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Commissioner Mike Woods
Deputy Chairman
Annual Review of Regulatory Burdens on Business
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Dear Commissioner Woods

Re: Annual Review of Regulatory Burdens on Business – Social and Economic Infrastructure Services

I am writing in relation to the above Review being conducted by the Commission. Medical practice obviously falls within the scope of this Review.

The AMA has made a number of submissions in recent years regarding the impact of red tape on patients, medical practices and the medical practitioners working in those practices. The AMA made a submission to the 2006 Regulation Review Taskforce Report (RRTR) and the 2003 Productivity Commission Research Report into General Practice Administration and Compliance Costs. Many of the recommendations outlined in these reports have never been implemented.

While the AMA welcomes this Review, it notes that the AMA has not seen any serious effort by recent Governments that demonstrate a commitment to release medical practice from the growing red tape burden so that it can deliver more services to patients. The AMA would encourage the Commission to revisit the earlier reports referred to above and assess what impact they have made in reducing the regulatory burden on medical practice.

In the current environment, where access to medical services in some areas is a significant problem, it would make good public policy sense to adopt measures that improved patient access to medical services. Red tape restricts patient access to care with some estimates suggesting that general practitioners, for example, spend up to nine hours per week complying with red tape obligations. Every hour a GP spends doing paperwork equates to around four patients who are denied access to a GP.

The reality is that a significant amount of red tape exists simply for measurement purposes. While the AMA recognises that there is a need to assess the impact of health care interventions and various Government programs, the current preoccupation with constructing initiatives so that they can be specifically measured often appears to be driven by political need with little regard for the compliance impact on medical practices.

This simply results in the proliferation of new rules and regulations or in the unnecessary introduction of new items in the Medicare Benefits Schedule. According to a media release issued by the Minister for Health and Ageing in December 2008, the number of primary care items alone in the Medicare Benefits Schedule more than tripled from 66 to 247 over a 10-year period. However, 92 per cent of all Medicare claims for primary care services relate to only 10 of these

items. The question needs to be asked why do we have so many MBS items given the pattern of utilisation.

It should come as no surprise that Governments want to tell the electorate just how many services etc have been delivered since a particular program was established. However, the available statistics about new programs and initiatives often give no real insight into their impact on improving people's health outcomes. In addition, it is often difficult for other stakeholders to access program statistics. Late last year, for example, the AMA was forced to make a Freedom of Information request to obtain information on MBS item usage that had been previously made available as a matter of course.

At a much more disturbing level, the Commonwealth Government uses red tape as a blunt rationing mechanism to discourage medical practitioners from providing more services and in some cases actively limiting the number of services medical practitioners can provide to patients and thus contain health costs. The funding of new services in the Medicare Benefits Schedule (MBS), for example, normally comes with prescriptive guidelines and rules that dictate how many times a service can be delivered for a patient, when it can be delivered, who it can be delivered to, how it must be delivered, what records must be kept and so on.

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

Compare this with the requirements set out in the Team Care Arrangement item (item 723) that was introduced into the MBS in 2005, which provides patients with a rebate to access GP referred allied health services. Requirements include:

- The GP must contact the proposed providers and obtain their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GP Management Plan (GPMP);

- The GP must collaborate with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient;

- The GP must document the goals, the collaborating providers, the treatment/services they have agreed to provide, any actions to be taken by the patient and a review date i.e. completing the TCA document; and

- The GP must provide the relevant parts of the TCA to the collaborating providers and to any other persons who, under the TCA, will give the patient the treatment/services mentioned in the TCA.

- The collaboration between the coordinating GP and participating providers must be based on two-way communication between them, preferably oral, or, if this is not practicable, in writing (including by exchange of fax or email, but noting that the means of

communication used must enable privacy to be safeguarded in relation to patient information). It should relate to the specific needs and circumstances of the patient. The communication from providers must include advice on treatment and management of the patient.

- To develop Team Care Arrangements for a patient, at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of the TCA. This includes people who will be organising or coordinating care services for the patient that will be provided by their organisation. Each of the health or care providers must provide a different kind of ongoing care to the patient. One of the minimum two service providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician but not usually another GP). The patient's informal or family carer may be included in the collaborative process but does not count towards the minimum of three collaborating providers.

The above requirements are unnecessarily prescriptive, thereby imposing extra red tape and unnecessary work and ignore the reality that GPs often have long established relationships with local allied health providers and know what services are available relevant to a patient's care needs. There is no flexibility in how the item can be delivered and nor does such a prescriptive approach take into account innovations in medical practice or local or patient circumstances.

This approach ignores the fact that doctors are highly trained professionals bound by strict codes of professional conduct and ethical practice. Doctors operate in a highly regulated environment and deliver the care patients need in accordance with accepted standards of high quality clinical practice. Additional prescriptive guidelines attached to MBS funding, such as those outlined above, do not aid the quality of care and nor do they enhance patient access to care.

