02/417

21 November 2005

Mr Gary Banks
Chair
Regulation Taskforce
PO Box 282
BELCONNEN ACT 2616

Dear Mr Banks

Reducing the Regulatory Burden on Business

The Australian Medical Association (AMA) welcomes the opportunity to provide the Regulation Taskforce with a submission on the above topic. The AMA is the pre-eminent body representing medical practitioners with over 28,000 members throughout Australia.

A significant proportion of the AMA's membership is in private practice, and close to 100% of these members would fall within the definition of a "small business".

The compliance burden is not just a result of regulation

The first thing that the AMA would highlight is that the compliance burden on medical practice is not simply driven by regulation. The burden is often a direct result of the administration of Government programs.

Government uses private medical practice to deliver many health care programs and to achieve stated health priorities. Australian medical practitioners are amongst the best trained in the world and use their clinical judgment wisely. Yet, Government often fails to recognise this professionalism and instead insist on meaningless paperwork or other compliance requirements.

These requirements can also be the result of the failure of bureaucracy to improve their own systems, and simply transfer the burden to business.

Practice Incentive Programs, Provider Number regulations, Authority Prescriptions and the administration of some workforce initiatives are all examples of where significant reform could be achieved. The Productivity Commission has already examined some of these areas, however, many of its recommendations are yet to be realised.

The attached paper prepared by the AMA General Practice Department discusses these issues in more detail, along with appropriate solutions.

The use of data by Government departments to administer programs is also inconsistent. For example, the Department of Health and Ageing (DoHA) uses a District of Workforce Shortage (DWS) measure to administer various workforce incentive programs. Until recently, different sections of DoHA collected DWS information at different times leading to anomalies.

Townsville was regarded as a DWS for the purposes of recruiting overseas trained doctors, but was not classified as a DWS to enable practices to access incentives to employ locally trained doctors. Clearly, there is a strong need for Government departments to put in place improved arrangements to cross-reference the use of data.

It is also clear that Governments often discount the need to make out a business case for medical practices to engage in Government programs. Programs are often designed with the needs of the bureaucracy in mind, rather than the medical practice.

The take up of information technology, including on line payment systems, by medical practices is lagging due to the failure by Government to acknowledge that there must be sufficient commercial benefit to the practice.

Slow payment times as well as restrictions on patient co-payments are seriously holding back Medicare on-line, which in the long run disadvantages patients and adds significantly to the cost of administering Medicare. Yet, rather than address the fundamental economics of the program, the Government increasingly looks like it will employ sticks to encourage take up. This is the wrong approach.

Contracting and tendering

Increasingly, the Commonwealth Government is moving to a one-size fits all approach to tendering for services. This is especially relevant to medical practitioners who are tendering for contracts with departments such as Defence or Veterans' Affairs.

A recent request for tender for medical services by the Department of Defence involved a phone book sized pile of documentation. This material went largely to small independent contractors who were already providing services to Defence.

The contracts included in the request for tender were complex and placed significant and unfair obligations and restrictions on tenderers. The material may well have been suitable for a major defence project tender, but was irrelevant to the medical practitioners who were interested in the tender.

It is doubtful that the tendering process yielded any financial savings for Defence, yet the AMA is aware that many practitioners chose not to proceed with the tender due to its complexity.

Clearly, Government departments must be given greater flexibility to allow them to deal more effectively with small business during tender processes. While we support greater consistency within Government, this does not preclude common sense initiatives that recognise the difficulty that small business has in dealing with much larger and much better resourced organisations.

Regulatory Impact Statements

One of the most disappointing aspects of the current regulatory environment is the lack of rigour that is applied to the preparation of an RIS. The RIS is often used as a justification for legislation, rather than being a careful and rigorous analysis of the costs and benefits of new legislation.

The preparation of an RIS is normally done by the policy making arm of Government responsible for the development of the relevant piece of legislation. The Office of Regulation Review is relatively powerless to intervene when it is clear that an RIS has not been completed to an adequate standard.

It is essential that a more robust process be established to review the impact of legislation, and that this process must be carried out by a body that is at arms length from the policy making arms of Government.

Appropriate thresholds

The Government has introduced a number of measures to exempt, or partially exempt, small business from the operation of certain legislative requirements, or to allow small business to access simplified arrangements for dealing with Government.

Thresholds for access to the Simplified Tax System, or cash based accounting for GST are two excellent examples. Yet, these thresholds are often set at artificially low levels and are not indexed.

The Taskforce must review these and similar thresholds to ensure that:

- They are set at levels that effectively encompass the majority of small businesses;
- They are consistent;
- They are appropriately indexed.

Australian Taxation Office

The ATO and its administration of taxation rulings require serious examination. Complaints from taxpayers frequently arise concerning apparent changes in approach from the ATO. The end result can be significant tax adjustments and/or significant changes to the way a business is run.

The recent Draft Tax Ruling (TR 2005/D5) concerning service arrangements is a case in point. The ATO released the ruling along with a draft booklet designed to assist with the interpretation of the ruling. This material is portrayed by the ATO as “supplementing” an earlier ruling on the subject – IT 276.

