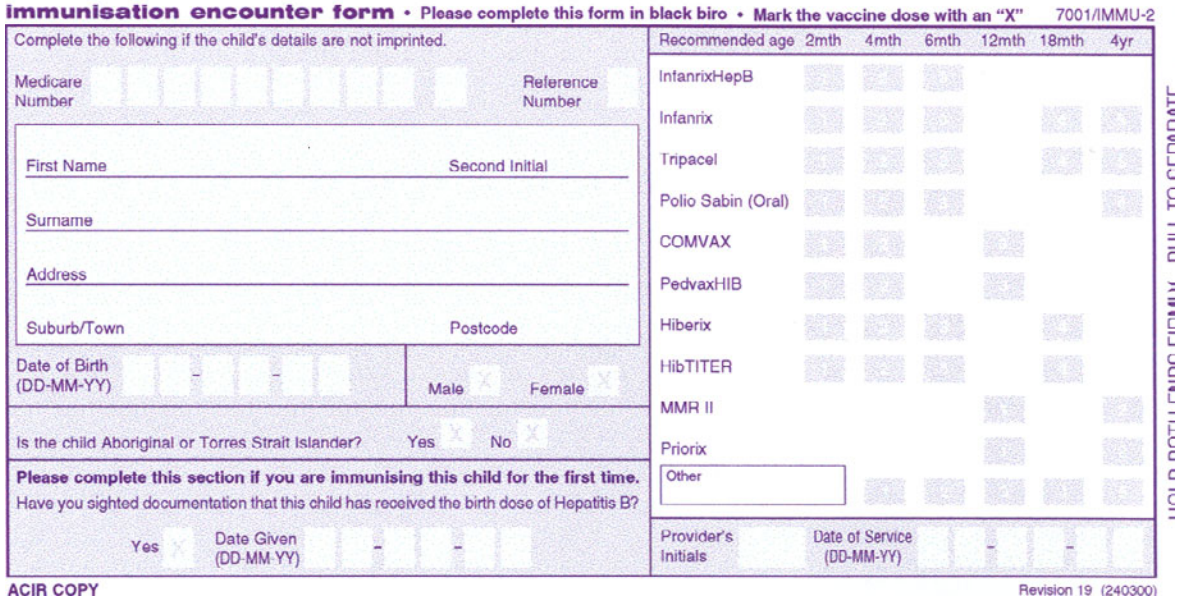
The objectives of Australian Childhood Immunisation Register (ACIR) are to promote age-appropriate childhood immunisation, improve the level of immunisation service delivery and increase the level of immunisation coverage for children under seven years of age.

ACIR is a national database containing information on the immunisation status of all Australian children under seven years of age. The HIC collects information about childhood immunisations from recognised immunisation providers. About half of all recognised immunisation providers are medical practitioners — predominantly GPs. The HIC also uses ACIR to administer the General Practice Immunisation Incentives (GPII) scheme (see below).

The HIC and DoHA are working to enhance the flow of information between immunisation providers and ACIR. This includes working with software developers to improve the ability of practice desktop software to upload immunisation data to ACIR, and improving feedback to practices and divisions through better reporting in electronic format (DoHA, sub. 23, p. 5).

GPs are automatically recognised as immunisation providers once they are entitled to bill Medicare (that is, they have a Medicare provider number). GPs provide information on immunisations to the HIC using ACIR Immunisation Encounter form (figure D.1).

Figure D.1 **ACIR Immunisation Encounter form**


immunisation encounter form • Please complete this form in black biro • Mark the vaccine dose with an "X" 7001/IMMU-2

Complete the following if the child's details are not imprinted.

Medicare Number

Reference Number

First Name

Second Initial

Surname

Address

Suburb/Town

Postcode

Date of Birth (DD-MM-YY)

Male

Female

Is the child Aboriginal or Torres Strait Islander? Yes No

Please complete this section if you are immunising this child for the first time.

Have you sighted documentation that this child has received the birth dose of Hepatitis B?

Yes

Date Given (DD-MM-YY)

Recommended age	2mth	4mth	6mth	12mth	18mth	4yr
InfanrixHepB						
Infanrix						
Tripacel						
Polio Sabin (Oral)						
COMVAX						
PedvaxHIB						
Hiberix						
HibTITER						
MMR II						
Priorix						
Other						

Provider's Initials

Date of Service (DD-MM-YY)

HOLD BOTH LABELS FIRMLY, PULL TO SEPARATE

ACIR COPY

Revision 19 (240300)

Source: DoHA (pers. comm., 20 March 2003).

If ACIR does not have the complete immunisation history of the child and another provider performed the service, GPs might also complete an immunisation history report (ACIR Immunisation History form).

If a GP wants an ACIR-registered child's immunisation report, he or she has to accept the terms associated with ACIR legislation for using and storing these data. To do this, a GP undertakes an Agreement under Section 46E(2) of the *Health Insurance Act 1973*.

GPs sometimes complete other forms to assist families to satisfy the immunisation eligibility requirements of the Child Care Benefit or Maternity Immunisation Allowance. If a child's parents conscientiously object to their child's immunisation, then the GP completes an Exemption from Vaccination Because of Conscientious Objection form. If a GP considers there is a medical reason for the child not being immunised, then the GP completes a Declaration of Vaccine Exemption due to Medical Contraindication form.

GPs can complete all the activities (forms) manually. Some activities (forms) can be completed online or via an electronic data interchange system. To gain access to ACIR electronic or online facilities, GPs request access and accept the terms and conditions associated with these facilities. GPs also provide the HIC with their account details so that they can receive payments.

In 2001-02, GPs received funding of approximately $5 million in ACIR payments. In 2001-02, total Government expenditure on the ACIR program was $12.2 million.

General Practice Immunisation Incentives scheme

The objectives of the GPII scheme are to improve the levels of immunisation coverage and service delivery, and to encourage at least 90 per cent of general practices to have at least 90 per cent of children in their practice fully immunised.

The HIC, through the GPII scheme, provides incentive payments to GPs and general practices that monitor, promote and provide age-appropriate immunisations to children under seven years of age. The GPII scheme was implemented using ACIR infrastructure to minimise the additional administrative activities GPs have to undertake in order to receive GPII incentive payments. There are three types of payments:

- service incentive payments — a payment made automatically to GPs who provide information to ACIR on a child's completed immunisations schedule;
- practice outcome payments — a tiered series of payments made to practices that achieve a certain immunisation coverage rate; and
- immunisation infrastructure funding — funding for organisations such as the divisions of general practice, who assist GPs in increasing the proportion of children immunised.

Practices already enrolled in PIP are automatically enrolled in the GPII scheme and are eligible to receive practice outcome payments. In addition, GPs providing immunisation information to ACIR automatically receive service incentive payments. Practices not already enrolled in PIP apply to the GPII scheme by completing an application form.

Practices can also complete a GPII Practice Report Request form to receive a hard copy report on children in their practice that are not fully immunised. Practices only apply for their first report; thereafter the HIC automatically generates and sends the report quarterly. Alternatively, GPs download the report from the HIC's secure website. Practices spend time analysing this report and following up on any children not fully immunised.

Over 5500 practices currently participate in the GPII scheme. In 2001-02, GPs received approximately $20 million in service incentive payments and practices received about $17 million in outcome payments (HIC 2002). In the same year, total Government expenditure on the GPII scheme was about $43 million.

D.3 Programs relating to providing information to departments and others

Pharmaceutical Benefits Scheme

The objective of the Pharmaceutical Benefits Scheme (PBS) is to provide Australians with affordable, reliable and timely access to necessary and cost-effective medicines. PBS medicines are available to all Australian residents and visitors from countries with which Australia has a Reciprocal Health Care Agreement.

Most medicines available on prescription are subsidised under the PBS. Medical practitioners — including specialists, GPs and other non-specialists — might prescribe PBS medicines. Generally, GPs are eligible to prescribe PBS medicines once they are entitled to bill Medicare and have been granted a PBS prescriber number. The PBS also provides for participating dental practitioners to prescribe certain medicines for dental treatment only.

In certain circumstances, patients can only receive PBS subsidised medicine if their GP seeks an authorisation from the HIC (at present authorities are generally completed by phone or in writing). These circumstances are:

- where it is an authority-required medicine — there are currently 309 medicines that require HIC authority approval; or
- where it is a non-authority-required medicine — prescribed at an increased number of repeats or a quantity greater than the maximum listed in the Schedule of Pharmaceutical Benefits.

GPs undertaking PBS authorisations provide information to the HIC, including their prescribing approval details, the patient's Medicare number and details regarding the patient's medical condition.

PBS authorisations can be completed over the telephone on the HIC's free-call number. After receiving telephone approval, GPs write an authority prescription for the patient and retain a copy on file for 12 months. PBS authorisations can also be completed manually through a free-mail service.

An electronic online computer based system is expected to be implemented on 1 August 2003, permiting instant processing of PBS authorisations. This is expected to reduce the time it takes GPs to obtain PBS authority approvals (DoHA pers. comm., 6 December 2002).

In 2001-02, about 19 000 GPs undertook 3.2 million phone authorisations and 7500 GPs undertook about 185 000 written authorities. In 2001-02, total Government expenditure on the PBS was in the order of $4.63 billion (which includes $4.58 billion on Pharmaceutical Benefits paid).

Commonwealth Hearing Services program

The objective of the Commonwealth Hearing Services program is to provide access for eligible adults to hearing services and products. Under the program, DoHA provides eligible adults with a hearing services voucher that entitles them, free of charge, to a hearing assessment, hearing rehabilitation, and the selection and fitting of hearing aids. A person seeking to participate in the program completes an Application for Hearing Services Voucher for Adult Applicants form.

A medical practitioner (GP or specialist) is required to complete the referral section (section B) of the application form for new applicants (figure D.2). Existing applicants can have the referral section completed by a medical practitioner or a hearing service provider.

In 2001-02, GPs completed about 89 500 Applications for Hearing Services Voucher for Adult Applicants. In 2001-02, total Government expenditure on the Commonwealth Hearing Service program was $177.6 million.

Private health insurance regulations

Under health insurance legislation, private health insurance funds are entitled to request information on a patient's condition or an explanation of why the patient is receiving a certain level of hospital care. The legislation relates to:

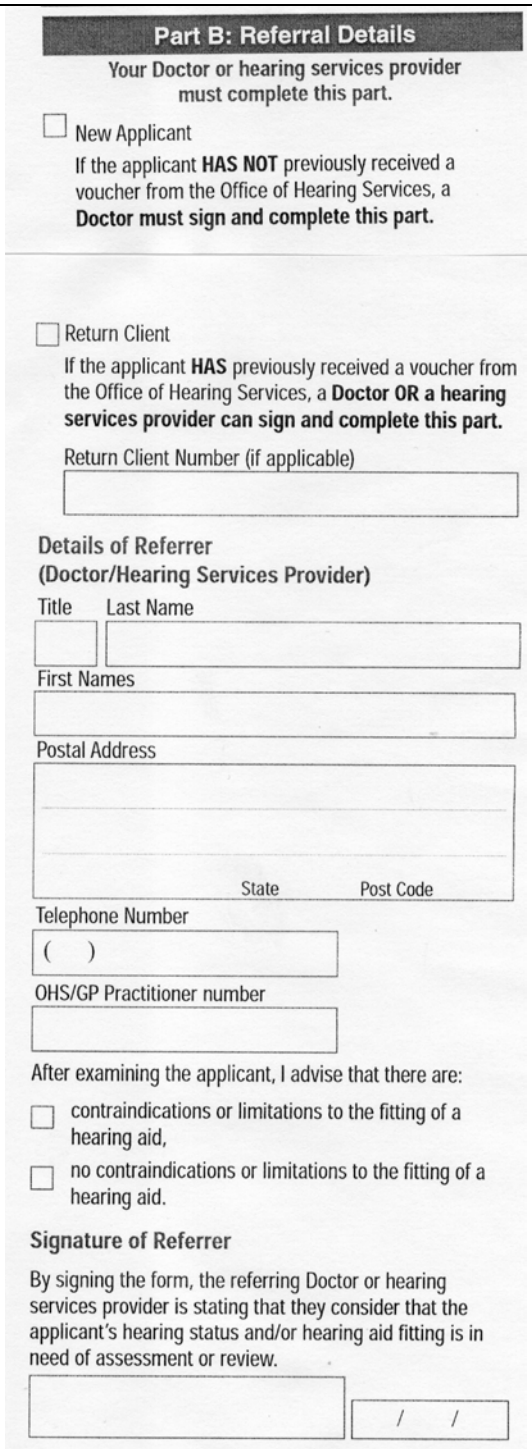
- pre-existing ailment waiting period — private health insurance funds can seek information on the signs and/or symptoms associated with a member's illness requiring hospital treatment, if the member recently improved their health insurance status (that is, entered into, or upgraded, their private health insurance);
- overnight certification — private health insurance funds can seek information on why a patient was admitted to hospital for an overnight stay, when they have undergone medical treatment that usually only requires a day visit to hospital; and
- acute-care certification — private health insurance funds can seek information on why a patient, who was in hospital continuously for 35 days, still requires acute care.

GPs might be required by the health insurance funds to complete forms that provide the funds with relevant information, for example, the pre-existing ailment waiting period form. Fewer GPs complete forms in relation to the acute-care and overnight certification programs because they only apply to GPs who can admit patients to hospitals.

Informed financial consent

Under legislation relating to informed financial consent, private health insurance members are entitled to receive an estimate of any 'gap' costs (costs that are not met by their combined private health insurance fund and Medicare benefits) they have to pay before they receive hospital treatment. A GP must provide an estimate and receive a patient's written acknowledgment prior to in-hospital episodes of care where this care is provided under an approved gap cover scheme, as detailed in the *National Health Act 1953*. These requirements only affect GPs who can admit patients to hospitals and who charge their patients 'gap' costs.

Figure D.2 **Application for Hearing Services Voucher for Adult Applicants section B — referral by medical practitioner**



Part B: Referral Details

Your Doctor or hearing services provider must complete this part.

☐ New Applicant

If the applicant **HAS NOT** previously received a voucher from the Office of Hearing Services, a **Doctor must sign and complete this part.**

☐ Return Client

If the applicant **HAS** previously received a voucher from the Office of Hearing Services, a **Doctor OR a hearing services provider can sign and complete this part.**

Return Client Number (if applicable)

Details of Referrer (Doctor/Hearing Services Provider)

Title Last Name

First Names

Postal Address

State Post Code

Telephone Number

( )

OHS/GP Practitioner number

After examining the applicant, I advise that there are:

☐ contraindications or limitations to the fitting of a hearing aid,

☐ no contraindications or limitations to the fitting of a hearing aid.

Signature of Referrer

By signing the form, the referring Doctor or hearing services provider is stating that they consider that the applicant's hearing status and/or hearing aid fitting is in need of assessment or review.

/ /

Source: DoHA (pers. comm., 27 September 2002).

D.4 Data

Programs to influence the quality and availability of general practice services

Practice Incentives Program

Table D.4 **Practices participating in PIP, by element and region, 2001-02[a, b]**

	IM and IT			*After-hours care*						*Sign-on for new incentives*			
Region	*Tier 1*	*Tier 2*	*Tier 3*	*Tier 1*	*Tier 2*	*Tier 3*	*Care Planning*	*Teaching*	*QPI*	*Asthma*	*Diabetes*	*Cervical Screening*	*Practice nurses*
Inner capital city	2 243	1 755	1 791	2 099	1 284	456	364	231	637	1 776	1 764	1 822	..
Outer capital city	894	730	735	841	563	248	179	78	204	740	739	758	9
Other metropolitan	376	309	303	355	241	90	70	53	69	290	291	297	15
Large rural centre	296	262	260	286	237	81	52	42	76	259	264	264	163
Small rural centre	286	249	247	269	246	104	53	47	65	237	236	246	168
Other rural area	602	526	523	580	539	293	80	115	140	503	503	512	337
Remote	133	98	98	119	100	73	22	17	20	98	100	103	58
Total	4 830	3 929	3 957	**4 549**	**3 210**	**1 345**	820	583	1 211	3 903	3 897	**4 002**	**750**

a Regions based on DoHA's Rural, Remote and Metropolitan Areas (RRMA) classification. This classification normally has seven categories — two metropolitan (capital city and other metropolitan areas), three rural (large rural centres, small rural centres and other rural areas) and two remote (remote centres and other remote areas). The Commission disaggregated capital city into two areas (inner and outer) and grouped all remote into one category. **b** The number of practices participating in most elements for each financial year is the average of the number participating in each of the four quarters. The exceptions are the quality prescribing initiative and the sign on incentive payments elements, which gives the total number of practices that participated over the financial year. .. Not applicable.

Source: HIC (pers. comm., 8 October 2002).

Table D.5 **PIP payments, by element and region, 2001-02[a]**

$'000

	IM and IT			*After-hours care*						*Sign-on for new incentives*				
Region	*Tier 1*	*Tier 2*	*Tier 3*	*Tier 1*	*Tier 2*	*Tier 3*	*Care Planning*	*Teaching*	*QPI*	*Asthma*	*Diabetes*	*Cervical Screening*	*Practice nurses*	*Rural loading*
Inner capital city	16 400	9 302	9 427	10 485	7 209	1 943	1 238	604	1 454	1 170	4 620	1 197	..	..
Outer capital city	8 281	4 768	4 811	5 269	3 902	1 513	668	239	581	593	2 360	604	125	108
Other metropolitan	3 143	1 841	1 827	2 030	1 526	521	363	112	173	217	867	221	156	34
Large rural centre	2 822	1 733	1 733	1 843	1 657	611	222	156	284	215	864	218	1 855	2 151
Small rural centre	3 000	1 872	1 836	1 944	1 846	949	344	203	253	220	870	227	2 011	3 136
Other rural area	4 668	2 862	2 840	3 033	2 864	1 600	436	621	342	341	1 364	348	3 232	9 651
Remote	624	336	326	383	319	217	35	85	35	40	161	41	364	1 119
Total	**38 938**	**22 714**	**22 800**	**24 987**	**19 323**	**7 354**	**3 306**	**2 020**	**3 122**	**2 796**	**11 106**	**2 856**	**7 743**	**16 199**

a An explanation of RRMAs is included in table D.4 (note **a**). **..** Not applicable.

Source: HIC (pers. comm., 31 January 2003).

Table D.6 **Practices participating in PIP, by element and socio-economic area, 2001-02[a, b]**

	IM and IT			*After-hours care*						*Sign-on for new incentives*			
SEIFA classification	*Tier 1*	*Tier 2*	*Tier 3*	*Tier 1*	*Tier 2*	*Tier 3*	*Care Planning*	*Teaching*	*QPI*	*Asthma*	*Diabetes*	*Cervical Screening*	*Practice nurses*
Most disadvantaged	347	267	276	317	200	85	69	28	77	268	266	272	32
-4	470	375	377	438	297	122	71	45	114	378	378	387	107
-3	431	352	342	402	292	107	83	56	106	351	353	361	129
-2	364	308	311	341	266	104	70	54	86	291	301	301	136
-1	425	342	348	405	286	129	81	55	105	347	351	359	107
0	404	333	337	385	300	126	63	51	77	327	327	334	98
1	468	379	386	448	311	150	69	58	107	377	375	385	71
2	358	287	288	340	239	121	74	43	90	302	299	308	36
3	417	345	342	403	278	112	81	54	122	344	340	354	20
4	545	448	455	510	354	120	79	63	154	445	436	450	10
Least disadvantaged	576	471	473	538	373	157	73	72	166	450	448	467	1
Other[c]	26	20	20	24	16	11	8	3	7	23	23	24	6
Total[d]	**4 831**	**3 927**	**3 955**	**4 551**	**3 212**	**1 344**	**821**	**582**	**1 211**	**3 903**	**3 897**	**4 002**	**753**

a Based on the ABS's 1996 Index of Relative Disadvantage, which is an index derived from attributes such as low income, low education attainment, high unemployment and jobs in relatively unskilled occupations (using data from the 1996 Census). Eleven Socio-Economic Indexes for Areas (SEIFA) categories were derived by DoHA by sorting postcodes into ascending order according to the value of the SEIFA index. Postcodes were then assigned into 11 groups, each with equal numbers. The lowest classification corresponds to areas that are the most disadvantaged, and the highest to the least disadvantaged. **b** An explanation of the number of practices participating in each element is included in table D.4 (note **b**). **c** Number of activities undertaken by practices located in postcodes that were not able to be assigned into one of 11 areas. **d** Totals based on SEIFA might not be the same as RRMA as a result of rounding.

Source: HIC (pers. comm., 8 October 2002).

Table D.7 **PIP service incentive elements, by type, 2001-02**

Type	*Services*[a]	*GPs participating*[b]
Asthma	27 670	2 780
Diabetes	76 286	4 438
Cervical screening	30 114	4 670
Total	**134 070**	**6 922**[c]

a Number of services from November 2001 to July 2002. **b** Number of GPs from November 2001 to June 2002. **c** Total number of GPs is not the sum of the numbers of GPs participating in each service incentive type because GPs can participate in more than one type.

Source: HIC (pers. comm., 10 February 2003); HIC (2003).

