

Battling red tape

GPs are inadequately reinforced and poorly funded — and don't mention the paperwork

“To tell you the truth, I thought of all the damned paperwork this was going to mean in the morning,” said United States General Walter Bedell Smith, recalling the signing of the armistice that ended World War II (*New York Times*, 8 May 1965). He might have been describing a typical afternoon in general practice. I timed myself one day: a fifth of the 2 hours seeing seven patients had been spent in skirmishes with paperwork. Soldiers fight, surgeons operate, and physicians treat — but GPs? We practise *consultatio interruptus* (courtesy M Van Der Weyden, MJA Editor).

Paperwork is an occupational hazard for GPs. One GP counted a barrage of 1574 individual communications monthly.¹ In cold cash terms, the Productivity Commission found that GPs' administrative costs from government programs in 2001–02 were an estimated 5% of GPs' total income in the base case (ie, \$13 100 annually for a GP working at least one day a week).² Putative financial incentives for GPs to provide quality care, such as vocational registration, the Practice Incentives Program (PIP), and Enhanced Primary Care (EPC) Medicare items, accounted for over three-quarters of these costs. The report also acknowledged the stress and frustration experienced by GPs in filling out forms and complying with government programs.

In response to the Commission's report, a GP Red Tape Taskforce has emerged.³ This cross-government group includes staff from the senior ranks of the departments of Health and Ageing and Veterans' Affairs, Centrelink and the Health Insurance Commission. After consulting GPs, GP groups, consumers and other stakeholders, a draft of possible responses was released in October last year. These included streamlining the government's information requirements, enhancing GP use of information technology, simplifying programs such as PIP, and minimising administrative costs.³ Discussions with GP groups since then have focused mostly on reworking PIP and EPC items. Predictably, actual reform is yet to materialise. Furthermore, within a year of the Taskforce becoming operational, the government announced its Medicare Plus package, which included tying allied healthcare services access to the EPC program.⁴ While laudable in its intent, it promised yet another salvo of red tape for GPs. Countermeasures raised since by GP groups will diminish this,⁵ but it remains an inherently flawed initiative.

This war on paper is allied to major themes in the 2004 MJA *General Practice* issue: general practice funding and workforce pressures. Are fragmented government payments in a fee-for-service system really the way to go? Data furnished by Britt et al (page 100) have implications for current negotiations on restructuring Medicare items. We also asked our Dutch (Van Weel, page 110), British (Weller and Maynard, page 109), Canadian (Martin and Hogg, page 111), American (Green, page 113) and New Zealand (Malcolm, page 106) colleagues to tell us how they fared with funding. The only constant in their replies is that of change, and change can be difficult. Nor is it often well evaluated, say Van Weel and Del Mar (page 98), marshalling the evidence for various payment systems. It is also clear that most of the countries featured in this issue favour deploying capitation (lump sum payment per patient on the GPs' "list") to pay their GPs.

As for workforce pressures, they're unlikely to improve in the near future (Charles et al, page 85). Some rural communities continue to

favour doctors more than other healthcare services (Smith et al, page 91). So find out how a few rural GPs successfully outflanked their workforce problems (Joyner et al, page 96).

This issue doesn't neglect clinical problems — for example:

- why we shouldn't panic about avian influenza (Isaacs et al, page 62);
- what we learnt in the aftermath of Implanon (Wenck and Johnston, page 117; Nisselle, page 64);
- who should eat which fish (Bambrick and Kjellström, page 61);
- what dilemmas GPs face in diagnosing and treating heart failure (Phillips et al, page 78);
- where the luxury of on-site psychologists seemed to benefit patients (Vines et al, page 74);
- how chronically ill patients like their GPs and their practices (Infante et al, page 74);
- how GPs can realistically tackle respiratory disease (Beilby et al, page 67) and childhood obesity (Wake and McCallum, page 82).

In this issue, we have attempted to enter the fray of real general practice. The campaign against red tape aims to free GPs for what most of us really want to work at — patient care. The battle against red tape is part of the healthcare war.

Mabel Chew

General Practitioner and Deputy Editor
The Medical Journal of Australia, Sydney, NSW.
medjaust@ampco.com.au

- 1 Hogan CD. Communication overload. *Med J Aust* 2002; 177: 688.
- 2 Productivity Commission. General practice administrative and compliance costs, research report. Canberra: Commonwealth of Australia, 2003.
- 3 Department of Health and Ageing. Red Tape Taskforce: Overview. Available at: www.health.gov.au/redtape/overview.htm (accessed June 2004).
- 4 Department of Health and Ageing. Medicare Plus: update, March 2004. Available at: www.health.gov.au/medicareplus/update_march_04/glance_04.htm#section2 (accessed June 2004).
- 5 The Royal Australian College of General Practitioners. General Practice Representative Group, 2 June 2004. Available at: www.racgp.org.au/document.asp?id=13319 (accessed June 2004). □

Illustrator: Futcher. First appeared in *Australian Doctor*, 2002.