TR 2005/D5 along with the draft booklet totals 45 pages, yet the original ruling these are designed to supplement - IT 276, runs to only 2 pages. Not surprisingly, members and their advisors alike believe that the latest ruling represents a significant shift in attitude and interpretation by the ATO. Medical practitioners will be forced to seek further advice on legitimate well-established service arrangements and in all likelihood will be forced to restructure these.

The cost to business is significant.

The role of the Inspector General of Taxation (IGT) needs to be significantly strengthened and the Tax Commissioner should be required to comply with recommendations made by the IGT.

In addition, consideration should be given to requiring the ATO to table Tax Rulings before the Parliament and making them a disallowable instrument. This would place significant onus on the ATO to get rulings right the first time, and to administer Tax laws in a consistent fashion.

Australian Competition and Consumer Commission

The ACCC plays an important role in the protection of consumer interests, yet sometimes this role runs counter to sensible health workforce policy.

Authorisation processes under the Trade Practices Act for medical rosters are expensive and discourage medical practitioners from entering into certain rostering arrangements designed to ensure continuing patient access to medical services. Rural areas in particular are disadvantaged.

A simplified notification process – similar to those recommended by the Dawson Review with respect to collective bargaining needs to be instituted to allow medical practitioners to notify rostering arrangements. This would significantly streamline processes and encourage medical practitioners to enter into certain arrangements that deliver better access to care as well as reduce the excessive hours worked by practitioners in rural areas.

There have been a number of reviews and reports that have looked at reducing the regulatory burden on business. Sadly, these reports have made little progress and where progress has been made, more and more pages of legislation quickly overwhelm this.

This short submission has sought to address some issues specific to the medical sector, however, we have no doubt that they are symptomatic of broader systemic problems. The AMA has also highlighted broad policy changes that we believe will deliver better outcomes for business. In particular, the requirement to properly weigh the costs and benefits of proposed legislation is fundamental if the growth in the compliance burden is to be contained in any way.

Yours sincerely

Dr E Robyn Mason
Secretary General

IMPLEMENTATION OF PRODUCTIVITY COMMISSION RECOMMENDATIONS

There has been very slow progress in implementing the measures in response to the findings of the Research Report into General Practice Administrative and Compliance Costs by the Productivity Commission in 2003.

After more than two years the Chronic Disease Management Items were introduced to replace the Enhanced Primary Care item identified as a major source of red tape for GPs. These new items have been highly successful and are a model of what can be achieved with real consultation with the profession.

However, changes to the Practice Incentive Program (PIP), have not yet occurred and consultation has been fragmented. The Productivity Commission identified the PIP as another source of significant red tape for GPs.

There has been little or no improvement in terms of a cross government approach, particularly to the issue of forms and other areas of duplication identified by the Productivity Commission.

None of the Recommendations (6.1 – 6.8) of the Productivity Commission report have been implemented.

PROVIDER NUMBERS

Under current rules governing access to Medicare, GPs are required to apply for and obtain a separate provider number for each practice location at which they work.

Obtaining a Medicare provider number requires completion of a five-page application form. Assessment and approval of the application form by the Health Insurance Commission takes a minimum of three weeks.

In addition to the red tape burden this creates for GPs, it has other implications in terms of practices obtaining staff, particularly as a matter or urgency or in emergencies.

Previously, locum GPs could have a provider number linked to their home base that they could use if providing a service for less than two weeks. However, now that the Medicare bulk billing incentives are based on geography, HIC must know a practice's location and locums are required to obtain a new provider number for every job no matter how short-term.

A single provider number that is combined with a location specific number for the practice where they are working when completing Medicare documents is the solution.

The AMA recently made a submission to the Biennial Review of Provider Numbers and called for a restructure of the provider number system to be considered.

Changing the system may be fairly straightforward as the Health Insurance Regulations provide that, for Medicare purposes, a valid account/receipt must contain the practitioners' name and either:

- The address of the place of practice from which the service was provided; or
- The provider number for the place of practice from which the service was provided.

At its meeting on 5 November the AMA's Federal Council passed the following resolution:

> *That Federal Council call on the Government to implement a new Medicare provider number system under which:*
> *- Medicare practitioners retain a single national provider number; and*
> *-Each practice location in Australia receives a location specific identification number.*

AUTHORITY PRESCRIPTIONS

The AMA is very concerned about the high level of bureaucratic red tape related to authority prescriptions that impinges on the time GPs could be spending with their patients. Authority prescriptions are by far the greatest source of complaint to the AMA from general practitioners in relation to bureaucratic red tape.

General practitioners are particularly frustrated by the need to continuously renew authority prescriptions for patients who are on such medications for long periods of time. These may include terminally ill or those with disease/problems that will continue for their lifetime. It is unnecessarily costly to the patient and unnecessarily costly to the doctor in terms of the red tape involved.

During consultations with the Red Tape Taskforce in 2004 the AMA consistently requested consideration of the massive red tape surrounding PBS Authorisations. The Steering Group was established jointly by the Department of Health and Ageing and the Department of Prime Minister and Cabinet to consider implementation of the findings of the Productivity Commission's Review of General Practice and Administration Costs. There was a significant reluctance in the bureaucracy to alter current PBS Authorisation arrangements.