Table D.8 **PIP forms completed, 2001-02**

Type of form	*Number*
PIP Application	3 102[a]
Teaching sessions	2 766
Service incentive payments banking details	1 747
PIP practice nurse incentive application	892[b]
Registration for PIP service incentive 'sign on' payments	na
Additional or new practitioner details	na
PIP confirmation statement	na

a Total applications since July 1999. **b** Includes applications for employing an Aboriginal health worker. **na** Not available.

Source: HIC (pers. comm., 17 September 2002).

Quality Innovative Funding

No additional data were provided on this program (section D.1).

Table D.9 **GPs participating in EPC, by region, 2001-02[a, b]**

	Care plans			*Care conferences*					*Health assessments*		
Region	*Organise aged care*	*Organise*	*Review*	*Organise aged care*	*Organise*	*Participate aged care*	*Participate*	*DMMRs*	*Patient's Home*	*Indigenous*	*Surgery*
Inner capital city	271	2 895	1 450	273	433	158	372	480	2 484	113	2 918
Outer capital city	70	1 464	754	80	166	59	155	169	1 087	63	1 188
Other metropolitan	43	567	288	49	73	29	79	86	496	24	544
Large rural centre	11	445	219	31	88	20	71	61	406	59	486
Small rural centre	47	570	263	38	123	12	102	69	431	44	507
Other rural area	43	900	420	111	278	63	192	75	800	78	821
Remote	na	110	44	18	34	na	27	na	48	53	81
Total[c]	**485**	**6 762**	**3 397**	**595**	**1 189**	**341**	**996**	**940**	**5 678**	**432**	**6 424**

a An explanation of RRMAs is included in table D.4 (note **a**). **b** The number of GPs providing EPC services was calculated at each location where services were provided rather than the major practice location of the GP. GPs included in this number are only those who had at least 1500 total non-referred attendances in the reference period. **c** Totals are not the sum of the RRMAs as some GPs provide the same services in more than one RRMA. **na** Not available.

Source: DoHA (pers. comm., 30 October 2002).

Table D.10 **EPC services, by region, 2001-02[a]**

	Care plans			*Care conferences*					*Health assessments*		
Region	*Organise aged care*	*Organise*	*Review*	*Organise aged care*	*Organise*	*Participate aged care*	*Participate*	*DMMRs*	*Patient's Home*	*Indigenous*	*Surgery*
Inner capital city	5 103	78 202	33 028	952	2 139	508	809	3 647	33 738	240	38 925
Outer capital city	1 082	43 393	17 449	306	441	177	322	1168	12 949	143	13 754
Other metropolitan	819	17 550	10 534	445	172	84	137	601	9 212	55	8 350
Large rural centre	119	11 149	5 720	49	203	42	172	291	5 447	227	6 487
Small rural centre	451	13 749	7 422	149	641	46	223	402	5 419	103	8 019
Other rural area	455	18 839	6 614	524	966	203	600	336	9 556	276	10 056
Remote	na	2 070	758	84	254	na	62	na	444	373	790
Total	**8 033**	**184 952**	**81 525**	**2 509**	**4 816**	**1 060**	**2 325**	**6 445**	**76 765**	**1 417**	**86 381**

a An explanation of RRMAs is included in table D.4 (note **a**). **na** Not available**.**

Source: DoHA (pers. comm., 30 October 2002).

Table D.11 **EPC payments, by region, 2001-02[a]**

$'000

	Care plans			*Care conferences*					*Health assessments*		
Region	*Organise aged care*	*Organise*	*Review*	*Organise aged care*	*Organise*	*Participate aged care*	*Participate*	*DMMRs*	*Patient's Home*	*Indigenous*	*Surgery*
Inner capital city	167	12 693	2 627	84	195	34	55	372	6 022	35	4 918
Outer capital city	35	7 047	1 408	25	43	13	21	119	2 310	20	1 737
Other metropolitan	27	2 844	849	37	15	6	9	61	1 643	8	1 054
Large rural centre	4	1 806	455	4	20	3	14	30	972	30	819
Small rural centre	15	2 228	597	13	56	3	16	41	966	15	1 012
Other rural area	15	3 054	522	44	81	13	42	34	1 706	38	1 270
Remote	na	336	61	7	21	na	5	na	79	53	100
Total	**263**	**30 008**	**6 519**	**214**	**431**	**72**	**162**	**657**	**13 698**	**199**	**10 910**

a An explanation of RRMAs is included in table D.4 (note **a**). **na** Not available**.**

Source: DoHA (pers. comm., 30 October 2002).

Table D.12 **GPs participating in EPC, by socio-economic area, 2001-02[a, b]**

	Care plans			*Care conferences*					*Health assessments*		
SEIFA classification	*Organise aged care*	*Organise*	*Review*	*Organise aged care*	*Organise*	*Participate aged care*	*Participate*	*DMMRs*	*Patient's Home*	*Indigenous*	*Surgery*
Most disadvantaged	19	548	243	na	70	12	52	49	385	42	403
-4	48	665	319	50	108	23	92	88	485	47	685
-3	34	683	331	53	125	32	95	88	566	62	646
-2	45	619	286	49	130	24	84	62	474	76	520
-1	na	721	380	49	109	28	96	97	510	52	598
0	22	594	261	50	89	36	89	76	473	33	540
1	46	617	286	46	105	20	116	98	507	28	628
2	29	609	317	39	93	na	70	90	481	25	540
3	53	713	339	62	109	33	85	87	594	26	642
4	58	757	400	65	106	50	101	103	716	22	737
Least disadvantaged	119	778	389	111	151	72	117	116	751	21	826
Other[c]	na	53	33	na	7	na	6	10	33	5	32
Total[d]	**485**	**6 762**	**3 397**	**595**	**1 189**	**341**	**996**	**940**	**5 678**	**432**	**6 424**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** An explanation of how the number of GPs providing EPC services was calculated is included in Table D.9 (note **b**). **c** Number of GPs located in postcodes that were not able to be assigned into one of 11 areas. **d** Totals are not the sum of the SEIFAs as some GPs provide the same services in more than one SEIFA . **na** Not available.

Source: DoHA (pers. comm., 30 October 2002).

Table D.13 **EPC services, by socio-economic area, 2001-02**[a]

	Care plans			*Care conferences*					*Health assessments*		
SEIFA classification	*Organise aged care*	*Organise*	*Review*	*Organise aged care*	*Organise*	*Participate aged care*	*Participate*	*DMMRs*	*Patient's Home*	*Indigenous*	*Surgery*
Most disadvantaged	313	15 667	7 196	na	208	38	172	340	5 406	230	5 856
-4	672	16 553	7 505	273	397	78	282	695	6 058	155	10 445
-3	505	17 701	7 851	161	543	93	187	712	6 820	199	10 018
-2	676	17 315	8 888	282	495	55	210	486	8 026	275	6 469
-1	na	22 094	8 694	205	573	73	180	612	6 645	140	7 639
0	458	14 427	6 119	190	384	88	187	412	5 957	100	6 617
1	635	14 089	6 192	289	435	44	310	934	5 658	64	9 026
2	401	16 846	8 643	156	238	na	87	750	6 257	91	5 467
3	978	15 301	6 095	274	453	135	220	587	8 401	70	6 931
4	1 018	17 174	7 726	203	434	91	211	495	8 871	28	8 682
Least disadvantaged	2 198	15 843	5 679	343	629	353	258	405	8 369	49	9 017
Other[b]	na	1 942	937	na	27	na	21	23	297	16	214
Total	**7 854**	**184 952**	**81 525**	**2 376**	**4 816**	**1 048**	**2 325**	**6 451**	**76 765**	**1 417**	**86 381**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Number of activities undertaken by GPs located in postcodes that were not able to be assigned into one of 11 areas. **na** Not available.

Source: DoHA (pers. comm., 30 October 2002).

Table D.14 **EPC payments by socio-economic area, 2001-02**[a]

$'000

	Care plans			*Care conferences*					*Health assessments*		
SEIFA classification	*Organise aged care*	*Organise*	*Review*	*Organise aged care*	*Organise*	*Participate aged care*	*Participate*	*DMMRs*	*Patient's Home*	*Indigenous*	*Surgery*
Most disadvantaged	10	2 543	579	na	19	2	10	35	965	32	740
-4	22	2 687	605	24	32	5	20	71	1 081	22	1 320
-3	17	2 868	626	14	47	7	13	73	1 216	28	1 265
-2	22	2 808	719	25	42	4	15	49	1 432	37	816
-1	na	3 586	702	20	51	5	13	62	1 187	21	965
0	15	2 340	489	16	38	6	13	42	1 063	14	835
1	21	2 286	488	23	35	3	20	95	1 009	9	1 140
2	13	2 733	694	12	22	na	6	77	1 117	14	690
3	32	2 480	486	22	41	9	16	60	1 500	11	875
4	33	2 788	614	16	43	7	14	50	1 582	4	1 097
Least disadvantaged	72	2 573	443	32	58	23	19	41	1 494	8	1 140
Other[b]	na	314	74	na	2	na	1	2	53	2	27
Total	**257**	**30 006**	**6 519**	**204**	**430**	**71**	**160**	**657**	**13 699**	**202**	**10 910**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Payments to GPs located in postcodes that were not able to be assigned into one of 11 areas. **na** Not available.

Source: DoHA (pers. comm., 30 October 2002).

GP access to Medicare programs

Table D.15 **Participation in GP access to Medicare, 2001-02**

Program	*GPs*	*Locations*
Vocational registration	13 324	na
RACGP fellowship	5 698	na
3GA programs		
General Practice Education and Training registrars	445	na
RACGP registrars	978	na
Pilot Remote Vocational Training registrars	11	na
Approved medical deputising service	74	na
Rural Locum Relief	1 307	2 382
Rural and Remote Area Placement	2	na
Temporary Resident Other Medical Practitioners	77	na
Other programs		
Rural Other Medical Practitioner	1 430	3 802
Section 19AB	1 379	4 910
Remote Area Exemption	663	na

na Not available.

Source: HIC (pers. comm., 10 September 2002); DoHA (pers. comm., 6 December 2002 and 7 March 2003).

Table D.16 **Forms completed for GP access to Medicare, 2001-02**

Form	*Number*
Application for Certification of Eligibility for Vocational Registration	4
Application for Re-Admission to the Register of Recognised General Practitioners (Vocational Register)	46
Request for Removal from the Vocational Register	206
Application for Recognition as a General Practitioner (RACGP fellow)	420
Application for Re-Admission to the Register of Recognised General Practitioners (fellows list)	30
Request for Removal from the fellows list	160
Application for Recognition as a General Practitioner — Australian General Practice Training Registrar	85
Application for Recognition as a General Practitioner — Australian General Practice Training Registrar	na
Supplementary Application to the Application for a provider number — Rural Locum Relief Program	2 382[a]
Application for Remote Area Exemption for 'R' Type Diagnostic Imaging Services for a Medical Practitioner	221[b]
Section 19AB exemption applications	5 039

a Productivity Commission estimate based on total number of GP placements in the program. **b** Productivity Commission estimate based on the number of GPs in the program. **na** Not available.

Source: HIC (pers. comm., 10 September 2002).

Rural and Remote General Practice program

No additional data provided in relation to this program (section D.2).

Rural Retention Program

Table D.17 **RRP central payments, by region, 2001-02[a]**

Region	*GPs*	*Payments*	*Bank detail forms*
	no.	$'000	no.
Capital city and other metropolitan areas	30	192	9
Large rural centre	50	217	2
Small rural centre	383	2 068	98
Other rural areas	1 144	7 448	188
Remote	305	3 901	76
Total	**1 912**	**13 826**	**373**

a An explanation of RRMAs is included in table D.4 (note **a**). Data for capital cities and other metropolitan areas are combined.

Source: HIC (pers. comm., 9 December 2002).

General Practice Registrars Rural Incentives Program

Table D.18 **GPRRIP by region, 2001-02[a, b]**

Region	*GPs*[c]	*Payments*	*Claim for payment forms*
	no.	$'000	no.
Capital city	65	672	85
Other metropolitan areas and large rural centre	39	565	51
Small rural centre	102	1 290	166
Other rural areas	211	2 542	348
Remote centres	40	520	59
Other remote areas	37	462	58
Total	**494**	**6 051**	**767**

a An explanation of RRMAs is included in table D.4 (note **a**). Data in relation to other metropolitan areas and large rural centres are combined. **b** Data relates to the period January 2001 to 9 December 2002. **c** The total number of GPs who claimed payments. A total of 450 GPRRIP registration forms have also been completed.

Source: HIC (pers. comm., 9 December 2002).

Rural Women's GP Service

No additional data provided in relation to this program (section D.2).

Aboriginal Community Controlled Health Services

No additional data provided in relation to this program (section D.2).

More Doctors for Outer Metropolitan Areas Measure

No data available in relation to this measure (some programs commenced January 2003 and DoHA is processing applications).

Programs to promote population health

Australian Childhood Immunisation Register

Table D.19 **ACIR notifications, by type and region, 2001-02[a]**

Region	*Not classified*	*Electronic data interchange*	*Manual and Scanning*	*Internet*
Inner capital city	25	143 637	328 503	20 812
Outer capital city	1	83 276	143 639	12 639
Other metropolitan areas	11	39 984	52 101	2 244
Large rural centre	2	39 857	29 474	3 789
Small rural centre	6	19 790	37 901	7 872
Other rural areas	..	39 079	61 835	10 131
Remote	..	11 648	8 699	1 598
Total	**45**	**377 271**	**662 152**	**59 085**

a An explanation of RRMAs is included in table D.4 (note **a**). **..** Not applicable.

Source: HIC (pers. comm., 27 September 2002).

Table D.20 **ACIR notifications, by type and socio-economic area, 2001-02[a]**

SEIFA classification	*Not classified*	*Electronic data interchange*	*Manual and Scanning*	*Internet*
Most disadvantaged	7	22 370	55 070	3 969
-4	1	41 478	67 139	6 327
-3	..	37 707	51 511	4 544
-2	..	24 673	42 463	4 456
-1	17	40 384	46 312	7 474
0	2	44 227	48 860	4 166
1	..	30 383	65 418	5 894
2	6	39 102	43 183	1 762
3	1	31 316	51 428	5 869
4	11	28 736	92 823	7 038
Least disadvantaged	..	33 685	93 086	7 469
Other[b]	..	3 210	4 859	118
Total	**45**	**377 271**	**662 152**	**59 086**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Number of activities undertaken by GPs located in postcodes that were not able to be assigned into one of 11 areas. **..** Not applicable.

Source: HIC (pers. comm., 27 September 2002).

Table D.21 **Other ACIR forms completed, 2001-02**

Type of form	*Number*
Request for online access	1 768
Application for authority to transmit electronically	324
Declaration of Vaccine Exemption due to Medical Contraindication	314
Exemption from Vaccination Because of Conscientious Objection	3 953
Notification of a child having natural immunity	3
ACIR Immunisation History	21 356[a]
Total	27 718

a Total includes immunisation histories completed by all immunisation providers, not only GPs.

Source: HIC (pers. comm., 27 September 2002).

General Practice Immunisation Incentives scheme

Table D.22 **GPII scheme, by region, 2001-02[a]**

Region	*Practices*	*Outcome payments*
	no.	$'000
Inner capital city	2 091	6 224
Outer capital city	907	4 180
Other metropolitan areas	384	1 391
Large rural centre	293	1 272
Small rural centre	286	1 311
Other rural areas	585	1 971
Remote	129	357
Total	**4 675**	**16 705**

a An explanation of RRMAs is included in table D.4 (note **a**).

Source: HIC (pers. comm., 27 September 2002).

Table D.23 **GPII scheme, by socio-economic area, 2001-02[a]**

SEIFA classification	*Practices*	*Outcome payments*
	no.	$'000
Most disadvantaged	345	1 037
-4	464	1 511
-3	426	1 537
-2	361	1 298
-1	401	1 548
0	398	1 610
1	443	1 592
2	350	1 339
3	401	1 529
4	530	1 866
Least disadvantaged	531	1 729
Other[b]	26	109
Total	**4 675**	**16 705**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Number of practices eligible for outcome payments located in postcodes that were not able to be assigned into one of 11 areas.

Source: HIC (pers. comm., 27 September 2002).

Programs relating to providing information to departments and others

Pharmaceutical Benefits Scheme

Table D.24 **PBS authorisations, by type and region, 2001-02[a]**

Region	*Phone*	*Written*	*Total*
Inner capital city	1 394 779	59 823	1 454 602
Outer capital city	617 268	36 915	654 183
Other metropolitan areas	289 375	20 415	309 790
Large rural centre	222 602	20 935	243 537
Small rural centre	250 080	18 448	268 528
Other rural areas	347 880	27 871	375 751
Remote	41 432	1 255	42 687
Total	**3 163 416**	**185 662**	**3 349 078**

a An explanation of RRMAs is included in table D.4 (note **a**).

Source: HIC (pers. comm., 15 October 2002).

Table D.25 **GPs undertaking PBS authorisations, by type and region, 2001-02[a]**

Region	*Phone*	*Written*
Inner capital city	9 468	3 274
Outer capital city	3 553	1 450
Other metropolitan areas	1 429	625
Large rural centre	1 151	517
Small rural centre	1 179	576
Other rural areas	1 913	938
Remote	373	96
Total	**19 066**	**7 476**

a An explanation of RRMAs is included in table D.4 (note **a**).

Source: HIC (pers. comm., 15 October 2002).

Table D.26 **PBS authorisations, by type and socio-economic area, 2001-02[a]**

SEIFA classification	*Phone*	*Written*	*Total*
Most disadvantaged	218 557	13 663	232 220
-4	316 685	22 152	338 837
-3	292 361	23 751	316 112
-2	251 110	15 651	266 761
-1	266 854	16 617	283 471
0	291 957	17 211	309 168
1	285 036	19 815	304 851
2	239 088	13 242	252 330
3	287 328	14 284	301 612
4	346 754	15 286	362 040
Least disadvantaged	349 992	12 952	362 944
Other[b]	17 694	1 038	18 732
Total	**3 163 416**	**185 662**	**3 349 078**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Number of activities undertaken by GPs located in postcodes that were not able to be assigned into one of 11 areas.

Source: HIC (pers. comm., 15 October 2002).

Table D.27 **GPs undertaking PBS authorisations, by type and socio-economic area, 2001-02[a]**

SEIFA classification	*Phone*	*Written*
Most disadvantaged	1 228	445
-4	1 641	673
-3	1 513	647
-2	1 294	592
-1	1 560	649
0	1 514	652
1	1 813	693
2	1 460	582
3	1 852	695
4	2 337	868
Least disadvantaged	2 702	931
Other[b]	152	49
Total	**19 066**	**7 476**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Number of GPs located in postcodes that were not able to be assigned into one of 11 areas.

Source: HIC (pers. comm., 15 October 2002).

Commonwealth Hearing Services

Table D.28 Applications for hearing services voucher for adult applicants, by region, 2001-02[a]

Region	*Applications*
Inner capital city	41 724
Outer capital city	15 528
Other metropolitan areas	7 651
Large rural centre	6 530
Small rural centre	7 198
Other rural areas	9 994
Remote	867
Other[b]	49
Total	**89 541**

a An explanation of RRMAs is included in table D.4 (note **a**). **b** Number of applications completed by GPs located in postcodes that were not able to be assigned to a RRMA classification.

Source: Productivity Commission estimates based on information provided by DoHA (pers. comm., 27 September 2002).

Table D.29 Applications for hearing services voucher for adult applicants, by socio-economic area, 2001-02[a]

SEIFA classification	*Applications*
Most disadvantaged	6 542
-4	10 155
-3	8 870
-2	6 733
-1	7 740
0	7 639
1	8 542
2	6 196
3	8 019
4	9 527
Least disadvantaged	8 624
Other[b]	954
Total	**89 541**

a An explanation of SEIFAs is included in table D.6 (note **a**). **b** Number of activities undertaken by GPs located in postcodes that were not able to be assigned into one of 11 areas.

Source: Productivity Commission estimates based on information provided by DoHA (pers. comm., 27 September 2002).

Programs relating to private health insurance

The Commission was unable to obtain data for these programs.

E Sources of information and data

In this appendix, the Commission outlines the sources of information and data used throughout the report. Information was collected from a variety of sources, including:

- Commonwealth departments and agencies;
- a pilot survey of general practitioners (GPs);
- focus group discussions attended by GPs;
- a review of six Commonwealth Government forms; and
- case studies of GPs.

E.1 Department data

The Commission obtained descriptions of programs and data from the Department of Health and Ageing (DoHA), the Department of Veterans' Affairs (DVA), the Department of Family and Community Services (FaCS), Centrelink, the Health Insurance Commission (HIC) and the Statistical Clearing House. Most of the information from the three key departments (DoHA, DVA and FaCS) is reported in appendices B, C and D.

Departments also provided limited data on estimates of GP administrative time (table E.1); however, due to the limited nature of this information, the Commission sought data from alternative sources (sections E.2 to E.5). Departments also provided information on payments to GPs (table E.2).