To give another practical illustration of just how complex the MBS has become, the Department of Health and Ageing (DoHA) now offers an online facility that allows medical practitioners to create a customised publication for one or more item numbers in the MBS. This material provides an outline of the item description, associated requirements as well as any other information on the rules and regulations relevant to the performance of an item. This is no doubt intended to make it easier for medical practices to understand and comply with MBS requirements.

Creating a publication using item number 721 Chronic Disease Management, for example, results in the production of 61-page document that a medical practitioner is expected to wade through. It is possible to refine this document further by excluding the general explanatory notes in the MBS, however, this still results in an 11-page document being produced. This needs to be considered in the context that there are over 4400 MBS items in total. Indeed, the list is so long that the Government is no longer providing a hard copy MBS publication on the basis that it is too expensive to produce.

What is needed is a much less prescriptive approach to drafting items in the MBS that simply requires a medical practitioner to perform a service consistent with accepted professional standards of practice which would stand up to scrutiny through a peer reviewed process.

The Minister for Health and Ageing in late 2008 announced a process to reform and simplify the MBS. The Minister essentially announced that the government would:

- Clarify and amend the item descriptors for level C and D items to provide better support for prevention and to remove any confusion over the use of these items.
- Streamline chronic disease management items by removing duplication in existing items.
- Rationalise the different health checks outlined in the MBS moving to a structure based on the complexity of the check.
- Retain items for Residential Aged Care Facility visits and rationalise the items for all other out of surgery visits.
- Rationalise the items for after hours care (this will include a review of the item descriptors and the value of items).
- Rationalise the case conferencing items.

This represents a much more restrained reform initiative than the Government flagged during the 2007 election campaign where a more substantial overhaul was promised. The Government has also made it clear that the above must be achieved in an overall cost neutral framework.

The overwhelming feedback from members is that the above announcement will not make any meaningful progress towards an MBS structure that is designed to support patients to access the care they need while releasing medical practitioners from unnecessary red tape.

While the AMA has acknowledged that the above appears to be a step in the right direction, the subsequent consultation process conducted by the Department of Health and Ageing has shown that there is no demonstrated appetite to ease the compliance burden imposed by the MBS.

The AMA believes that the underlying barrier to real reform in this area is a view that a lower compliance burden would allow medical practitioners to deliver more services for patients and thus breach the underlying cost neutrality principle set down by the Government. It seems to be a self-defeating exercise where red tape is considered necessary to reduce the number of real services that medical practitioners can provide.

Streamlined Authorities

The RRTR did result in one initiative that has helped to cut red tape in medical practice the streamlined authorities program that was introduced in 1 July 2007. Although the program does not go as far as the recommendation outlined in the RRTR to remove authority approval requirements altogether, it has meant that medical practitioners no longer need to ring Medicare Australia to obtain authority to prescribe around 200 of the 450 Pharmaceutical Benefits Scheme (PBS) listed authority medicines. Eligibility rules have not been changed.

This program has recently been reviewed with the evaluation demonstrating that there has been no appreciable change in prescribing trends for PBS streamlined medicines. This is prima facie evidence that medical practitioners adhere to the PBS prescribing requirements and that forcing them to comply with unnecessary systems and processes simply lowers productivity without achieving any real cost savings within individual health programs.

The streamlined authority program has been a very successful exercise in removing unnecessary red tape for medical practitioners. It has significantly reduced the time medical practitioners waste on the phone to Medicare Australia. Given the authority system is essentially a rubber-stamping exercise, and that there is evidence of little risk to government expenditure, the authority system should now be removed altogether.

Other sources of red tape

There are a range of other areas where Government imposes unnecessary red tape on medical practitioners. These include:

- Centrelink programs
- Department of Veterans Affairs programs
- The Practice Incentive Program paperwork and compliance requirements
- Workforce programs such as the rural retention program
- Roads and Traffic Authority
- Subsidised taxi services for patients

The AMA provided an extensive submission to the 2003 Productivity Commission Research Report into General Practice Administration and Compliance Costs regarding these programs and also supported the subsequent report findings. The AMA does not propose to revisit these issues in any detail other than to say that little, if any, progress has been made towards addressing these issues.

Conclusion

The Commonwealth and state/territory governments invest significant resources to support medical workforce training. Given this investment, it is difficult to understand why the Commonwealth does not provide an environment where medical practitioners are able to get on with what they do best which is seeing and treating patients. In a time of medical workforce constraints Government policy should be directed towards the efficient use of what is a very precious community resource.

Red tape in medical practice represents a significant cost to the community. While Government may take some comfort in the fact that it may reduce the number of services it has to pay for, by taking up time in administration instead of patient care, and provide masses of statistics (that often never see the light of day), this short-sighted approach ignores the subsequent downstream costs to the health system, costs to the health of patients and the inefficiencies it generates within medical practices. If this review does nothing else, it must shine a spotlight on the Government's inappropriate use of red tape to ration services for patients and to count services simply for the sake of doing so.

Yours sincerely

Dr Rosanna Capolingua
President