Government ultimately presented two options for discussion by the Taskforce's Technical Working Group (stakeholders). The first option that involved doctors being able to opt in to a no authority system on the basis that they be subjected to an enhanced compliance mechanism was rejected outright. The second option was preferred. It allowed doctors to reuse PBS authority approval numbers approved previously by the HIC. The Taskforce estimated that this option could lead to a 40% reduction in total number of authority approvals – a significant reduction in red tape for GPs.

There was has been no progress on these ideas since around 2004 when they were first proposed.

NON VOCATIONALLY RECOGNISED GENERAL PRACTITIONERS (NON VR GPS)

The AMA has called for a rationalisation of programs that deliver A1 Medicare rebates to the patients of non VR GPs. The table below outlines the numerous programs with varied criteria that currently give access to non-VRs under different circumstances. The program is complex, confusing and is without doubt administratively costly to Government.

Summary of existing non VR programs that provide access to A1 rebates

Program	**Eligibility**	**Hours**	**Funding**
Rural Other Medical Practitioners (ROMPs)	Began in 2001. All OMPs who provide GP services in rural and remote areas of Australia that are classified as RRMA (Rural Remote and Metropolitan Areas) 4-7 may be eligible for the Program. This includes OMPs who are: • Non-VR GPs • Overseas Trained Doctors • Temporary Resident Doctors • Special Interest Practitioners who wish to specialise in General Practice • Doctors providing GP services in RRMA 4-7 through the Rural Locum Relief Programs and the State Overseas Trained Doctors (SOTD) initiative. Must work towards FRACGP.	All hours	$38m/4years
Outer Metropolitan Other Medical Practitioners	The Outer Metropolitan OMPs Program aims to improve access to medical practitioner services in outer metropolitan areas of the six State capital cities and the ACT. The Program has two components. The first is aimed at encouraging non-vocationally recognised general practitioners to move to outer metropolitan areas with doctor shortages. The second component encourages non-vocationally recognised general practitioners already working in these under-supplied outer metropolitan areas to remain there. The program provides access to the higher A1 Medicare rebate for approved doctors who agree to undertake a pathway to FRACGP. If vocational recognition has not been achieved by 30 November 2006, the program end date, access to A1 Medicare rebates will cease, and doctors will only be eligible to access A2 Medicare rebates.	All hours	

MedicarePlus Other Medical Practitioners	Introduced under MedicarePlus. All non VR GPs who were practising before 1996 and work in an area of workforce shortage. Once they have practised for five years in an area of workforce shortage they can access A1 rebates for life regardless of practice location. Must meet CPD requirements	All hours	$22.4m/
Medical Deputising Service After Hours Other Medical Practitioners (OMPs) Program	Introduced August 2004. All non VR GPs registered with a State or Territory Medical Registration Board. Have access to Medicare Benefits. Be providing clinic based after hours only services in clinics operated as part of an accredited Medical Deputising Service. Satisfy ongoing continuing professional development requirements. This includes non VRs, OTDs and Temporary Resident Doctors.	After hours only.	
After Hours OMPs	Introduced January 2005. All non-VRs registered with a State or Territory Medical Board with current access to MBS benefits who provide after hours GP services through an accredited general practice or MDS. Must agree to enrol for RACGP assessment leading to FRACGP within four years and satisfy ongoing CPD requirements.	After Hours only.	

According to Department of Health figures, there were 4,109 non VR GPs practising in Australia in 2003-04, but only 1,247 are working full-time.

Patient rebates for a standard Non-VR GP consult were frozen at $17.85 from 1991, with a recent increase to 100% of the Schedule Fee ($21.00) under a Government election commitment that came into effect on 1 January 2005. This is in stark contrast to current patient rebate for a standard consultation with a VR GP of $31.45.

Non VR GPs have increasingly been viewed as a group available for manipulation in the search for workforce solutions. As a consequence a raft of programs that give non-VRs access to A1 rebates as long as they work in rural areas, after hours or wherever else a perceived shortfall exists, have been introduced.

Initial programs to give non VR GPs access to A1 item numbers were focussed on retaining and attracting this workforce to the bush. However, in spite of Government initiatives Non VR workforce participation in rural areas is no better than in urban areas.

There is, however, a dire need to implement measures that address this largely demoralised section of the GP workforce that focus on retention and an increased participation rate.

It is estimated that through the Government initiatives 55% of non VRs are already accessing A1 GP rebates. The additional cost to the MBS of implementing a final round of grandfathering will thus be limited to providing access to A1 rebates to the estimated 45% of Non VR GPs who are unable to do so through current programs. The Government will, without doubt, accrue significant savings from reduced administration costs currently associated with the management of the range of complex programs that deliver A1 rebates to Non VR GPs under a range of different criteria.

Importantly the patients of 45% of the Non VR GP workforce are suffering discrimination in relation to Medicare for no reason that has anything to do with quality of service.