Table E.1 **Departmental estimates of GP administrative time**

Average minutes per activity

Program	*Activity*	*GP time*
Department of Health and Ageing		
Pharmaceutical Benefits Scheme	Phone authorisation	1.37
Sharing Health Care Initiative	ACT Flinders education	750.00
Sharing Health Care Initiative	Flinders Uni. education	180.00
Sharing Health Care Initiative	Population health education	2 400.00
Sharing Health Care Initiative	RACGP education	120.00
Sharing Health Care Initiative	RACGP workshop	120.00
Department of Family and Community Services/Centrelink		
Disability Support Pension	Treating Doctor's Report	20.38
Various departments		
Surveys	Forms	59.78

Source: Centrelink (pers. comm., 11 September 2002); DoHA (pers. comm., 24 October and 6 November 2002); Statistical Clearing House (pers. comm., 6 August 2002).

Table E.2 **Commonwealth payments to GPs, 2001-02**

	Type of payment [a]	*Payments to GPs*
		$'000
Program to influence general practice		
Practice Incentives Program (PIP)	Direct	189 000
Programs to influence GP services		
Department of Health and Ageing		
Enhanced Primary Care	Direct	62 880
Vocational registration	Direct[b]	> 493 775[b]
PIP — service incentive payments	Direct	4 200
Domiciliary Medication Management Reviews	Direct	658
Department of Veterans' Affairs		
Prescriber Intervention Feedback Program	None	na[c]
Local Medical Officers	Direct[d]	na
Local Medical Officer forms[e]	None	..
Local Medical Officer selected health services[f]	Direct	12 558[g]
Programs to provide information to assist departmental assessments		
Access to payments		
Department of Family and Community Services / Centrelink		
Disability Support Pension	Indirect[h]	na
Sickness Allowance	Indirect[h]	na
Newstart Allowance	Indirect[h]	na
Youth Allowance	Indirect[h]	na
Mobility Allowance	Indirect	na
Carer Payment	Indirect	na
Carer Allowance	Indirect	na

(Continued next page)

Table E.2 (continued)

	Type of payment[a]	*Payments to GPs*
		$'000
Department of Veterans' Affairs		
Disability Pension	Direct	73.7[i]
Disability Allowances	Direct	24.3
Service Pension	Direct	132.8
Military Compensation Scheme	Direct	na
Access to particular medical products and services		
Department of Health and Ageing		
Pharmaceutical Benefit Scheme	Indirect[j]	..
Commonwealth Hearing Services Program	Indirect[j]	..
Department of Veterans' Affairs		
Repatriation Pharmaceutical Benefits Scheme	Indirect[j]	..
Referral to allied health provider	None	..
Programs to address shortages of GPs in some regions		
Department of Health and Ageing		
Rural and Remote General Practice Program	Direct	na
Rural Retention Program	Direct	14 580
General Practice Registrars Rural Incentives Program	Direct	3 797
Aboriginal Community Controlled Health Services	Indirect	..
Doctors for Outer Metropolitan Areas Measure	Direct	na
Rural Women's GP Service	Direct	na
Programs to promote population health		
Department of Health and Ageing		
Australian Childhood Immunisation Register	Direct	5 000
General Practice Immunisation Incentives Scheme	Direct	37 000
Participating in Commonwealth Government Surveys		
Statistical Clearing House surveys	None[k]	..
Division of General Practice surveys	None	..

[a] *Direct* refers to direct payments from the Commonwealth Government for undertaking the administrative activity. *Indirect* refers to payments through Medicare for completing forms during a medical consultation. [b] Vocationally registered GPs receive higher rebates under Medicare than other medical practitioners. For example, for a level B surgery consultation (which accounts for the majority of GP consultations), the rebate for vocationally registered GPs is $6.60 higher than the rebate for non-vocationally registered GPs — $24.45 and $17.85, respectively under the MBS effective from November 2001. In 2001-02, there were 74.8 million level B consultations. [c] Under this program, GPs might undertake a medication review for which they are remunerated. [d] Local Medical Officers receive higher payments from DVA compared to Medicare (100 per cent of the MBS fee compared to 85 per cent for other consultations). [e] Includes applications to become a Local Medical Officer and for rural allowances. [f] Health services include DVA care plans, case conferences, health assessments and medication reviews. [g] Estimate. Expenditure for the period July 2001–March 2002 was $9 418 549. [h] A Medicare consultation rebate (23B and 36C) of up to $47.60 is claimable provided that forms are completed as part of the consultation. [i] Likely to be an underestimate. As presented in table 3.5 (chapter 3), there were 53 441 disability pension claim forms received in 2001-02 and GPs were paid about $22.05 to complete each form (suggesting a total expenditure of about $1.2 million). DVA noted that these payments might have been incorrectly attributed to other expenditure estimates, leading to this underestimation. [j] These activities are likely to be conducted during a medical consultation, for which GPs receive payments under Medicare. [k] GPs participating in the BEACH survey receive quality assurance points that contribute to meeting requirements for vocational registration. **na** Not available. **..** Not applicable.

Source: DVA (pers. comm., 12, 17 and 23 September, and 10 October 2002); DoHA (pers. comm., 20 January and 7 March 2003).

E.2 Pilot survey

Survey objectives

The Commission's original intention was to conduct a survey of GPs. The two key objectives to be achieved by the survey were to:

- obtain statistically robust data on the time taken to prepare for and comply with simple administrative activities (for example, completing departmental forms); and
- obtain qualitative information relating to:
  - the degree of frustration and difficulty experienced by practice staff associated with administrative activities;
  - the purpose of the administrative activities;
  - the impact of the administrative activities on practice and clinical care; and
  - the possible options to reduce administrative costs.

The survey was not intended to collect information on the administrative costs of participating in more complex Commonwealth Government programs (such as the Practice Incentives Program (PIP)). This cost information was to be collected through case studies (section E.5).

Method

The Commission undertook an open tender process to engage a consultant to design, test and conduct the survey of GPs. The Commission sought proposals from consultants through advertisements in the *Australian Financial Review* and *The Australian* on 29 and 30 July 2002. Seven proposals were received, and each was assessed against the selection criteria set out in the Commission's consultancy brief. The Commission interviewed three consultants and awarded the project to Millward Brown Australia.

In September 2002, Millward Brown Australia conducted three focus group discussions in Victoria to collect information on GPs' perceptions and to help develop the pilot survey of GPs. The discussions were held in St Kilda, Wantirna and Bendigo. Vocationally registered GPs who had been practising for at least 2 years were recruited. A detailed description of the focus group discussions is reported in Millward Brown Australia (2002c).

The method agreed to for the pilot survey was to send an initial letter to a random stratified sample of 200 GPs, informing them of the upcoming survey and highlighting that they 'might' be contacted. GPs were then recruited to participate over the phone and were sent a log book and a qualitative questionnaire to complete over the trial period. Information was collected from participants using a computer automated telephone interviewing method. A detailed description of the survey method is reported in Millward Brown Australia (2002b).

In October 2002, Millward Brown Australia undertook a pilot survey of GPs to test the survey method. A number of problems were revealed with the approach to collecting data. First, of the 200 GPs originally sampled, 90 GPs or 45 per cent could not be contacted due to incorrect contact and address details in the database provided by DoHA. Second, there was a low response rate by GPs to participate in the survey. Of the 110 GPs who were successfully contacted, only 26 agreed to participate and 21 GPs completed the survey. Third, many Commonwealth forms were not encountered or were encountered in small numbers. Finally, GPs experienced difficulty in recognising the various types of forms. GPs during the three preliminary focus group discussions had difficulty in differentiating between Commonwealth forms, and State and Local Government forms. They also considered the distinction irrelevant as all forms generated requirements for GPs (Millward Brown Australia 2002b).

Taking these problems into account and advice from the consultant and the Commonwealth Government's Statistical Clearing House (figure E.1), the Commission decided against conducting the main survey and instead undertook 10 further focus group discussions with GPs (section E.3).

Figure E.1 **Statistical Clearing House letter — page 1 of 3**

www.abs.gov.au
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CENTRAL OFFICE
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John Salerian
Assistant Commissioner
Productivity Commission
Locked Bag 2
Collins St East
Melbourne Vic, 8003.

Dear John,

The purpose of this note is to summarise the position of the Commonwealth Government Statistical Clearing House (SCH) with regards to the Productivity Commission's GP Compliance Costs Study.

A summary of the SCH position is as follows:

1. the SCH agrees with the consultant's recommendation that the log book approach will not produce data of suitable quality and should not go ahead.
2. the SCH advises against the alternative survey approach put forward by the consultant, as it will result in data which will contain considerable (but unquantifiable) response biases.
3. the SCH recommends that focus groups should be used to collect information for the study.

Large scale surveys are only appropriate where results are required which represent the entire population. Survey results can often suffer from bias which limits the degree to which the results can be generalised. In some cases, the bias becomes so large that the result should not be generalised, and can produce misleading results. The size of the bias is difficult to measure, but increases with the level of non-response. Bias undermines the credibility of survey data.

In cases where there is significant bias, alternative collection techniques, such as focus groups, provide analogous results. These alternative techniques place significantly less load on the providers of the data. They are generally cheaper and quicker to conduct.

Figure E.1 **Statistical Clearing House letter — page 2 of 3**

Initial Log Book Approach

The SCH has the following concerns with a log book approach to the collection of data:

- the current environment of heavy sampling of GP has resulted in an hostile environment for Commonwealth Surveys. We are currently experiencing low response rates for all surveys in the field. The SCH expects a low response rate for the PC collection.
- the log book approach has traditionally resulted in lower response rates. For example the ABS Household Income and Expenditure Survey uses a log book approach, with a response rate of around 70%, compared with 90+% for other similar surveys.

The pilot test has strengthened SCH concerns. In addition, the pilot test has raised concerns about the recognition of government forms and identified poor quality contact details on the frame. The SCH agrees with the consultants recommendation that the survey in the current form not be progressed.

Face to Face Interview Approach

The alternative approach suggested by the consultant overcomes the recognition problem by displaying forms in a face to face interview. However, the approach does not resolve the problem of the expected response rate (at best 30%). As discussed previously, any statistical inferences based on the data collected will not be valid.

Recall difficulties for respondents is also a significant problem with the alternative survey approach. Respondents will be asked to recall completing forms and the time taken to complete forms for up to 2 months previously. The time lapse is too great for responses to be a true reflection of the types of forms completed and the time taken. These recall difficulties will again introduce bias into the survey estimates, and decrease the capacity for estimates to represent the true time taken.

This survey approach will not allow nationally representative estimates to be produced.

In the event that Productivity Commission were to adopt this approach the SCH would require caveats to be placed around each usage of the data from the survey. A cautionary note would also be required at the front of the report, explaining in detail the problems associated with the collection. These caveats would point to the short comings of the data, particularly the impact of response rates on the estimates.

As the face to face option is a survey of businesses, we will be required to place information about the survey on the Commonwealth Business Surveys Register. This register is located on the SCH website.

Figure E.1 **Statistical Clearing House letter — page 3 of 3**

Focus Groups

The SCH recommends the use of a non-survey technique. While such techniques also do not produce nationally representative estimates in the statistical sense, they have other advantages.

The SCH suggests that focus groups would be a suitable vehicle for collecting data for the study. The advantages of focus groups in this case are:

- achievable within the budget and limited time frames;
- will allow you to collect more detailed information from doctors through discussion (rather than asking a limited set of structured questions such as in a survey approach); and
- discussion of the issues within the focus groups may stimulate memory and you will quite likely get better quality responses than in the survey format.

A focus group approach will make it clear to users of the data that the results are not nationally representative in the statistical sense. There is often a perception that the results which are derived from samples are statistically valid. In cases where sample have low response rates or are subject to response bias, results may not represent the population. This likely to be the case with the survey options presented here. Users may not take the appropriate degree of caution. That is, the data is may be used in a manner which can lead to misinformed policy decisions We believe that in this instance a series of focus groups can inform the Productivity Commission's investigation, and give analogous results to a larger survey.

The SCH recommends that the Productivity Commission pursue a focus group approach for this investigation.

Please contact me if you would like further clarification on the SCH's position.

Yours sincerely,

Michael Meagher
Director
Statistical Clearing House

14th October, 2002

Data

The data collected during the pilot survey on the time taken by practice staff to undertake administrative activities are presented in table E.3.

Table E.3 **Pilot study — administrative time by practice staff**[a, b]
Average minutes per activity

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing					
CHS	Hearing services application	2.13	0	1.25	0
Department of Veterans' Affairs					
Compensation	GARP assessment	10.00	0	0	0
Compensation	Medical diagnosis report	15.00	0	0	0
Compensation	Pension claim form	15.00	0	0	0
Department of Family and Community Services/Centrelink					
Carer Allowance	Forms	30.00	0	0	0
Carer Payment	Forms	9.25	0	0	0
DSP	Review TDR	24.42	0	0	0.33
DSP	TDR	17.50	0	0	1.67
Mobility Allowance	Forms	5.67	0	0	0.67
Newstart Allowance	Medical certificates	8.92	0	0	0
Sickness Allowance	Medical certificates	9.33	0	0	0
Youth Allowance	Medical certificates	8.92	0	0	0

[a] Abbreviations listed at the front of the report. [b] A zero indicates that time data were either not applicable or not identified.

Source: Unpublished data from Millward Brown Australia (2002b).

E.3 Focus group discussions

Millward Brown Australia conducted 10 focus group (workshop) discussions with GPs as an alternative to the cancelled survey. The two key objectives in undertaking the focus group discussions were to:

- collect data on the time taken to prepare for and complete selected Commonwealth forms; and
- collect information on the intangible costs associated with meeting these specific Commonwealth requirements.

The forms selected for discussion were:

- FaCS/Centrelink's *Disability Support Pension Treating Doctor's Report* (TDR) (pre and post September 2002);

- FaCS/Centrelink's *Medical Review — Disability Support Pension* (part B), review TDR (pre and post September 2002);
- FaCS/Centrelink's *Medical Certificate* for the Newstart Allowance, Youth Allowance and Sickness Allowance (pre and post September 2002);
- DVA's *Claim for Disability Pension and/or Application for Increase in Disability Pension* form;
- DVA's associated *Guide to the Assessment of Rates of Veterans' Pensions Medical Impairment Assessment* forms;
- DoHA's *Pharmaceutical Benefits Scheme Authority Prescription* form; and
- DoHA's *Australian Childhood Immunisation Register — Encounter Form*.

The focus group discussions were conducted in:

- Victoria — in St Kilda, Deer Park and Shepparton;
- New South Wales — in Mosman, Liverpool, Tamworth and Bathurst;
- Queensland — in Brisbane and Toowoomba; and
- Tasmania — in Hobart.

All GPs except those in Tasmania were randomly recruited by Millward Brown Australia, based on the region where the GPs practised. The Southern Tasmanian Division of General Practice recruited GPs in Tasmania. In total, 62 GPs participated in the discussions. A summary of the focus group discussions is reported in Millward Brown Australia (2002a).

Data

Table E.4 lists qualitative information on some of the forms that participating GPs encountered during the focus group discussions.

GPs participating in the focus group discussions also provided estimates of how long it took them to complete each form. The Commission included the average estimates (table E.5) in its calculation of total GP administrative costs.

Table E.4 **Qualitative information from GPs on selected forms[a]**

Form	Sample size	Time spent completing form: Somewhat to very reasonable	Time spent completing form: Somewhat to very unreasonable	Level of difficulty: Fairly to very	Level of difficulty: Not very to not at all	Understand reason for information requested: Yes	Understand reason for information requested: No	Level of frustration: Fairly to very	Level of frustration: Not very to not at all
	no.	%	%	%	%	%	%	%	%
Department of Family and Community Services/Centrelink									
DSP TDR									
Pre September 2002 form	33	30	70	64	36	94	6	85	15
New form	29	31	69	76	24	66	34	76	24
DSP review TDR									
Pre September 2002 form	21	19	81	71	29	81	19	95	5
New form	9	44	56	44	56	89	11	44	56
Medical Certificate[b]									
Pre September 2002 form	41	78	22	20	80	83	18	24	76
New form	13	62	38	15	85	77	23	62	38
Carer Allowance[c]	3	33	67	67	33	67	33	67	33
Carer Payment/Allowance[d]	8	100	0	13	88	100	0	13	88
Department of Veterans' Affairs									
GARP forms	15	53	47	47	53	93	7	67	33
Disability Pension claim form	5	20	80	60	40	100	0	60	40
Department of Health and Ageing									
PBS/RPBS authorisations[e]	62	72	28	14	86	85	15	36	63
ACIR immunisation notification	24	83	17	0	100	100	0	8	92
Hearing services application	4	100	0	0	100	100	0	0	100

a A zero indicates that time data were either not applicable or not identified. **b** For Sickness Allowance, Newstart Allowance and Youth Allowance. **c** Where the person being cared for is aged less than 16 years. **d** Where the person being cared for is aged 16 years or over. **e** Pharmaceutical Benefit Scheme or Repatriation Pharmaceutical Benefit Scheme.

Source: Unpublished data from Millward Brown Australia (2002a).

Table E.5 **Focus group discussions — administrative time by practice staff[a, b]**

Average minutes per activity

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing					
ACIR	Immunisation notification — electronic data interchange	0.75	1.50	0	0.08
ACIR	Immunisation notification — manual & scanning	1.11	0.72	0.33	0.39
CHS	Hearing services application	1.63	0	0	0
PBS	Phone authorisation	3.18	0	0	0
Department of Veterans' Affairs					
Compensation	GARP assessment	7.40	0	0	0
Compensation	Pension claim form	19.75	0	0	0
Department of Family and Community Services/Centrelink					
Carer Allowance	Forms[c]	10.00	0	0	0
DSP	Review TDR[c]	23.91	0	0	0
DSP	TDR[c]	16.06	0	0	0.15
Newstart Allowance	Medical certificate[c]	4.55	0	0	0
Sickness Allowance	Medical certificate[c]	4.55	0	0	0
Youth Allowance	Medical certificate[c]	4.55	0	0	0

[a] Abbreviations listed at the front of the report. [b] A zero indicates that time data were either not applicable or not identified. [c] Pre September 2002 forms.

Source: Unpublished data from Millward Brown Australia (2002a).

As noted in appendix B, Centrelink introduced a number of changes to its forms in September 2002. Where possible, the Commission obtained estimates of the time taken to complete new Centrelink forms (table E.6).

Table E.6 **Focus group discussions — administrative time by practice staff to complete new FaCS/Centrelink forms[a, b]**

Average minutes per activity

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
DSP	Review TDR	15.23	0	0	0
DSP	TDR	20.48	0	0	0
Newstart Allowance	Medical certificate	6.88	0	0	0
Sickness Allowance	Medical certificate	6.88	0	0	0
Youth Allowance	Medical certificate	6.88	0	0	0

[a] Post September 2002 forms. [b] A zero indicates that time data were either not applicable or not identified.

Source: Unpublished data from Millward Brown Australia (2002a).

E.4 Independent review of Commonwealth Government forms

The Commission engaged Ms Deborah Doyle (of Living Proof — Book Editing) to undertake an independent review of six Commonwealth Government forms and to assess them against her understanding of best practise for production of forms designed and used for information collection. The forms scrutinised were:

- FaCS/Centrelink's *Disability Support Pension TDR* (post September 2002);
- FaCS/Centrelink's *Medical Certificate* (post September 2002) for the Newstart, Youth Allowance and Sickness Allowance;
- FaCS/Centrelink's *Carer Allowance TDR* for a child younger than 16;
- DVA's *Health Care Plans: A Guide for Local Medical Officers*;
- DVA's *Foot Condition: Medical Impairment Assessment*; and
- DoHA's *Practice Incentives Program and General Practice Immunisation Incentives Application Form*.

A detailed account of the problems identified in, and suggested changes to improve, the forms is reported in Doyle (2002).

E.5 Case studies

The Commission undertook an open tender process to engage a consultant to conduct case studies of general practices. The Commission sought proposals from consultants through advertisements in the *Australian Financial Review* on 3 September 2002. Eight proposals were received, and each was assessed against the selection criteria set out in the Commission's consultancy brief. The Commission interviewed three consultants and awarded the project to Campbell Research & Consulting.

Campbell Research & Consulting was engaged to undertake 13 case studies, collecting information on the costs (labour and non-labour costs) incurred by GPs and other practice staff in complying with some of the complex Commonwealth Government programs. The programs were:

- PIP (including the cost of accreditation);
- the Enhanced Primary Care (EPC) program (in particular health assessments and care plans);
- the requirements associated with GP vocational registration and the Royal Australian College of General Practitioners fellowship;

- Centrelink — assessments for entitlement for disability, illness or injury payments;
- DVA — assessments for entitlement for pension and allowances; and
- the Pharmaceutical Benefit Scheme — phone and written authorisations.

Method

Campbell Research & Consulting recruited practices across Victoria, Western Australia and South Australia. Practices were recruited primarily based on their size and type — small/solo (1–2 GPs), group and corporate practices — and location (inner metropolitan areas, outer metropolitan areas, and rural and remote areas).

A logbook was sent to each participating practice, asking the GP to record the activities, time and resources devoted to each program over a three-day period.

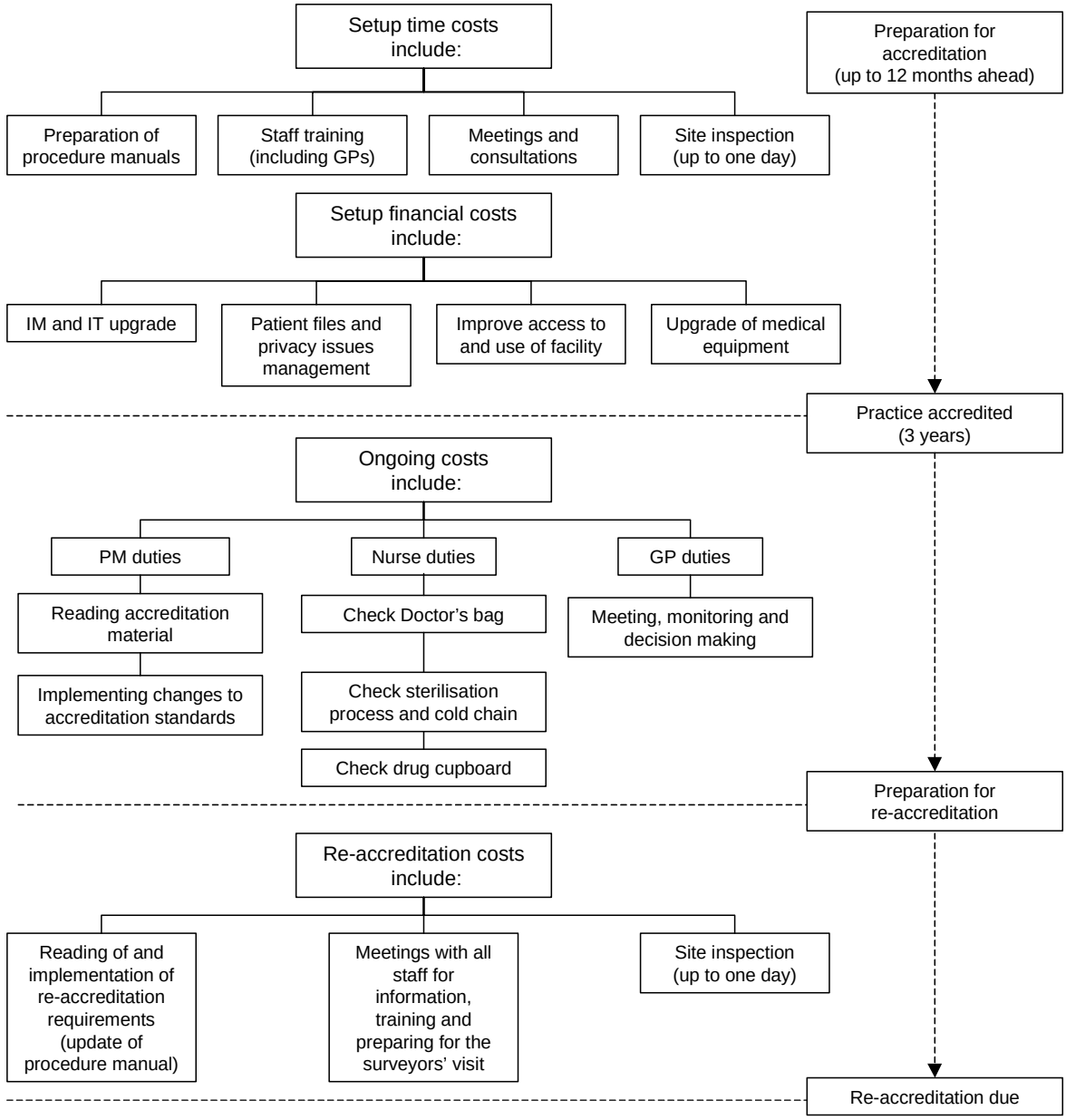
The consultant then undertook a series of in-depth interviews with the practice principal and practice manager, plus other practice staff where relevant. Information was collected on the activities undertaken by staff within each practice to comply with the programs and the practice staffs' perceptions of the programs. Priority was given to the more complex programs such as the PIP and the EPC program.

Detailed financial and administrative data was also collected from practices, including the practice income and expenditure statement for 2001-02, and the annual wages, salaries and remuneration levels, or hourly rates of the personnel involved in complying with the programs. Confidential information was not made available to the Commission, Government or any other party.

For individual case studies, the consultant described the activities developed within the practice in order to comply with each program, using *activity maps*. Activity maps are a diagrammatic representation of the individual activities involved in a process. Aggregate activity maps were also constructed, summarising the activities developed across all participating practices (figures E.2 to E.9).

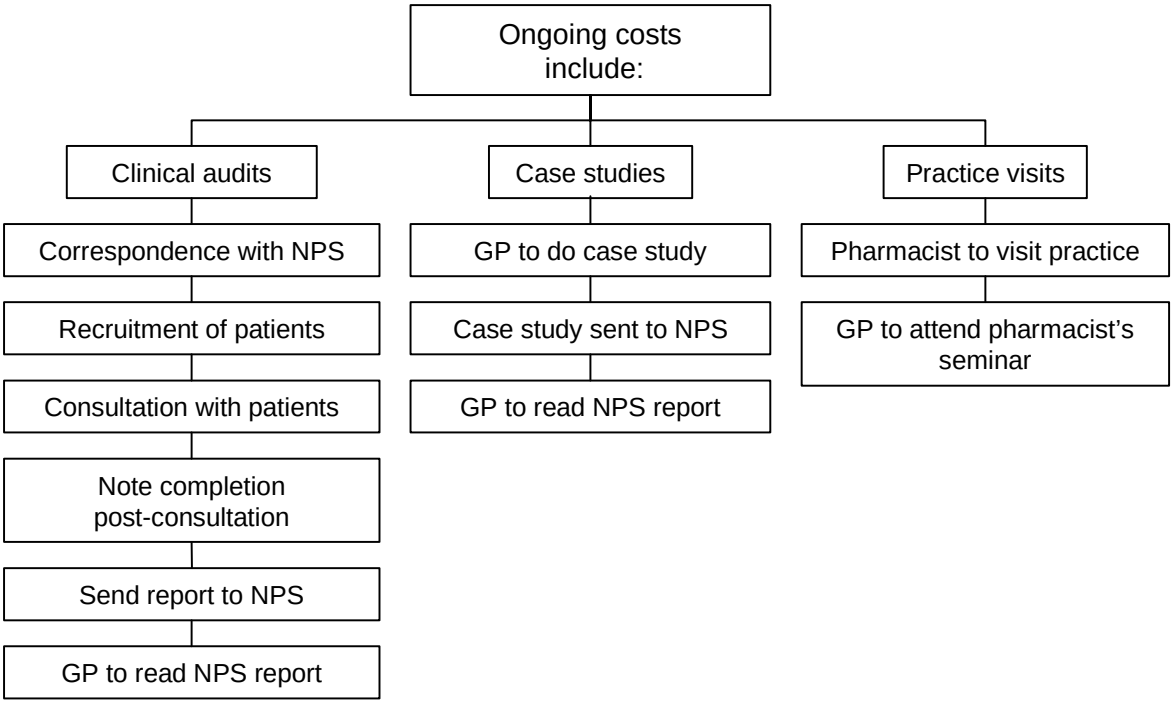
Finally, a cost model was developed for each practice, measuring the administrative costs of undertaking each activity. The cost models were constructed based on the financial information, time data and activity maps. A detailed description of the case studies is presented in Campbell Research & Consulting (2003).

Figure E.2 **PIP — accreditation activity map**



Source: Campbell Research & Consulting (2003, vol. 1, pp. 13–14).

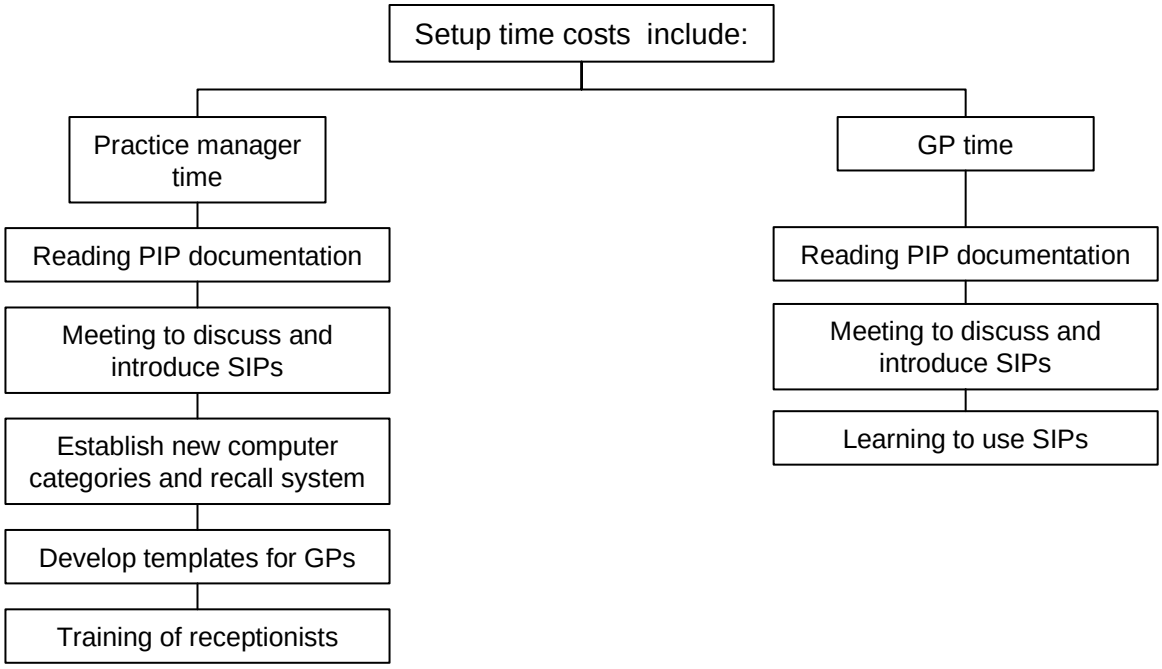
Figure E.3 **National Prescribing Service activity map[a]**



a The National Prescribing Service is also called Quality Prescribing Initiative.

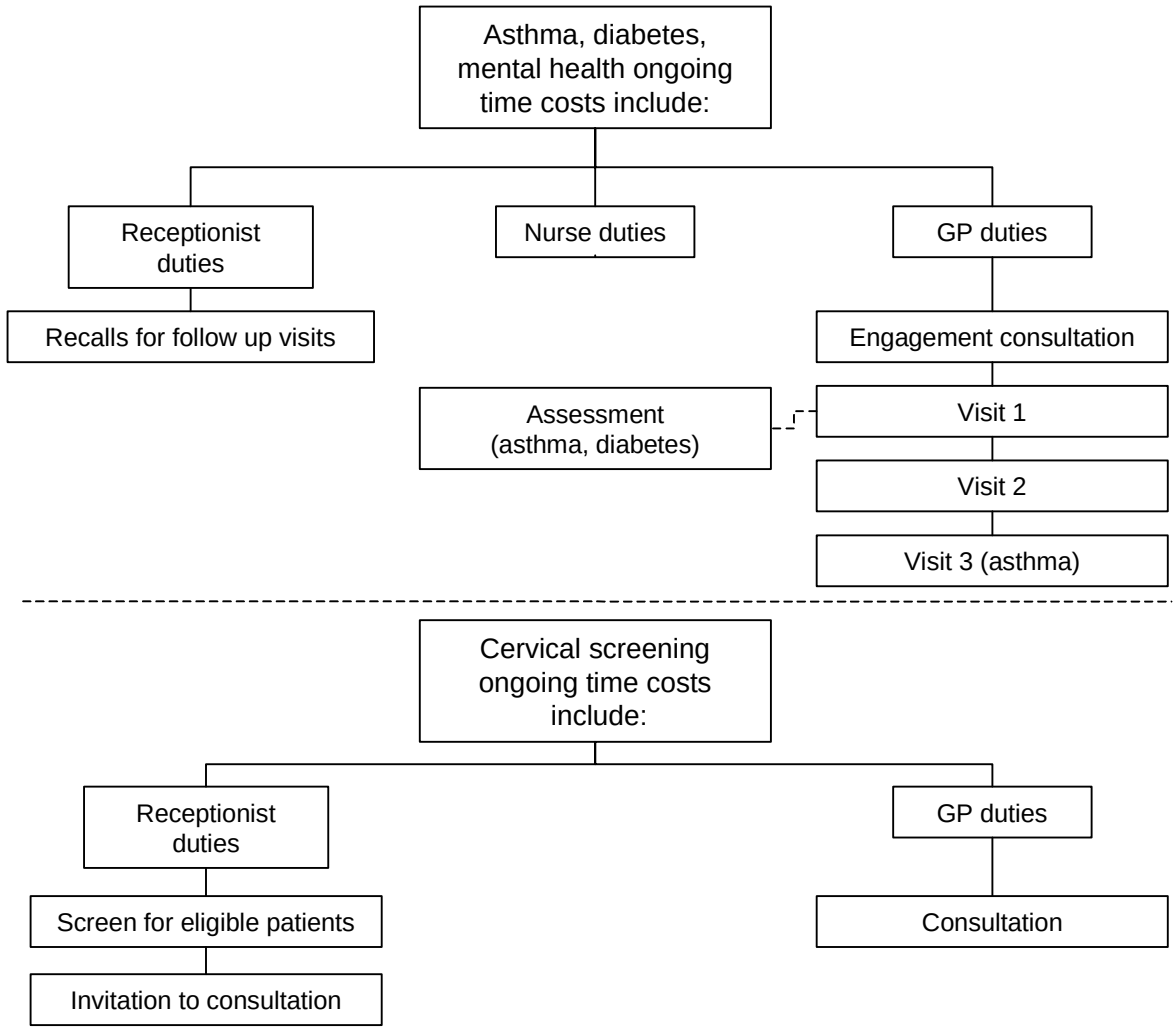
Source: Campbell Research & Consulting (2003, vol. 1, p. 17).

Figure E.4 **PIP — service incentive payments, setup time costs activity map**



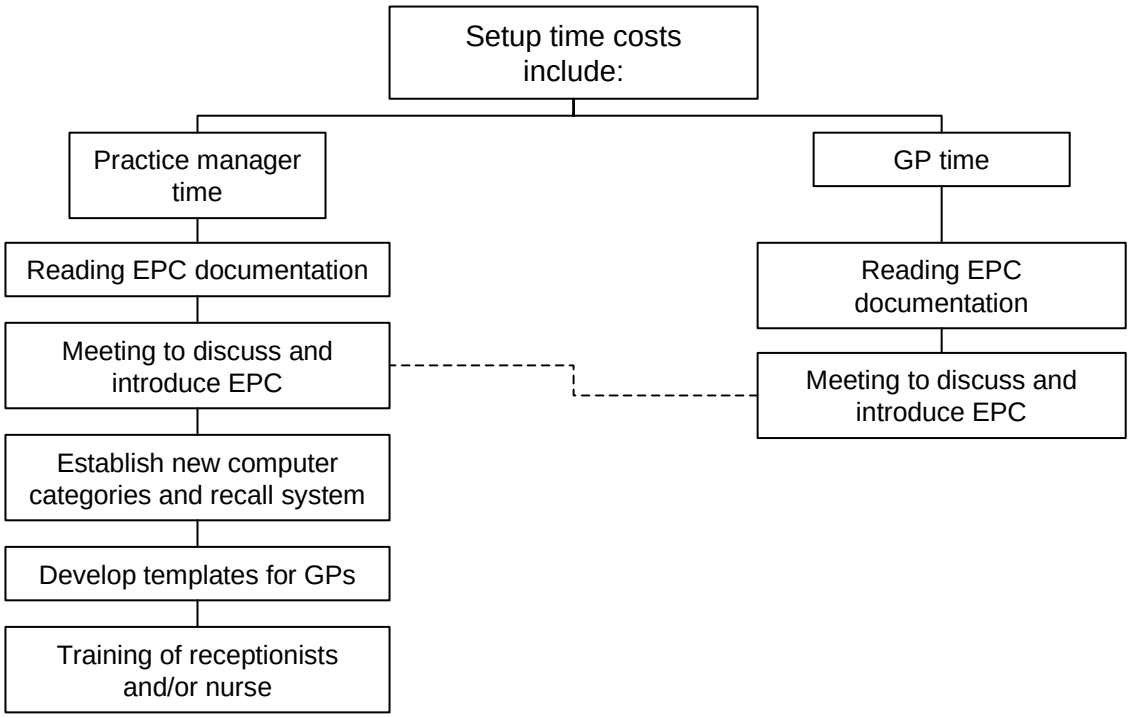
Source: Campbell Research & Consulting (2003, vol. 1, p. 19).

Figure E.5 **PIP — service incentive payments, ongoing time costs activity map**



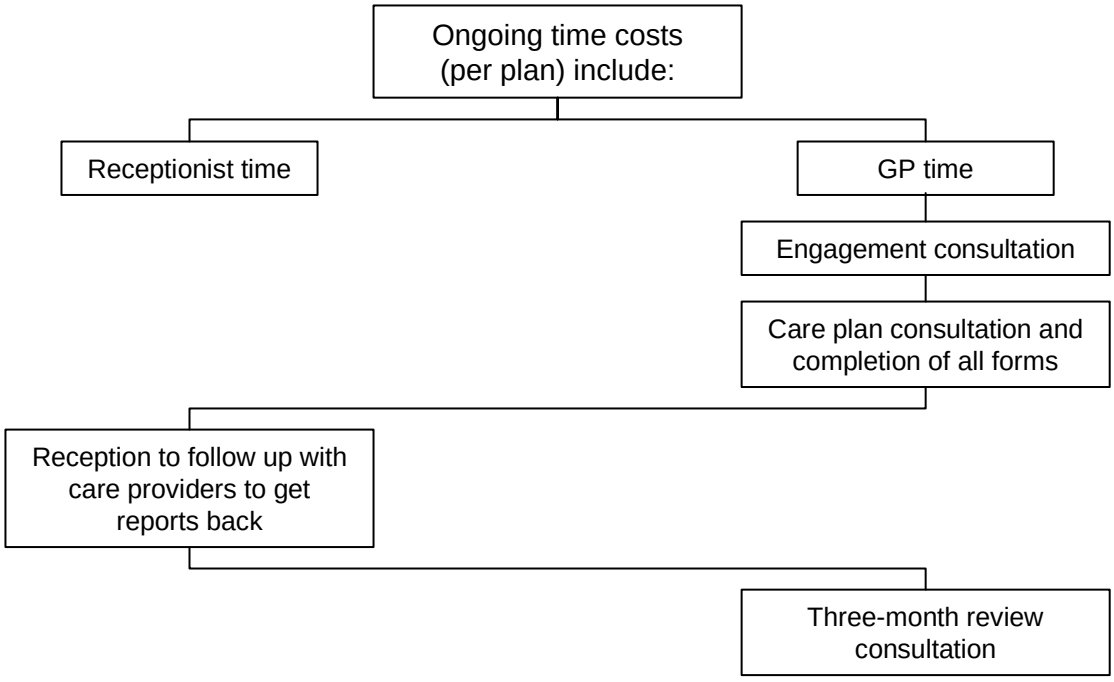
Source: Campbell Research & Consulting (2003, vol. 1, p. 20).

Figure E.6 **EPC health assessments and care plans, setup time costs activity map**



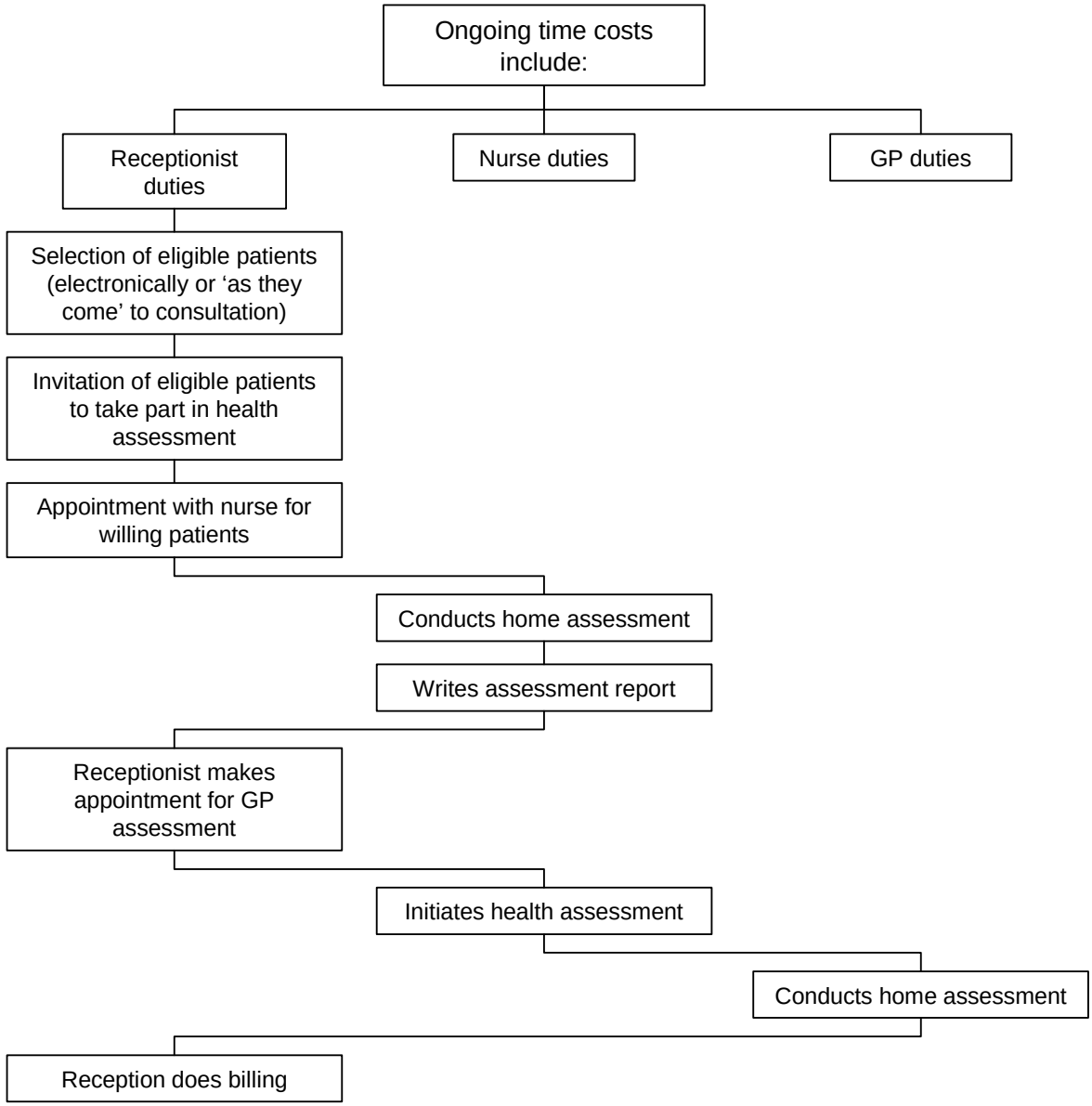
Source: Campbell Research & Consulting (2003, vol. 1, p. 27).

Figure E.7 **EPC care plans activity map**



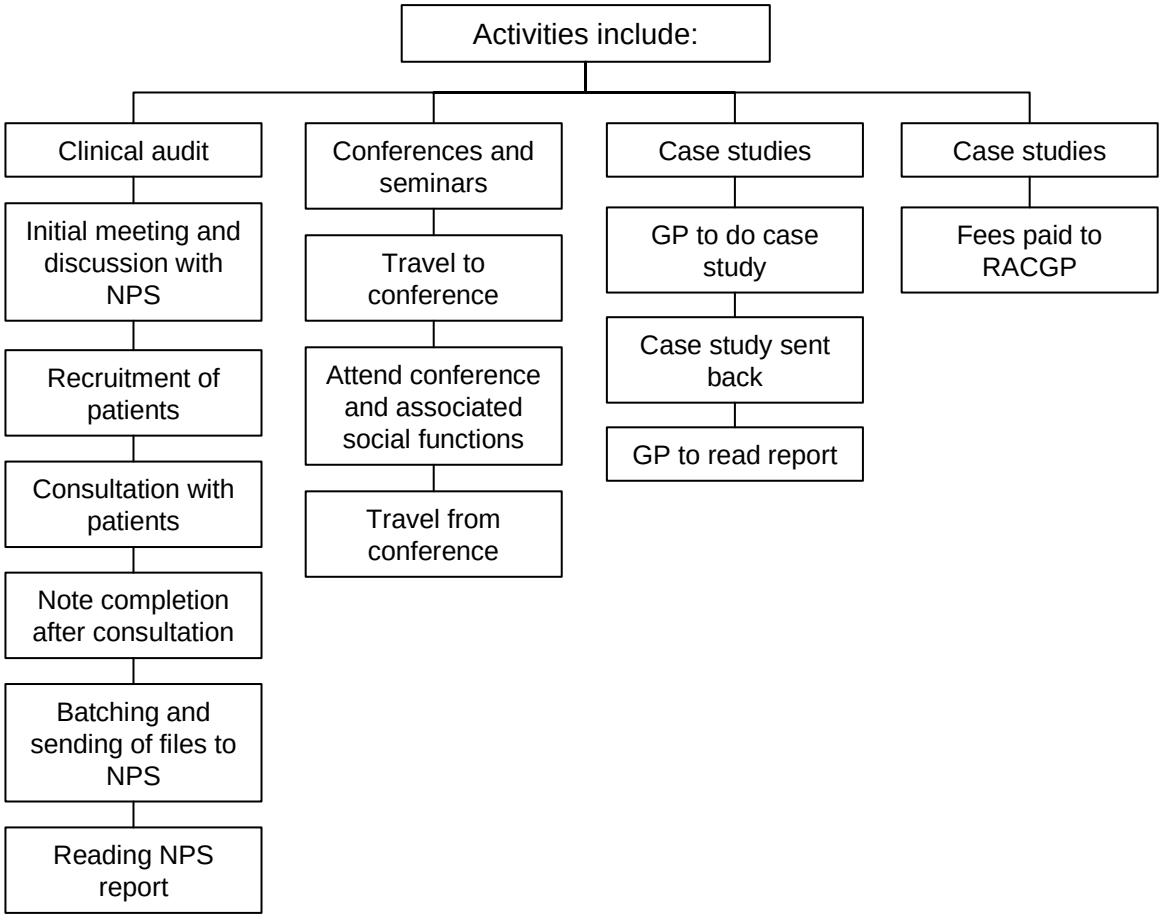
Source: Campbell Research & Consulting (2003, vol. 1, p. 29).

Figure E.8 **EPC health assessment activity map**



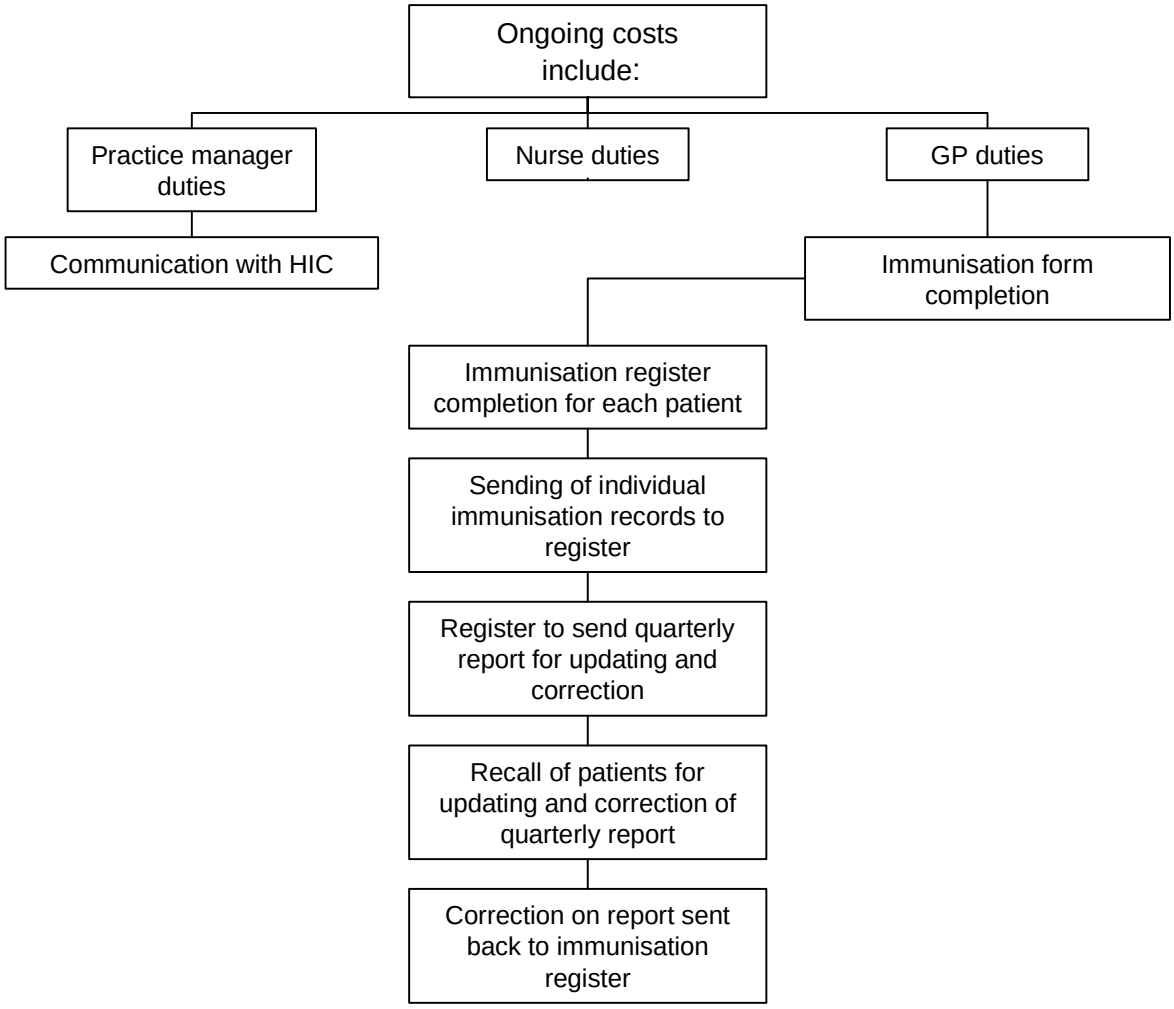
Source: Campbell Research & Consulting (2003, vol. 1, p. 28).

Figure E.9 **Vocational registration activity map**



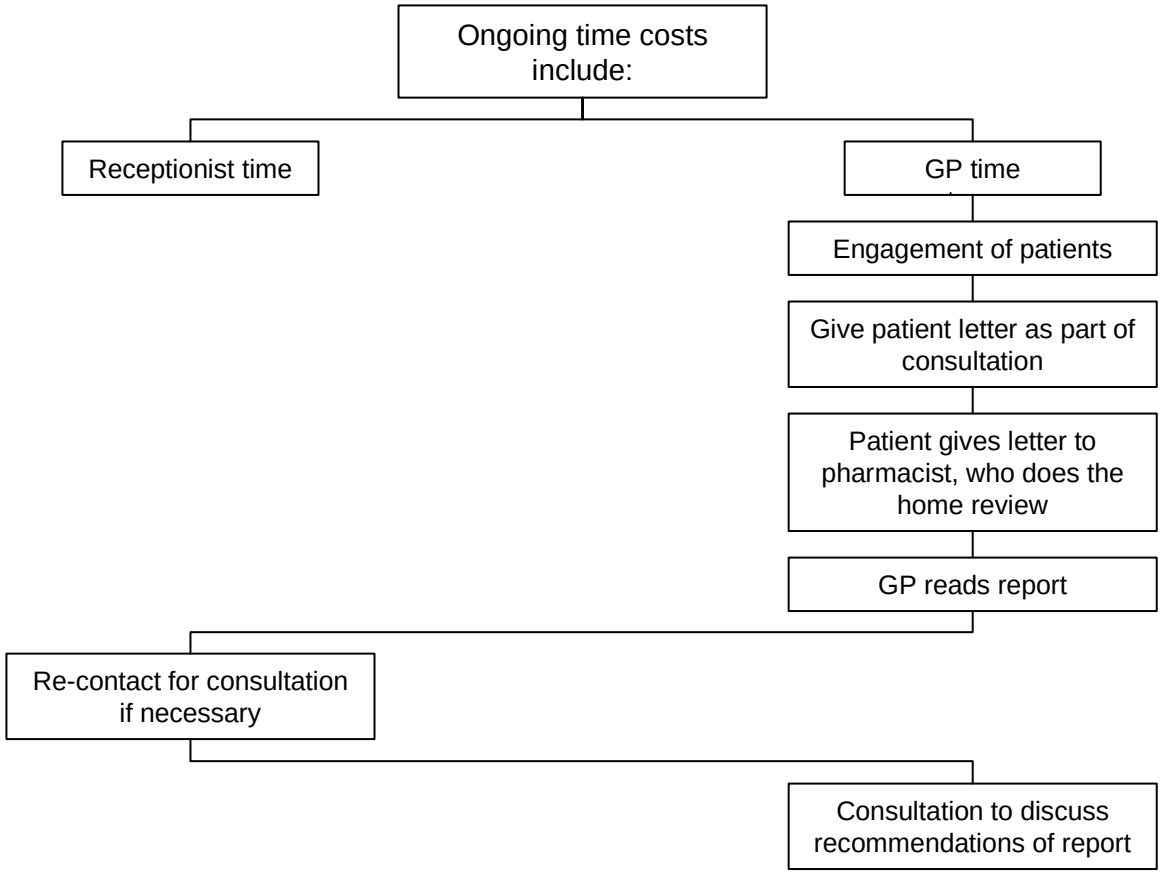
Source: Campbell Research & Consulting (2003, vol. 1, p. 31).

Figure E.10 **General Practice Immunisation Incentives scheme activity map**



Source: Campbell Research & Consulting (2003, vol. 1, p. 16).

Figure E.11 **Domiciliary Medication Management Reviews activity map**



Source: Campbell Research & Consulting (2003, vol. 1, p. 29).

Data

GPs participating in the case studies provided estimates of how long it took each staff member to complete each administrative activity. The Commission included the estimates of time (table E.7) in its calculation of total GP administrative costs.

Table E.7 **Case studies — administrative time by practice staff, 2001-02**[a, b]

Average minutes per activity

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing					
EPC	Care plans	49.25	15.00	0	4.17
EPC	Case conference	60.00	0	0	0
EPC	DMMR	36.25	0	0	2.50
EPC	Health assessments	34.29	107.07	0.71	3.48
GPII	GPII	1.25	0.55	0	0.91
PBS	Phone authorisation	4.13	0	0	0
PBS	Written authorisation	9.50	0	0	0.92
PIP	Quality Prescribing Initiative	115.06	0	0	5.42
PIP	Teaching	4.00	0	0	0
PIP	SIP — Asthma	16.00	15.00	0	40.00
PIP	SIP — Cervical screening	3.75	1.60	0	0
PIP	SIP — Diabetes	19.17	5.00	0	5.00
Department of Veterans' Affairs					
Compensation	Pension claim form	24.06	na	0	1.25
Health	Care plans	49.25	15.00	0	4.17
Health	Case conference	60.00	0	0	0
Health	Medication reviews	36.25	0	0	2.50
Health	Health assessments	34.29	107.07	0.71	3.48
Department of Family and Community Services/Centrelink					
Carer Allowance	Forms	12.50	0	0	0
Carer Payment	Forms	11.78	0	0.56	0
DSP	Review TDR	5.00	0	0	0
DSP	TDR	19.92	0	0	0
Mobility Allowance	Forms	5.50	0	0	0
Newstart Allowance	Medical certificate	10.00	0	0	0
Sickness Allowance	Medical certificate	9.29	0	0	0
Youth Allowance	Medical certificate	10.00	0	0	0

[a] Abbreviations listed at the front of the report. [b] A zero indicates that time data were either not applicable or not identified.

Source: Campbell Research & Consulting (2003).

F Estimating GP administrative costs — further details

In this appendix, the Commission outlines the method used to estimate administrative costs to general practitioners (GPs) (section F.1); the time and cost data used to derive these estimates (section F.2) and sensitivity analyses of these estimates (section F.3).

This appendix includes various examples of how the Commission has estimated GP administrative costs for programs. The issues of whether the costs associated with the programs are incremental to the programs or are normal activities undertaken by GPs, are discussed in chapters 1 and 4.

F.1 Method used to estimate GP administrative costs

The Commission used an 'activity-based incremental cost model' method to estimate GP administrative costs (chapter 4). Some of the important issues involved in developing this model were:

- defining incremental cost categories;
- annualising periodic costs; and
- determining the appropriate hourly earnings rate for GPs and other practice staff.

This section discusses these issues and provides examples of how the costs were estimated for particular activities.

Defining incremental cost categories

GPs and general practices participating in the programs in the scope of this study incur different costs. These costs have been classified into three categories: service-based, GP-based and practice-based.

Service-based costs vary with the number of patient services provided, such as completing a Treating Doctor's Report (TDR) for the Department of Family and Community Services (FaCS)/Centrelink, or undertaking a care plan for a patient.

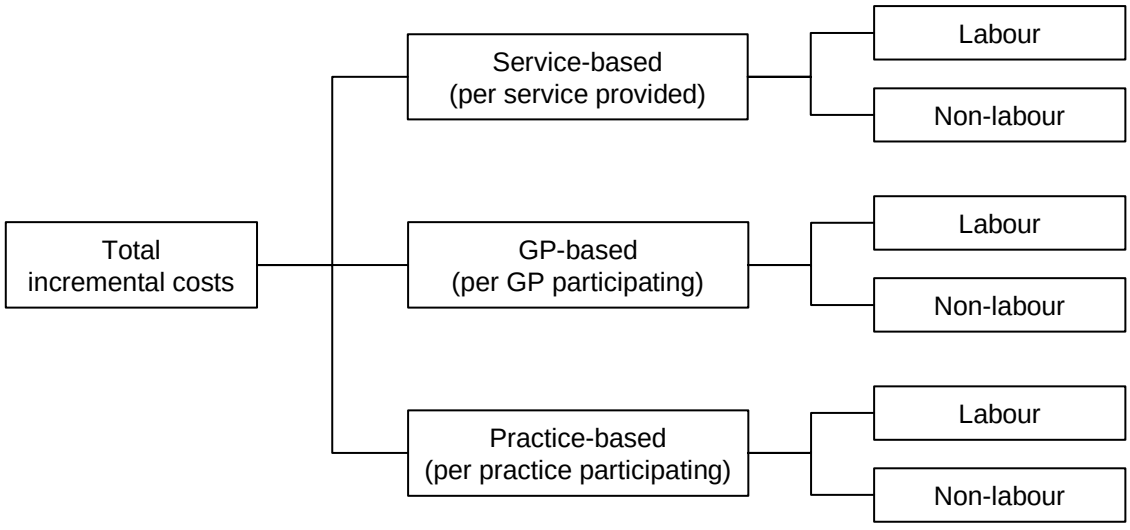
The national estimate of costs for these services is obtained by multiplying the incremental cost of a service by the number of services provided nationally.

GP-based and practice-based costs do not vary with the number of services. In this sense, they are viewed by the GP or general practice as the 'fixed' costs of participating in programs. An example of a GP-based cost is the cost of acquiring the points necessary to maintain vocational registration. The national estimate of costs for this activity is obtained by multiplying the incremental cost of vocational registration by the number of GPs who are vocationally registered. An example of a practice-based cost is the cost to a practice of maintaining its accreditation. The national estimate of costs for this activity is obtained by multiplying the incremental cost of practice accreditation by the number of practices enrolled in the Practice Incentives Program (PIP).

Service-based, GP-based and practice-based costs are disaggregated into labour and non-labour costs (figure F.1). Labour costs are costs for the time taken by four types of practice staff (GPs, nurses, practice managers and receptionists) undertaking program activities. Examples include:

- the cost for the time spent by a GP completing a FaCS/Centrelink TDR;
- the cost for the time spent by a practice manager assisting the GP to undertake vocational registration; and
- the cost for the time spent by a nurse checking the sterilisation process and cold chain in order to maintain the practice's accreditation standards. An activity map outlining the broad activities involved in maintaining accreditation standards is presented in appendix E.

Figure F.1 **Incremental costs categories**



Non-labour costs include the travel and Royal Australian College of General Practitioners (RACGP) fees associated with vocational registration and paying accreditation agencies under the PIP. These costs also include any capital investments necessary for practice accreditation, such as installing wash basins in GPs' consulting rooms.

It is possible for some programs to have more than one category of costs. Enhanced Primary Care (EPC) care plans, for example, have three categories of costs: service-based labour costs, GP-based labour costs and GP-based non-labour costs (see example below).

Annualising periodic costs

For some programs, labour and/or non-labour costs can be incurred periodically, rather than continuously. For both labour and non-labour costs, the periodic costs have been amortised over the 'life' of the investment using an appropriate discount rate to convert them to equivalent annual values. The method used to amortise these costs is illustrated using the costs of PIP accreditation as an example.

The costs associated with practice accreditation include practice-based labour and non-labour costs. Labour costs might include the amount of time taken by a GP (or another staff member of the practice) to familiarise his or herself with the processes associated with the accreditation. Non-labour costs might include the purchase and installation of equipment required as part of the accreditation process. The case studies undertaken for this study provided estimates of these costs.

The labour and non-labour costs associated with assets purchased or activities undertaken for accreditation tend to be incurred in one period (for example, the year in which a practice applies for accreditation). However, the likely life or benefit of the assets (or the activities) is generally spread over a number of years (for example, the three years for which accreditation is granted). The Commission therefore 'annualised' the costs of each asset purchased or activity performed to ensure that their costs were spread over their estimated 'life' years, rather than attributing the total costs to one year. The life of each asset or activity differed; therefore, the costs were annualised over the expected number of life years associated with the asset or activity. For instance:

- fixed labour costs were annualised over three years — the duration of accreditation;

- fixed non-labour costs, unless specifically identified as annual costs, were annualised over their expected life of:
  - three years (the duration of accreditation) — for example, expenses on telephone calls, and travel fees;
  - five years — for example, capital improvements on building a disabled toilet; or
  - ten years — for example, installing locks for all GP rooms.

In annualising the costs, instead of simply dividing the total cost of each asset (or activity) with the expected life years of that item, the Commission calculated the annual amortised cost, which reflects the opportunity cost of time and depreciation (Drummond et al. 1999). The formula used to calculate this cost is:

$$c = C\left(1-\frac{1}{(1+i)}\right)\Bigg/\left(1-\frac{1}{(1+i)^{n}}\right)$$

Where:

c = annual amortised cost of the asset (or activity);

C = total cost of investing in a particular asset (or activity);

n = the expected life years of the asset (or activity); and

i = interest rate, which reflects the opportunity cost of time. The annual interest rate of 7.58 per cent is derived using the method in the Relative Value Study, and is the sum of the 10-year (long-term) Treasury bond rate of 5.58 per cent (for 31 October 2002 (RBA 2003)) and the standard bank overdraft risk factor of 2 per cent (PricewaterhouseCoopers 2000, vol. 1, p. 42).

Using one of the practices in the case studies as an example, the Commission illustrates in table F.1 how it calculated the fixed costs associated with achieving and maintaining accreditation for this practice. For each of the assets or activities, either the labour or a non-labour annual amortised cost is calculated using the above formula. The fixed labour and non-labour costs per year are estimated at $4327 and $8525, respectively. The total fixed costs associated with accrediting the practice from this case study is $12 852 (table F.1).

Table F.1 **Fixed labour and non-labour costs associated with the accreditation process for the practice in case study 1**

	Total time	*Wage*	*Total cost*	*Years annualised*	*Annualised cost per year*[a]
	mins.	$ per hr	$	no.	$
Fixed labour costs					
Practice manager time					
Preparing for accreditation	5 760	20	1 930	3	691
Maintaining accreditation	720	21	241	1	241
Nurse time					
Developing procedure manuals	7 200	19	2 321	3	831
Maintaining accreditation	7 800	19	2 514	1	2 514
Receptionist time					
Training	480	16	125	3	45
Interview	60	16	16	3	6
Total fixed labour costs					**4 327**

	Total time	*Wage*	*Total cost*	*Years annualised*	*Annualised cost per year*[a]
	mins.	$ per hr	$	no.	$
Fixed non-labour costs					
Travel and accommodation	..	..	700	3	251
Telephone calls	..	..	100	3	36
Postage and printing	..	..	50	3	18
Purchasing and installing locks for all GP rooms	..	..	4 800	10	652
Purchasing and installing new autoclave	..	..	7 000	5	1 612
Building new cabinet	..	..	13 000	5	2 993
Purchasing and installing disabled toilet and new extension work	..	..	2 500	5	576
Accreditation fees to AGPAL	..	..	6 670	3	2 388
Total	..	..			**8 525**
Total fixed costs for achieving and maintaining accreditation					**12 852**

[a] The yearly time and costs have been annualised using the formula above. .. Not applicable.

Source: Campbell Research & Consulting (2003).

Earnings

As noted, the Commission used an 'activity-based incremental cost model' method to estimate GP administrative costs. Using this method, resources employed to undertake each activity are individually identified and costed (chapter 4). To value

or cost GPs' and other practice staff's time, the Commission estimated their respective pre-tax hourly earnings. GPs' pre-tax hourly earnings is used rather than average GPs' pre-tax gross billing rate, as this approach prevents double counting (chapter 4).

General practitioners

The estimate of the pre-tax hourly earnings for GPs is derived by taking into account two broad types of GPs, whose earning rates are expected to differ. Some GPs are employees, but most are partners or associates of their medical practice. Campbell Research & Consulting (1997) estimated that 24 per cent of GPs were salaried employees or trainees (registrars) and 76 per cent were partners, associates or sole practitioners.

Employee GPs generally earn less than partner or associate GPs — they have no ownership in the practice and are usually less senior. Based on ABS data, the average pre-tax earnings in 2002 for employee GPs was estimated to be $45.06 per hour (ABS May 2000 data indexed to June 2002).

For the 76 per cent of GPs who are self-employed or partners, calculating average pre-tax earnings can be complex. These GPs often receive both a salary income and profits from their practice. How an individual GP's income from a general practice is paid depends on many factors, including the practice's structure and ownership, income splitting between family members who are employed in the same practice, and the use of trusts and other legitimate accounting and tax reduction measures.

In this study, the Commission has not considered in detail the potential effects of these factors on GPs' pre-tax earnings. However, these factors suggest that salaries reported in financial accounts might underestimate the total income derived by principal GPs from their medical practices. This is further complicated by variations in profitability between medical practices.

In the 13 case studies conducted by Campbell Research & Consulting (2003) for the Commission, the average pre-tax earnings per hour for principal GPs was $69.77. The Commission estimated a weighted average hourly income for all GPs. Assuming 24 per cent of GPs are employees who earn an average salary or wage of $45.06 per hour and 76 per cent of GPs are principals, partners or associates who earn, on average, $69.77 per hour from their practice, then the weighted average pre-tax earnings for all GPs is $63.84 per hour.

This average of $63.84 per hour for all GPs is higher than the estimate of $47.14 for all full-time GPs in the Australian Medical Association's (AMA) 2002 survey (Access Economics 2002). However, it is lower than the value proposed in the

Relative Value Study ($75.64 — indexed to June 2002 (PricewaterhouseCoopers 2000)) and lower than a rate of $100, based on the earnings implied by the AMA's proposed rate of $200 per hour (sub. PR36, p. 2) and then assuming half of this rate is attributable to practice costs.[1] However, the AMA's and Relative Value Study rates are proposed or recommended rates and not based on actual observation.

Other practice staff

Deriving the estimates of the pre-tax hourly earnings for other practice staff is more straightforward. The estimates are derived from ABS estimates (2000) of earnings for other practice staff, which the Commission has indexed for inflation, using the ABS *Wage Cost Index* (2002b).

Examples

The following examples show how the Commission estimated the GP administrative costs for EPC care plans and PIP accreditation.

EPC care plans

EPC care plans involve both service-based and GP-based costs. The service-based costs are driven by the labour costs associated with the staff time taken to complete a care plan (no service-based non-labour cost were identified). For each care plan, the estimated average time taken by each GP is 49 minutes. Assuming an average hourly wage of $63.84, the average cost of the GP's time is $52 per care plan (table F.2). Similarly, the average cost for the nurse's time (for example, time spent organising and following up on an individual patient's care plan) is $5 and for the receptionist's time is $1 (for example, time spent photocopying the plan and sending it to other care providers). Together these labour costs result in an average cost of $58 per care plan, generating national total service-based costs of about $16 million in 2001-02, based on 274 506 care plans completed.

There are also GP-based labour and non-labour costs involved in care plans. The labour costs are the fixed costs associated with the staff time taken per year to set up the GP to undertake care plans. For GPs, the average annual time spent in these activities is 90 minutes. Assuming an average earning rate of $63.84 per hour, the annual cost to a GP to undertake these activities is $96. Similar calculations are

[1] Based on information contained in the AMA's unpublished 2001 GP survey (Access Economics 2001) and GPSRG (1998), which suggests that practice costs are about half of practice revenue.

made for the time costs of practice managers and receptionists, who might assist GPs to set up for care plans (for example, the practice manager might be responsible for setting up the care plan folder for the GP), resulting in a labour cost of all staff, per GP per year of $238. The GP-based non-labour costs for care plans (for example, the material costs of the care plan folder) were $2 per GP per year.

Together, the GP-based costs resulted in an average annual cost of $240 per GP, generating a total national GP-based cost of about $1.7 million in 2001-02, based on 6951 GPs providing care plans. In 2001-02, the total national administrative cost associated with care plans was about $17.7 million, which is the sum of the total service- and GP-based costs.

Table F.2 **GP administrative costs of undertaking EPC care plans**

Cost category	*Average time per care plan*	*Hourly earnings*	*Average cost per care plan*	*Care plans*	*Total annual cost*
Service-based costs	minutes	$ per hour	$	no. per annum	$'000
Labour costs					
GP	49	63.84	52	274 506	14 385
Nurse	15	19.34	5	274 506	1 327
Practice manager	0	20.10	0	274 506	0
Receptionist	4	15.64	1	274 506	298
Total labour costs			58	274 506	16 010
Total non-labour costs			0	274 506	0
Total service-based costs			**58**	**274 506**	**16 010**
	Average time per annum	*Hourly earnings*	*Annual cost per GP*	*GPs*	*Total annual cost*
GP-based costs	minutes	$ per hour	$	no.	$'000
Labour costs					
GP	90	63.84	96	6 951	666
Nurse	0	19.34	0	6 951	0
Practice manager	20	20.10	7	6 951	47
Receptionist	520	15.64	136	6 951	942
Total labour costs			238	6 951	1 654
Total non-labour			2	6 951	12
Total GP-based costs			**240**	**6 951**	**1 666**
Total administrative costs					**17 676**

Source: Productivity Commission estimates.

Practice accreditation for PIP

Practice accreditation for PIP involves practice-based labour and non-labour costs. The labour costs are the costs associated with the average time taken by practice staff per year to undertake and maintain accreditation (an activity map outlining the broad activities involved in undertaking and maintaining accreditation standards is presented in appendix E). As the time is incurred periodically once every three years, it has been converted to an equivalent annual value, as explained above. For GPs, the estimated time is 1143 minutes per year (or about 19 hours). Assuming an average earning rate of $63.84 per hour, the annual cost to a practice of GPs' time spent on accreditation activities is $1217 (table F.3). Similar calculations are made for the costs for practice managers, nurses and receptionists who assist with accreditation, resulting in a labour cost of all staff of $6 097 per practice per year.

The non-labour costs are the average annualised costs associated with undertaking and maintaining accreditation, including the costs of purchasing and installing an autoclave and accreditation agency fees. The estimated costs are $3993 per practice per year.

Together these practice-based costs resulted in an average annual cost of $10 090 per practice per year, generating a total national administrative cost for PIP accreditation of about $48.7 million in 2001-02, based on 4829 practices participating in the program.

Table F.3 **GP administrative costs of accreditation for PIP**

Cost category	*Average time per annum*	*Hourly earnings*	*Annual cost per practice*	*Practices*	*Total annual costs*
	minutes	$ per hour	$	no.	$'000
Practice-based costs					
Labour costs					
GP	1 143	63.84	1 217	4 829	5 875
Nurse	4 628	19.34	1 492	4 829	7 205
Practice manager	3 496	20.10	1 171	4 829	5 655
Receptionist	8 505	15.64	2 217	4 829	10 705
Total labour costs			6 097	4 829	29 440
Total non-labour costs			3 993	4 829	19 284
Total administrative costs			**10 090**	**4 829**	**48 723**

Source: Productivity Commission estimates.

F.2 Time and cost data used by the Commission

This section contains tables of data used to derive the Productivity Commission estimates of GP administrative costs. The tables presented include the:

- estimates of administrative time (based on information from the pilot study, departments, case studies and focus group discussions) for activities that are:
  - service-based (table F.4);
  - GP-based (table F.5); and
  - practice-based (F.6).
- estimates of non-labour costs (based on the case studies) (table F.7);
- estimates of total administrative costs by program activities (table F.8); and
- estimates of the administrative costs for each cost category, for each program activity (table F.9).

Table F.4 **Productivity Commission estimates of service-based administrative time, by practice staff, 2001-02**

Average minutes per activity

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing					
ACCHS	Medicare access arrangements	222.22	0	0	0
ACIR	Immunisation notification — EDI	0.75	1.50	0	0.08
ACIR	Immunisation notification — manual & scanning	1.11	0.72	0.33	0.39
CHS	Hearing services application	1.88	0	1.25	0
EPC	Care plans — aged care	49.25	15.00	0	4.17
EPC	Care plans — preparation	49.25	15.00	0	4.17
EPC	Care plans — review	49.25	15.00	0	4.17
EPC	Case conference — organise age care	60.00	0	0	0
EPC	Case conference — organise	60.00	0	0	0
EPC	Case conference — part aged care	60.00	0	0	0
EPC	Case conference — participation	60.00	0	0	0
EPC	DMMR	36.25	0	0	2.50
EPC	Health assessments — at home	34.29	107.07	0.71	3.48
EPC	Health assessments — indigenous	34.29	107.07	0.71	3.48
EPC	Health assessments — in surgery	34.29	107.07	0.71	3.48
GPII	GPII	1.25	0.55	0	0.91
PBS	Phone authorisation	3.32	0	0	0
PBS	Written authorisation	9.50	0	0	0.92
PIP	Quality Prescribing Initiative	115.06	0	0	5.42
PIP	Teaching	4.00	0	0	0

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Table F.4 (continued)

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing (continued)					
SHCI	ACT Flinders education	750.00	0	0	0
SHCI	Flinders education	180.00	0	0	0
SHCI	Population health education	2400.00	0	0	0
SHCI	RACGP education	120.00	0	0	0
SHCI	RACGP workshop	120.00	0	0	0
PIP	SIP — Asthma	16.00	15.00	0	40.00
PIP	SIP — Cervical screening	3.75	1.60	0	0
PIP	SIP — Diabetes	19.17	5.00	0	5.00
Department of Veterans' Affairs					
Compen.	Assessment consultation	30.00	0	0	0
Compen.	GARP assessment	7.52	0	0	0
Compen.	Medical diagnosis report	15.00	0	0	0
Compen.	Pension claim form	20.85	0	0	0.37
Health	Care plans	49.25	15.00	0	4.17
Health	Case conference	60.00	0	0	0
Health	Medication reviews	36.25	0	0	2.50
Health	Health assessments	34.29	107.07	0.71	3.48
Health	Referrals	5.00	0	0	0
Health	Country Taxi Voucher Scheme	2.00	0	0	0
Department of Family and Community Services/Centrelink					
Carer Allowance	Forms	13.93	0	0	0
Carer Payment	Forms	11.32	0	0.45	0
DSP	Review TDR	23.38	0	0	0.07
DSP	TDR	17.22	0	0	0.37
Mobility Allowance	Forms	5.60	0	0	0.40
Newstart Allowance	Forms	5.62	0	0	0
Sickness Allowance	Forms	5.82	0	0	0
Youth Allowance	Forms	5.62	0	0	0
Responding to Commonwealth Government surveys					
Surveys	Forms	59.78	0	0	0

Source: Productivity Commission estimates based on information from pilot study, case studies, departments and focus groups, where available.

Table F.5 **Productivity Commission estimates of GP-based annual administrative time, by practice staff**

Average minutes per GP

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing					
EPC	Administration	105.0	45.0	555.0	60.0
EPC	Care plans — Organise	90.0	0	20.0	520.0
EPC	Health assessments — In surgery	26.4	60.7	287.1	17.1
Medicare access	RACGP training program	1 250.9	0	540.0	0
Medicare access	Vocational registration	2 957.9	0	40.0	10.0
PIP	SIP — Asthma	3.0	1 392.0	6.0	0
PIP	SIP — Cervical screening	30.0	0	12.5	105.0
PIP	SIP — Diabetes	5.0	960.0	0.8	0
PIP	SIP — Administration	35.6	33.3	320.0	8.9
Department of Veterans' Affairs					
Health	Care plans	90.0	0	20.0	520.0
Health	Health assessments	26.4	60.7	287.1	17.1

Source: Productivity Commission estimates based on information from Campbell Research & Consulting (2003).

Table F.6 **Productivity Commission estimates of practice-based annual administrative time, by practice staff**

Average minutes per practice

Program	*Activity*	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Department of Health and Ageing					
GPII	GPII	16.4	1543.6	741.8	1 568.2
PIP	Administration	26.9	0	468.5	0
PIP	After-hours care (tier 2)	0	196.4	16.4	0
PIP	After-hours care (tier 3)	2 592.0	0	12.0	0
PIP	Accreditation	1 143.4	4 628.5	3 495.9	8 504.7
PIP	IM and IT (tier 2)	150.3	160.0	17.2	34.4
PIP	IM and IT (tier 3)	360.0	0	327.8	0
PIP	Quality Prescribing Initiative	2.5	0	0	5.0
PIP	Teaching	54.0	0	288.0	0

Source: Productivity Commission estimates based on information from Campbell Research & Consulting (2003).

Table F.7 **Productivity Commission estimates of non-labour costs**

Program	*Activity*	*Practice-based*	*GP-based*
		$ per practice per year	$ per GP per year
Department of Health and Ageing			
EPC	Care plans — Organise	0	1.7
EPC	Health assessments — In surgery	0	28.6
Medicare access	Vocational registration	0	736.7
PIP	After-hours care (tier 1)	466.7	0
PIP	After-hours care (tier 2)	318.2	0
PIP	Accreditation	3 993.5	0
PIP	IM and IT (tier 2)	331.0	0
PIP	IM and IT (tier 3)	1 036.8	0
PIP	Quality Prescribing Initiative	106.7	0
PIP	SIP — Asthma	0	99.4
Department of Veterans' Affairs			
Health	Care plans	0	1.7
Health	Health assessments	0	28.6

Source: Productivity Commission estimates based on information from Campbell Research & Consulting (2003).

Table F.8 **Total GP administrative costs by program activities, 2001-02[a, b]**

Department	*Program*	*Activity*	*Cost*	*Proportion of total costs*
			$'000	%
DoHA	Medicare access	Vocational registration	74 184	32.59
DoHA	PIP	Accreditation	48 723	21.40
DoHA	EPC	Care plans	17 676	7.76
DoHA	EPC	Health assessments	13 030	5.72
DoHA	PBS	Phone authorisation	11 191	4.92
DoHA	PIP	IM and IT (tier 3)	6 050	2.66
DoHA	GPII	GPII	5 480	2.41
DoHA	PIP	SIP — Diabetes	3 769	1.66
DoHA	PIP	After-hours care (tier 3)	3 711	1.63
DVA	Health	Health assessments	3 238	1.42
FaCS	Newstart Allowance	Forms	3 203	1.41
DoHA	PIP	SIP — Asthma	2 729	1.20
FaCS	DSP	TDR	2 393	1.05
DoHA	EPC	Administration	2 299	1.01
DoHA	PIP	IM and IT (tier 2)	2 188	0.96
FaCS	DSP	Review TDR	2 176	0.96
DoHA	PIP	After-hours care (tier 1)	2 123	0.93

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Table F.8 (continued)

Department	*Program*	*Activity*	*Cost*	*Proportion of total costs*
			$'000	%
DVA	Compensation	GARP assessment	2 094	0.92
DoHA	Medicare access	RACGP training program	2 056	0.90
DoHA	PBS	Written authorisation	1 921	0.84
FaCS	Carer Allowance	Forms	1 795	0.79
DVA	Compensation	Assessment consultation	1 765	0.78
DoHA	ACIR	Immunisation notification	1 647	0.72
DVA	Health	Care plans	1 537	0.68
DoHA	PIP	Quality Prescribing Initiative	1 294	0.57
DoHA	PIP	After-hours care (tier 2)	1 242	0.55
DoHA	PIP	SIP — Administration	1 094	0.48
DVA	Compensation	Medical diagnosis report	904	0.40
DoHA	PIP	Administration	896	0.39
FaCS	Carer Payment	Forms	732	0.32
DoHA	EPC	Case conference	684	0.30
DVA	Health	Referrals	592	0.26
FaCS	Sickness Allowance	Forms	502	0.22
DoHA	PIP	SIP — Cervical screening	477	0.21
Various	Surveys	Forms	443	0.19
FaCS	Youth Allowance	Forms	406	0.18
DoHA	PIP	Teaching	262	0.11
DoHA	EPC	DMMR	253	0.11
DoHA	CHS	Hearing services application	216	0.09
DVA	Health	Medication reviews	214	0.09
DVA	Health	Country Taxi Voucher Scheme	177	0.08
DVA	Health	Case conference	112	0.05
FaCS	Mobility Allowance	Forms	75	0.03
DVA	Compensation	Pension claim form	75	0.03
Other			14	0.01
Total			**227 643**	**100.00**

a Data relate to the base case earnings, vocational registration and EPC assumptions. **b** Abbreviations listed at the front of the report.

Source: Productivity Commission estimates.

Table F.9 **Total GP administrative costs by program activities and category of cost, 2001-02[a, b, c]**

$'000

			Service-based[d]		*GP-based*[e]		*Practice-based*[f]		
Department	*Program*	*Activity*	*Labour*	*Non-labour*	*Labour*	*Non-labour*	*Labour*	*Non-labour*	*Total*
DoHA	Medicare access	Vocational registration	0	0	60 171	14 013	0	0	74 184
DoHA	PIP	Accreditation	0	0	0	0	29 440	19 284	48 723
DoHA	EPC	Care plans	16 010	0	1 654	12	0	0	17 676
DoHA	EPC	Health assessments	11 872	0	971	187	0	0	13 030
DoHA	PBS	Phone authorisation	11 191	0	0	0	0	0	11 191
DoHA	PIP	IM and IT (tier 3)	0	0	0	0	1 950	4 101	6 050
DoHA	GPII	GPII	0	0	0	0	5 480	0	5 480
DoHA	PIP	SIP — Diabetes	2 371	0	1 398	0	0	0	3 769
DoHA	PIP	After-hours care (tier 3)	0	0	0	0	3 711	0	3 711
DVA	Health	Health assessments	3 238	0	0	0	0	0	3 238
FaCS	Newstart Allowance	Forms	3 203	0	0	0	0	0	3 203
DoHA	PIP	SIP — Asthma	1 191	0	1 262	276	0	0	2 729
FaCS	DSP	TDR	2 393	0	0	0	0	0	2 393
DoHA	EPC	Administration	0	0	2 299	0	0	0	2 299
DoHA	PIP	IM and IT (tier 2)	0	0	0	0	889	1 300	2 188
FaCS	DSP	Review TDR	2 176	0	0	0	0	0	2 176
DoHA	PIP	After-hours care (tier 1)	0	0	0	0	0	2 123	2 123
DVA	Compensation	GARP assessment	2 094	0	0	0	0	0	2 094
DoHA	Medicare access	RACGP training program	0	0	2 056	0	0	0	2 056
DoHA	PBS	Written authorisation	1 921	0	0	0	0	0	1 921
FaCS	Carer Allowance	Forms	1 795	0	0	0	0	0	1 795
DVA	Compensation	Assessment consultation	1 765	0	0	0	0	0	1 765
DoHA	ACIR	Immunisation notification	1 647	0	0	0	0	0	1 647
DVA	Health	Care plans	1 537	0	0	0	0	0	1 537
DoHA	PIP	Quality Prescribing Initiative	1 160	0	0	0	5	129	1 294
DoHA	PIP	After-hours care (tier 2)	0	0	0	0	221	1 021	1 242

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Table F.9 (continued)

			Service-based[d]		*GP-based*[e]		*Practice-based*[f]		
Department	*Program*	*Activity*	*Labour*	*Non-labour*	*Labour*	*Non-labour*	*Labour*	*Non-labour*	*Total*
DoHA	PIP	SIP — Administration	0	0	1 094	0	0	0	1 094
DVA	Compensation	Medical diagnosis report	904	0	0	0	0	0	904
DoHA	PIP	Administration	0	0	0	0	896	0	896
FaCS	Carer Payment	Forms	732	0	0	0	0	0	732
DoHA	EPC	Case conference	684	0	0	0	0	0	684
DVA	Health	Referrals	592	0	0	0	0	0	592
FaCS	Sickness Allowance	Forms	502	0	0	0	0	0	502
DoHA	PIP	SIP — Cervical screening	181	0	296	0	0	0	477
Various	Surveys	Forms	443	0	0	0	0	0	443
FaCS	Youth Allowance	Forms	406	0	0	0	0	0	406
DoHA	PIP	Teaching	172	0	0	0	90	0	262
DoHA	EPC	DMMR	253	0	0	0	0	0	253
DoHA	CHS	Hearing services application	216	0	0	0	0	0	216
DVA	Health	Medication reviews	214	0	0	0	0	0	214
DVA	Health	Country Taxi Voucher Scheme	177	0	0	0	0	0	177
DVA	Health	Case conference	112	0	0	0	0	0	112
FaCS	Mobility Allowance	Forms	75	0	0	0	0	0	75
DVA	Compensation	Pension claim form	75	0	0	0	0	0	75
Other			14	0	0	0	0	0	14
Total			**71 315**	**0**	**71 203**	**14 488**	**42 680**	**27 957**	**227 643**

[a] Data relate to the base case earnings, vocational registration, EPC and SIP assumptions. [b] A zero indicates that cost data were either not applicable or not identified. [c] For abbreviations, see the abbreviations list at the front of the report. [d] Costs are derived by multiplying the average incremental unit cost of a service by the number of services; for example, the cost per health assessment is multiplied by the number of health assessments undertaken. [e] Costs are derived by multiplying the average incremental unit cost of an activity by the number of GPs involved in the activity; for example, the cost of vocational registration is multiplied by the number of VRGPs. [f] Costs are derived by multiplying the average incremental unit cost of an activity by the number of practices involved in the activity; for example, the cost of accreditation by the number of practices enrolled in PIP.

Source: Productivity Commission estimates.

F.3 Sensitivity analyses

Alternative assumptions

In reviewing the estimates of the administrative costs to GPs, the Commission considered that certain assumptions are particularly important in influencing the size of the administrative costs. These assumptions relate to:

- GPs' earnings;
- the amount of incremental time GPs spend maintaining their vocational registration (that is, the amount of time above what they would have spent in the absence of the government program);
- whether or not the time spent undertaking health assessments and care plans for the EPC program is in addition to that which would have occurred in the absence of the program; and
- whether or not the costs of practice accreditation for PIP are in addition to those that would have been incurred in the absence of the program.

The Commission undertook sensitivity analyses to indicate how the national estimates of total GP administrative costs might vary with changes in these important assumptions. Variations to other assumptions were also undertaken (such as whether GPs or practices incur setup costs for service incentive payments) but there was little overall difference in the estimates of GP administrative costs.

Earnings

Three earnings assumptions are outlined in table F.10. The Productivity Commission estimate (base case) assumption is based on the earnings to principal GPs reported in the case studies, together with ABS estimates (ABS 2000) of earnings for salaried GPs and other practice staff, which the Commission has indexed for inflation, using the ABS *Wage Cost Index* (2002b) (section F.1).

The Relative Value Study assumption corresponds to earnings rates proposed in that study indexed for inflation (Healthcare Management Advisors 2000).

The 'AMA recommended' assumption corresponds to an estimate of what GPs receive if they charge the AMA's proposed rate of $200 per hour (sub. PR36, p. 2), after taking into account practice costs and ABS estimates (indexed for inflation) for other practice staff. As outlined in section F.1, this rate does not reflect current

earnings of GPs and the Commission does not endorse this assumption. It is presented here to illustrate the impact of such an earnings rate for GPs on the estimates of GP administrative costs.

Table F.10 **Earnings assumptions for general practice staff, 2001-02**
Dollars per hour

Earnings assumptions	*GP*	*Practice nurse*	*Practice manager*	*Receptionist*
Productivity Commission estimate (base case)[a]	63.84	19.34	20.10	15.64
Relative Value Study[b]	75.64	19.89	23.16	17.28
AMA recommendation[c]	100.00	19.34	20.10	15.64

[a] The Productivity Commission estimate (base case) rate for GPs is based on the method outlined in section F.1. The rates for other general practice staff are derived from ABS Cat. no. 6306.0, indexed to June 2002 (using ABS Cat. no. 6345.0). [b] The Relative Value Study rates for all general practice staff (including GPs) are based on the study results, indexed to June 2002 (ABS Cat. no. 6345.0). [c] The AMA recommended rate for GPs is based on the assumptions that GPs charge the AMA recommended fee of $50 per 15 minute consultation and that half of this $200 hourly billing rate is attributable to practice costs. The rates for other general practice staff are derived from ABS Cat. no. 6306.0, indexed to June 2002 (using ABS Cat. no. 6345.0).

Source: ABS (2000, 2002b); AMA (sub. PR36); Healthcare Management Advisors (2000); PricewaterhouseCoopers (2000); Productivity Commission estimates.

Vocational registration

Almost all GPs are vocationally registered. One of the ongoing requirements for vocational registration is participation in Continuing Professional Development (CPD) activities (appendix D).

There are issues associated with determining the costs to GPs in undertaking CPD activities that are incremental, in the sense that they would not be incurred in the absence of vocational registration. First, many GPs appear to spend more time in these activities than necessary to meet the minimum requirements. The RACGP (which administers the points system) suggests that GPs reported they had accrued, on average, twice as many points as the minimum required to be reported (sub. PR41, p. 2). The Relative Value Study also found that GPs generally spent more than twice as much time on CPD (120 hours per year) than the minimum necessary time (about 45 hours per year) estimated by the consultants (Healthcare Management Advisors 2000, p. 47).

Second, there is an issue as to how much of GPs' time spent in these activities should be acknowledged as incremental costs, as some GPs say they would meet the

requirements anyway in order to maintain their professional skills. One GP interviewed in the case studies conducted for this study stated that he:

> … does not undertake these activities in order to gain vocational points. He considered that it is his duty to stay informed and that the work he does will also be beneficial to the division. (Campbell Research & Consulting 2003, vol. 2, p. 100)

This point was reinforced by the RACGP (sub. PR41, p. 1). The RACGP considers that in the absence of vocational registration, the 'vast majority of GPs would continue to undertake CPD as a part of their commitment to their craft'.

It is unrealistic to assume that GPs would do no CPD in the absence of vocational registration (that is, assume all costs associated with the time spent on CPD are incremental). Similarly, it is unrealistic to assume that none of the CPD is induced by the program (that is, assume there are no incremental costs associated with CPD) (chapter 4).

In the base case, the Commission assumes the incremental costs are based on half of the average time spent on CPD by the 12 GPs in the Commission's case studies (98.6 hours per year per GP), that is 49.3 hours.

The Commission's alternative assumption adopts the RACGP's suggested approach. The RACGP noted that it:

> … would see it as reasonable, based on the available data, to suggest that 5 per cent of GPs have a compliance burden with respect to the hours they spend undertaking CPD.
>
> The RACGP would, however, strongly prefer that only the costs of reporting involvement in continuing professional development be reflected in the report as a compliance cost.
>
> It is appropriate to include the cost of reporting involvement in CPD, as reporting CPD activity to a register is clearly a requirement imposed by the Federal Government program, which GPs would be unlikely to undertake were the program requirement not present. The RACGP estimates that this reporting would take less than one hour per year. The associated fee paid to the College is legitimately characterised as a compliance cost.

The Commission's alternative assumptions, based on the RACGP view, are presented in table F.11.

EPC program

Two key activities in the EPC program are the undertaking of health assessments and care plans. GPs and their practices spend significant amounts of time undertaking these activities.

The base case assumption is that these activities are not normal activities of being a GP (that is, GPs would not undertake these activities if this program did not exist). Consequently, the administrative costs of these health assessments and care plans include the time taken to complete each health assessment and care plan (table F.11).

The alternative assumption is that these activities are the normal activities of being a GP (that is, GPs would still undertake these activities even if this program did not exist). Consequently, the administrative costs of health assessments and care plans only include the time taken to set up the practice to undertake these activities, and do not include the time taken to complete them. These setup costs are included on the basis that GPs or practices would be unlikely to incur them in the program's absence (for example, the time a practice manager spends preparing the forms and other documentation to meet the program requirements).

Table F.11 **Other assumptions for GP administrative costs**

Program	*Base case*	*Alternative*
Vocational registration	For all VRGPs, per year: • 49.3 hours undertaking and reporting CPD;[a] • other practice staff time; and • $737 non-labour costs.[b]	For 5 per cent of VRGPs, per year: • 49.3 hours undertaking CPD; • 1 hour reporting CPD; and • $189 (annual RACGP admin fee). For 95 per cent of VRGPs, per year: • 1 hour reporting CPD; and • $189 (annual RACGP admin fee).[c]
EPC	Health assessments and care plans are not normal activities[d]	Health assessments and care plans are normal activities[e]
Accreditation for PIP	Practice accreditation is not a normal activity[f]	Practice accreditation is a normal activity[g]

[a] Derived by dividing the average time from the case studies (98.6 hours per year per GP) by two. [b] Includes the annual RACGP administration fee. [c] Derived based on RACGP (sub. PR41). [d] Assumes undertaking health assessments and care plans are not 'normal activities' of GPs. Therefore, administrative costs are associated with the time to undertake each activity (along with other fixed costs to set up). [e] Assumes undertaking health assessments and case plans are 'normal activities' of GPs. Therefore, each service incurs no administrative costs (but practices still incur fixed costs). [f] Therefore, administrative costs are incurred. [g] Therefore, no administrative costs are incurred.

Source: Productivity Commission estimates.

Practice accreditation for PIP

A prerequisite for practices to participate in PIP is that they are accredited. As with vocational registration, there is debate about the extent to which accreditation is a 'normal' activity of a general practice.

The base case assumption is that practice accreditation is not a normal activity for practices (that is, practices would not have undertaken the incremental activities to comply with accreditation if this program did not exist). Consequently, the administrative costs of accreditation for PIP are based on the time taken to meet the requirements (table F.11).

The alternative assumption is that practice accreditation is a normal activity for practices (that is, practices would have incurred the incremental costs of being accredited even if PIP did not exist). Consequently, the administrative costs of accreditation associated with PIP would be zero.

Results

In the preceding discussion, the Commission identified three possible assumptions about GPs' earnings and two assumptions with respect to vocational registration, EPC and accreditation for PIP. Various combinations of these assumptions could be presented. In table F.12, six of these combinations are illustrated. The numbers should not be interpreted as a range of estimates of GP administrative costs. Rather, they are an illustration of what these costs would be if particular combinations of assumptions are made. For example:

- if the AMA's preferred earnings assumption of $100 per hour for GPs (based on its proposed rate of $200 per hour (sub. PR36, p. 2) taking into account practice costs) were used instead of the Commission's estimated level of $63.84, and all other assumptions were unchanged, the estimate of GP administrative costs would increase from $228 million to $305 million; and
- if the RACGP's suggested approach for vocational registration (only including the time spent *undertaking* CPD for 5 per cent of GPs and the time and cost of *reporting* CPD for all GPs) were adopted, and EPC health assessments, EPC care plans and accreditation for PIP were assumed to be normal activities, the cost estimate would fall from $228 million to $85 million.

Table F.12 **Total GP administrative costs by earnings and other assumptions, 2001-02[a]**

$ million

	Earnings assumption		
Other assumptions	*Productivity Commission estimate (base case)*	*Relative Value Study*	*AMA recommendation*
Base case			
Vocational registration	74.2	85.3	108.1
EPC — care plans	17.7	20.6	26.2
EPC — health assessments	13.0	14.5	16.5
PIP — accreditation	48.7	52.0	52.1
Other	74.0	84.4	101.9
Total	**227.6**	**256.8**	**304.8**
Alternative			
Vocational registration	7.8	8.6	10.2
EPC — care plans	1.7	1.9	2.0
EPC — health assessments	1.2	1.3	1.3
PIP — accreditation	0.0	0.0	0.0
Other	74.0	84.4	101.9
Total	**84.6**	**96.2**	**115.4**

a Earnings assumptions are listed in table F.10 and other assumptions are listed in table F.11.

Source: Productivity Commission estimates.

Monte Carlo simulations

The Commission used data from a wide range of sources (appendix E). The precision of the data provided by the different sources varied.

The data on the numbers of forms, services and practices associated with various programs are generally precise, as they are based on actual numbers provided by the relevant Commonwealth departments. Similarly, the time data in relation to PBS authority phone calls — based on the actual total time spent on all calls (by Health Insurance Commission staff) in one year, divided by the total number of calls — is also considered precise.

In contrast, other labour/time cost and non-labour cost estimates are indicative only because they were derived from non-random small samples. In particular, the data derived from the case studies are not considered precise. Only 13 practices were examined in the case studies, of which a number did not participate in all the activities. For example, only six of the case study practices conducted EPC care plan activities.

Not only were the case study estimates based on a small non-random sample, there was considerable variation in the costs estimated between the case studies. To some extent, this variation is expected, given that the 13 case studies differed — by design — in terms of size, location and ownership arrangements. The Commission assumed that if a practice participated in an activity and no costs were reported, the incremental cost to this practice of this activity was zero. This assumption contributed further to this variability. Only one of the six case studies, for example, identified non-labour costs in relation to setting up GPs to undertake care plans. Therefore, the average incremental non-labour costs for care plans is based on six practices, five of which had costs of zero in this category.

To provide an understanding of how this variability might affect the estimates of total cost, and the cost estimates of particular programs and activities, the Commission conducted a Monte Carlo simulation analysis. Monte Carlo simulation analysis is often used in cost–benefit risk analysis to generate a probability distribution of the net benefits of alternative policy choices (Vaughan et al. 2000; Drummond et al. 1999). This analysis helps to overcome some of the limitations of sensitivity analysis, such as how to choose the alternative values used in sensitivities and interpreting the sensitivities given the 'arbitrariness' of the method often used for determining the values (Drummond et al. 1999).

The first step in undertaking this analysis was to generate — based on case study data — probability distributions of key cost categories for the four most costly program activities (vocational registration, PIP accreditation, EPC care plans, EPC health assessments) (table F.13).[2] A distribution was also generated for the Commission's base case GPs' hourly earnings rate, using GPs' earnings data from the case studies (section F.1).

Total administrative costs were then computed repeatedly (1000 times). With each computation, the input values were randomly selected from the distributions of the cost categories and earnings rate. This generated a frequency distribution of the total GP administrative costs (figure F.2). Figure F.2 indicates that about 70 per cent of the simulations generated estimates of total administrative costs in the range of $140 to $260 million and the mean of the 1000 simulations was $227.6 million. Disaggregated frequency distributions were also generated for key activities, including vocational registration, PIP and EPC (figures F.3–F.6).

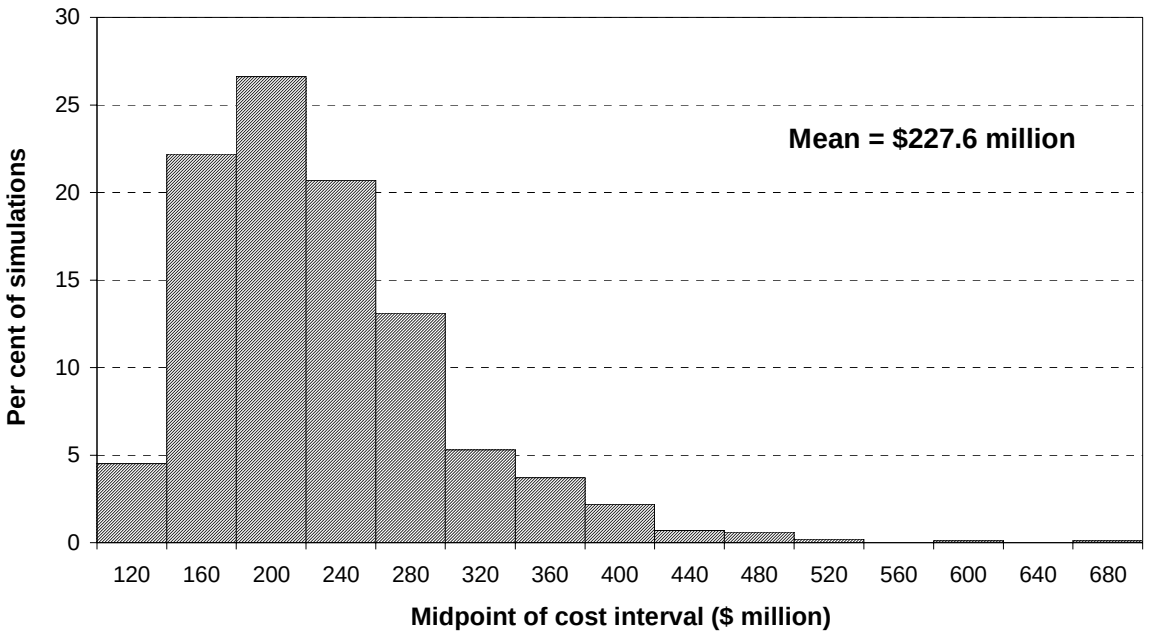
[2] Gamma and subjective triangular distributions were fitted to the data. These distributions were used as they ensure non-negative values are generated. Normal distributions were not used as they can generate negative values for the labour and non-labour costs.

Table F.13 **Cost categories used in the Monte Carlo simulation analysis**

	Activities			
Cost categories	*Vocational registration*	*PIP accreditation*	*EPC care plans*	*EPC health assessments*
Service-based labour costs				
GP time	..	..	Yes	Yes
Nurse time	..	..	Yes	Yes
Practice- or GP-based labour costs				
GP time	Yes	Yes	No	No
Nurse time	No	Yes	No	No
Practice manager time	No	Yes	No	No
Receptionist time	No	Yes	No	No
Practice- or GP-based non-labour costs	Yes	Yes	Yes	Yes

.. Not applicable.

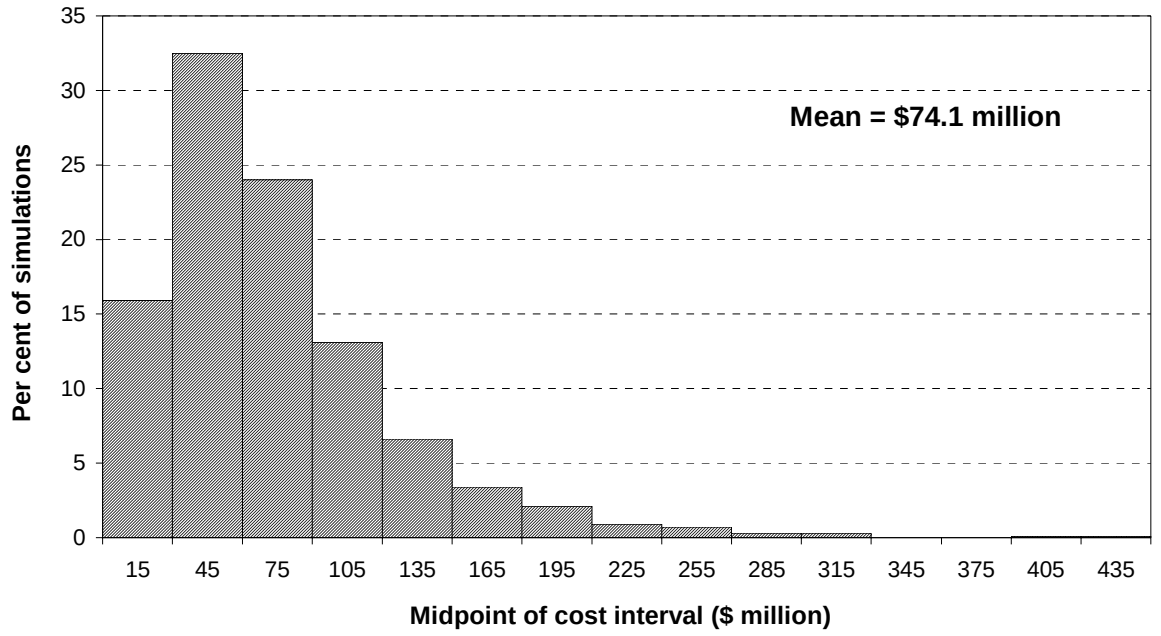
Figure F.2 **Distribution of total GP administrative costs[a]**



a Based on 1000 Monte Carlo simulations. Each cost interval has a width of $40 million.

Data source: Productivity Commission estimates.

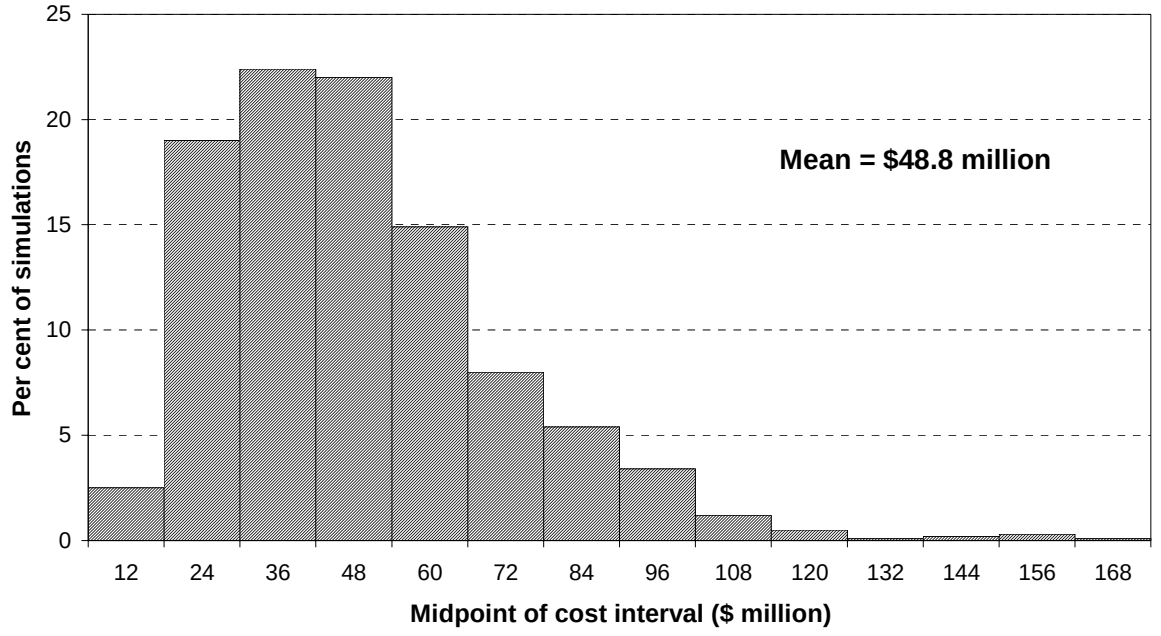
Figure F.3 **Distribution of vocational registration costs[a]**



a Based on 1000 Monte Carlo simulations. Each cost interval has a width of $30 million.

Data source: Productivity Commission estimates.

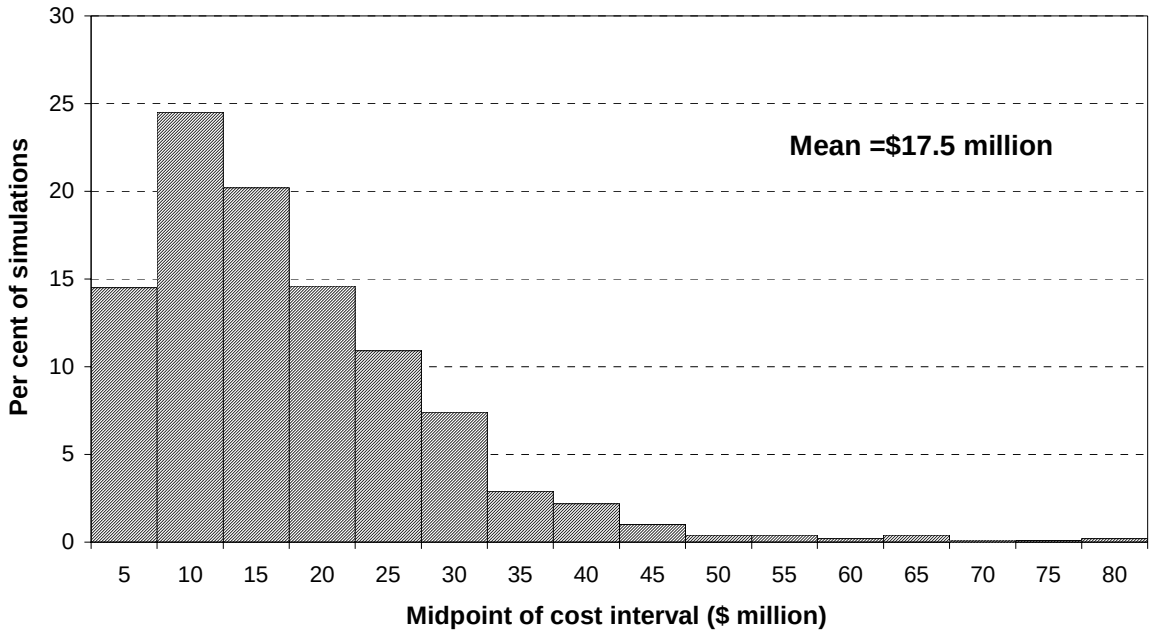
Figure F.4 **Distribution of PIP accreditation costs[a]**



a Based on 1000 Monte Carlo simulations. Each cost interval has a width of $12 million.

Data source: Productivity Commission estimates.

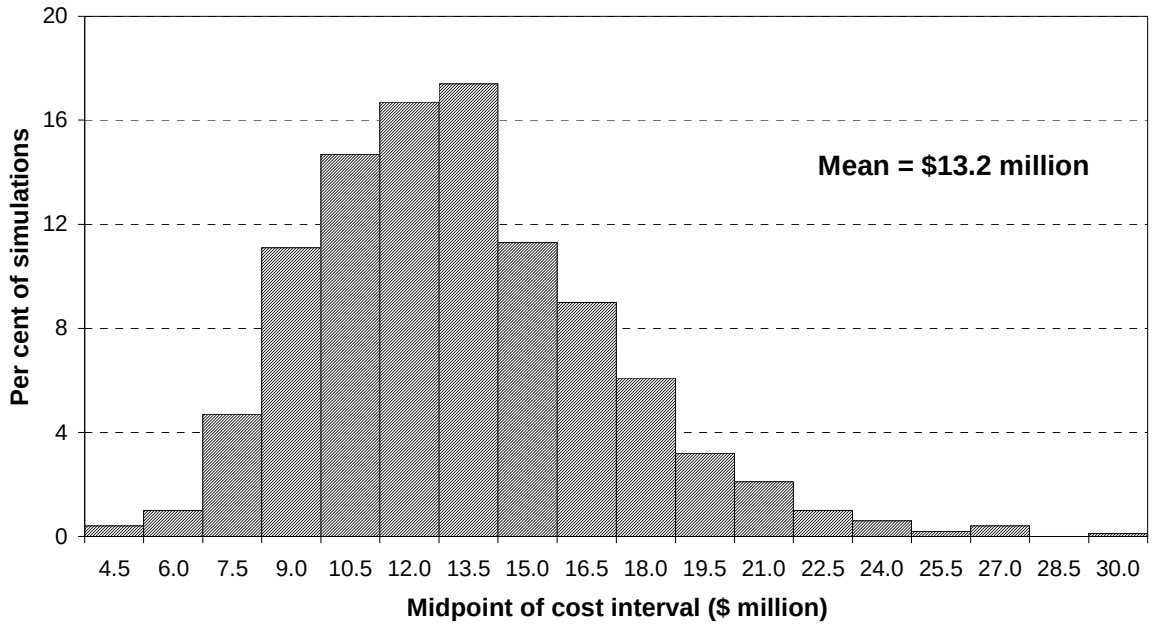
Figure F.5 **Distribution of EPC care plan costs[a]**



a Based on 1000 Monte Carlo simulations. Each cost interval has a width of $5 million.

Data source: Productivity Commission estimates.

Figure F.6 **Distribution of EPC health assessment costs[a]**



a Based on 1000 Monte Carlo simulations. Each cost interval has a width of $1.5 million.

Data source: Productivity Commission estimates.

References

ABS (Australian Bureau of Statistics) 1996, *Private Medical Practitioners: Australia, 1994-95,* Cat. no. 8689.0, ABS, Canberra.

—— 1997, *Private Medical Practice Industry: Australia, 1994-95*, Cat. no. 8685.0, ABS, Canberra.

—— 2000, *Employee Earnings and Hours, May 2000*, Cat. no. 6306.0, ABS, Canberra.

—— 2002a, *Private Medical Practitioners: Australia, 2002,* Cat. no. 8689.0, ABS, Canberra.

—— 2002b, *Wage Cost Index: Australia, June quarter 2002*, Cat. no. 6345.0, ABS, Canberra.

Access Economics 2001, *The General Practice Workforce in Australia: Results of the AMA GP Survey*, Unpublished report prepared for the Australian Medical Association, Canberra.

—— 2002, *An Analysis of the Widening Gap Between Community Need and the Availability of GP Services*, Canberra, http://www.accesseconomics.com.au/reports/amagpsur.pdf (accessed 4 July 2002).

ADGP (Australian Divisions of General Practice) 2001, *Report — Practice Nurse Scoping Study*, Canberra.

AIHW (Australian Institute of Health and Welfare) 2000, *Medical Labour Force 1998*, AIHW National Health Labour Force Series no. 15, Canberra.

—— 2003, *Medical Labour Force 1999*, AIHW National Health Labour Force Series no. 24, Canberra.

Bickerdyke, I. and Lattimore, R. 1997, *Reducing the Regulatory Burden: Does Firm Size Matter?*, Industry Commission Staff Research Paper, AGPS, Canberra.

Britt, H., Miller, G.C., Knox, S., Charles, J., Valenti, L. and Henderson, J. 2002, *General Practice Activity in Australia 2001-02*, AIHW General Practice Series no. 10, Canberra.

Cabalu, H., Doss, N. and Dawkins, P. 1996, *Employers' Compliance Costs*, Discussion Paper 96/10, Centre for Labour Market Research, Curtin University of Technology, Perth.

Campbell Research & Consulting 1997, *The General Practices Profile Study: A National Survey of Australian General Practices,* Report prepared for the General Practice Branch, Department of Health and Family Services, Melbourne.

—— 2003, *General Practice Compliance Costs Case Study Project*, vols 1 and 2, Report prepared for the Productivity Commission, Melbourne, http://www.pc.gov.au/research/studies/gpcompliance/consultancy5/index.html (accessed 20 March 2003).

Cresswell, A. 2002a, 'A bitter pill to swallow', *Australian Doctor*, 12 July, pp. 25–27.

—— 2002b, 'A day a week for govt forms', *Australian Doctor*, 12 April, pp. 1–2.

DEWR (Commonwealth Department of Employment and Workplace Relations) 2003, *Australians Working Together: Helping People to Move Forward*, Canberra, http://www.together.gov.au/aboutThePackage/default.asp (accessed 4 March 2003).

Doyle, D. 2002, *Review of Six Commonwealth Government Forms*, Report prepared for the Productivity Commission, Melbourne, http://www.pc.gov.au/research/studies/gpcompliance/consultancy4/consultancy4.pdf (accessed 20 March 2003).

DoHA (Department of Health and Ageing) 2000, *General Practice in Australia: 2000*, Canberra.

—— 2003, *Medicare Benefits Schedule Book*, http://www.health.gov.au/pubs/mbs/index.htm (accessed 19 February 2003).

Drummond, M., O'Brien, B., Stoddart, G. and Torrance, G. 1999, *Methods for the Economic Evaluation of Health Care Programmes*, 2nd edn, Oxford University Press, Oxford.

DVA (Department of Veterans' Affairs) 1998, *Guide to the Assessment of Rates of Veterans' Pensions*, 5th edn, Department of Veterans' Affairs, Canberra.

—— 2002, Schedule of fees for LMOs and other general practitioners – effective 1 November 2002, http://www.dva.gov.au/health/provider_fees/lmofees.htm (accessed 7 January 2003).

FaCS (Department of Family and Community Services) 2001, *Characteristics of Disability Support Pension Customers*, http://www.facs.gov.au/disabilities/ood/dsp_report/dsp_2001_final.htmood/dsp_report/dsp_2001_final.htm (accessed 5 August 2002).

—— 2002a, *Annual Report 2001-02*, http://www.facs.gov.au/annreport_2001-02/toc.html (accessed 12 February 2003).

—— 2002b, *Australians Working Together: Better Assessment and Early Intervention*, http://www.together.gov.au/whoIsInvolved/peopleWithADisability/measureOverviewPaper.doc (accessed 13 February 2003).

GPCG (General Practice Computing Group) 2001, *Work Program: 2001–2004*, Canberra, http://www.gpcg.org/publications/docs/workprogram2001_2004.pdf (accessed 31 January 2003).

GPSRG (General Practice Strategy Review Group) 1998, *General Practice: Changing the Future through Partnerships*, Commonwealth Department of Health and Family Services, Canberra.

Gramlich, E. M. 1990, *A Guide to Benefit–Cost Analysis*, 2nd edn, Prentice Hall, New Jersey.

Harding, J. 2000, 'The supply and distribution of general practitioners', in DoHA (2000), Canberra.

Healthcare Management Advisors 2000, *Remuneration Rates Study Final Report*, Medicare Schedule Review Board, Canberra.

HIC (Health Insurance Commission) 2002, *General Practice Immunisation Incentives: 2000/01 Statistical Report*, http://www.hic.gov.au/CA256976001D0618/Lookup/PDF_GENERAL_GPII/$file/2000_2001_statistical_report.pdf (accessed 25 September 2002).

—— 2003, *Practice Incentives Program: What is the Practice Incentives Program*?, http://www.hic.gov.au/providers/incentives_allowances/pip.htm (accessed 20 March 2003).

Howe, the Hon. B.L., Minister for Health, Housing and Community Services 1991, *Health Insurance Amendment Bill 1991: Second Reading*, Hansard, 20 August, Canberra.

Hoy, M. 1976, 'Paper work in general practice: A medical service? Who benefits?', *The Medical Journal of Australia*, vol. 1, pp. 200–2.

Hynes, T. 2000, 'The financing of general practice', in DoHA (2000), Canberra.

Killer, G. 2002, 'Results of the Benzodiazepines Prescriber Feedback Program Initiative', *Veterans' Health*, Department of Veterans' Affairs, vol. 68, p. 16.

KPMG 2000, *Corporatisation of General Practice Scoping Paper*, Report for Department of Health and Ageing, Canberra.

Mackay, K. 1998, *The Development of Australia's Evaluation System*, World Bank, http://lnweb18.worldbank.org/oed/oeddoclib.nsf/a4dd58e444f7c6118525680800 6a0008/c01fcb333a36cc3c852567fc005344a7/$FILE/ECD_WP4.pdf (accessed 23 January 2003).

MED (Ministry of Economic Development) 2001, *Business Compliance Cost Statements: Guidelines for Departments*, Wellington, New Zealand, http://www.med.govt.nz/buslt/compliance/guidelines/guidelines.pdf (accessed 14 May 2002).

Millward Brown Australia 2002a, *General Practice Compliance Costs: Feedback and Context for the Assessment of Commonwealth Forms*, Report prepared for the Productivity Commission, Melbourne, http://www.pc.gov.au/research/studies/gpcompliance/consultancy3/consultancy3.pdf (accessed 20 March 2003).

—— 2002b, *General Practice Compliance Costs: Quantitative Project: Pilot Stage — Topline Report*, Report prepared for the Productivity Commission, Melbourne, http://www.pc.gov.au/research/studies/gpcompliance/consultancy2/consultancy2.pdf (accessed 20 March 2003).

—— 2002c, *General Practice Compliance Costs: Qualitative Project — Topline Report*, Report for the Productivity Commission, Melbourne, http://www.pc.gov.au/research/studies/gpcompliance/consultancy1/consultancy1.pdf (accessed 20 March 2003).

Mott, K., Kidd, M. and Weller, D. 2000, 'Quality and outcomes in general practitice', in DoHA (2000), Canberra.

National Centre for Classification in Health 2000, *Professional Relativities Study Final Report*, Medicare Schedule Review Board, Canberra.

New Zealand General Practice Test Panel on Compliance Costs 2001, *Report to the Minister of Health from the General Practice Test Panel on Compliance Costs*, Ministry of Health, Wellington, New Zealand, http://www.moh.govt.nz/moh.nsf/7004be0c19a98f8a4c25692e007bf833/6b0a2d6d22203772cc256a0f000c423b?OpenDocument&Highlight=0,paperwork (accessed 4 July 2002).

OECD (Organisation for Economic Co-operation and Development) 2001, *Businesses Views on Red Tape: Administrative and Regulatory Burdens on Small- and Medium- Sized Enterprises*, Paris.

Office Of Management and Budget 1996, *Economic Analysis of Federal Regulations under Executive Order 12866*, Executive Office of the President of the United States, Washington, http://www.whitehouse.gov/omb/inforeg/riaguide.html (accessed 10 February 2002).

ORR (Office of Regulation Review) 1998, *A Guide to Regulation*, 2nd edn, AusInfo, Canberra.

OSD Comptroller (Office of the Under Secretary of Defense (Comptroller)) 2002, *Activity-Based Costing: Accounting for Operational Readiness*, Washington, http://www.dod.mil/comptroller/icenter/learn/abconcept.pdf (accessed 24 January 2003).

PC (Productivity Commission) 2002, *Regulation and its Review 2001-02*, Annual Report Series, Canberra.

—— 2003, *General Practice Administrative and Compliance Costs, Progress Report*, Canberra.

Power, P. 2000, 'The operating environment of general practice', in DoHA (2000), Canberra.

Public Health and Health Promotion SERU (Support and Evaluation Resource Unit) 2000, *The Role of General Practice in Population Health: The Way Forward*, SERU Discussion Paper: The Legacy Document, Part 2, Centre for Health Program Evaluation, Melbourne.

PricewaterhouseCoopers 2000, *A Resource-Based Model of Private Medical Practice in Australia — Final Report*, Medicare Schedule Review Board, vols 1–4, Canberra.

RACGP (Royal Australian College of General Practitioners) 2000, *Standards for General Practices 2nd Edition*, Melbourne.

RBA (Reserve Bank of Australia) 2003, *Interest Rates and Yields: Money Market and Commonwealth Government Securities*, http://www.rba.gov.au/Statistics/OP10_update.xls (accessed 3 March 2003).

Repatriation Commission 2001, *Annual Report 2000-01*, AusInfo, Canberra.

—— 2002, *Annual Report 2001-02*, AusInfo, Canberra.

Rimmer, J. and Wilson, S. 1996, *Compliance Costs of Taxation in Australia*, Staff Information Paper, Office of Regulation Review, AGPS, Canberra.

Sandford, C., Godwin, M. and Hardwick, P. 1989, *Administrative and Compliance Costs of Taxation*, Fiscal, Bath, United Kingdom.

Schattner, P. 1996, *An Analysis of Forms in General Practice*, Final Report, Department of Community Medicine and General Practice, Monash University, Melbourne.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2003, *Report on Government Services 2003*, Canberra.

United Kingdom Cabinet Office Public Sector Team and Department of Health 2001, *Making a Difference: Reducing General Practitioner (GP) Paperwork*, Report 1, http://www.cabinet-office.gov.uk/regulation/PublicSector/reports.htm (accessed 4 July 2002).

—— 2002, *Making a Difference: Reducing General Practitioner (GP) Paperwork*, Report 2, http://www.cabinet-office.gov.uk/regulation/PublicSector/reports.htm (accessed 4 July 2002).

US Department of Defense 1995, *ABC Guidebook Chapter 1: Introduction to Activity-Based Costing*, http://www.c3i.osd.mil/bpr/bprcd/0201c1.htm (accessed 8 August 2002).

Vaughan, W.J., Darling, A.H. and Rodriguez, D.J. 2000, *Uncertainty in the Economic Appraisal of Water Quality Improvement Investments: the Case for Project Risk Analysis*, Inter-American Development Bank, Washington.

Wooldridge, M. (Minister for Health and Aged Care) 2001, 'Opening Address', *National Chronic Disease Self-Management Conference Sharing Health Care*, Sydney, 31 July – 1 August 2000, Conference Proceedings, Department of Health and Ageing, Canberra, http://www.health.gov.au/pubhlth/chronic/pdfs/prodeed.pdf (accessed 2 October 2002).