

Report of the Attendance Item Restructure Working Group

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Executive Summary

Under the current attendance item structure, financial incentives favour shorter consultations. Current broad time bands mean, for example, that the Medicare Benefit Schedule rebate is the same for a six minute general practitioner consultation as for a 19 minute consultation. The Attendance Item Restructure Working Group was formed in February 2002 to develop proposals for reform of the attendance item structure to address this issue and improve incentives for the provision of quality care.

This report of the Working Group considers in surgery unreferred attendance items, that is, Level A, B, C and D general practitioner consultations. It is provided for consideration to the Minister for Health and Ageing and general practitioner organisations.

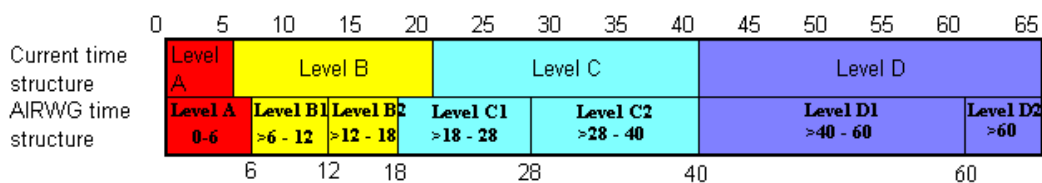
The Working Group undertook an extensive review of available evidence on the relationship between quality and length of consultation and concluded that an increasing body of international evidence suggested that 'longer' consultation times are associated with better health outcomes. The Working Group concluded that the existing item structure, with financial incentives favouring shorter consultations, was not optimal for the purposes of supporting quality care.

In designing an alternative item structure that would better reward quality care, the Working Group identified structural issues, that is, issues relating to the composition of an alternative attendance item structure, and implementation issues, that is, its potential impact or implications.

Structural Issues

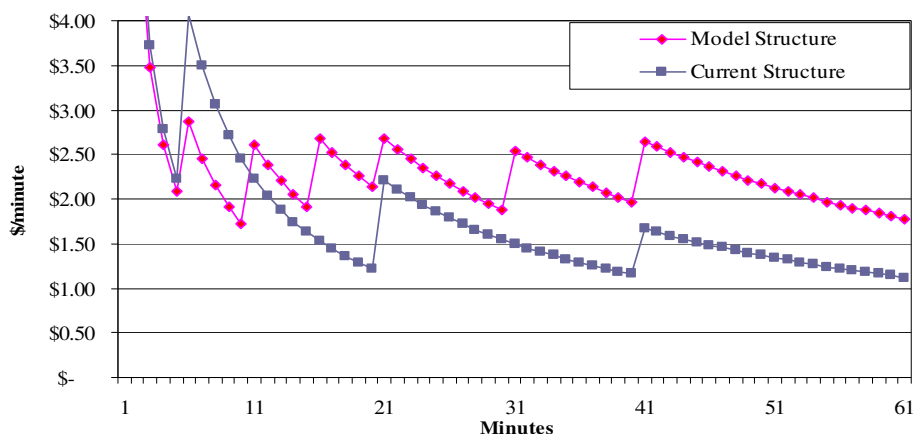
Structural issues included the number and length of attendance items. The Working Group identified a preferred time structure with an increased number of items. This structure, by decreasing the width of item time bands, reduces the variation in fee-per-minute in the current structure.

Preferred Time Structure



The following Chart compares the rebate fee-per-minute in the current and proposed (model) structures in a Model 1 context, that is, where no additional funding is involved. In the new structure, within the same overall budget, the rebate per minute for all items generally ranges from \$2 to \$2.50, whereas for the current structure, the rebate per minute ranges from \$2 to \$4 for consultations less than ten minutes but only \$1 to \$2 for consultations greater than ten minutes. As such, the new structure removes incentives towards consultations of less than twelve minutes inherent in the current structure.

Rebate fee-per-minute in the proposed and current item structures (Model 1)



Factors such as “efficacy” (intensity and complexity) of consultations¹, indirect (non-face-to-face) consultation time and flagfall² were used to determine the relative value (relativity) of items in the new structure.

The Working Group considered the issue of non-face-to-face consultation time at some length. This is an important issue as the relative cost of any consultation depends on the total consultation time (face-to-face and non-face-to-face time), but items have historically been based only on the face-to-face time of the consultation.

The Working Group identified a lack of robust and current evidence around non-face-to-face consultation time and noted that this had significantly constrained their work and would also constrain general practice workforce planning. The Working Group concluded that further research in this area is a priority.

Another complex issue considered by the Working Group was the relative importance of ‘content’ versus ‘time’ to define an item, where content refers to the work to be undertaken in respect of an item, and time refers to the time band for an item, for example, >6 to 12 minutes for a Level B1 item.

The Department was in favour of fixed time bands as easier for both general practitioners and patients in being more explicit, avoiding the subjective judgement of content and allowing Commonwealth expenditure to be more accurately forecast.

General practitioner groups were in favour of indicative time bands with associated content descriptors. They noted that this approach enhances quality and efficiency by defining the minimal content of a consultation item, reducing clock-watching and rewarding experience and expertise where it enables more rapid problem solving.

¹ See page 15 of the report for a full discussion and definition

² See page 16 of the report for a full discussion and definition

Implementation Issues

In relation to implementation, the Working Group considered that adoption of a new structure that removed financial disincentives to longer consultations would be likely to have a significant impact on the pattern of general practitioner service provision. It used two approaches to quantify this impact. Both of these approaches, which were initially limited to a pure “price” response, were later modified by assumptions about the likely impact of patient demand and clinical factors.

The Working Group considered the possible workforce implications of a structure that removed the financial disincentives for a general practitioner to perform longer consultations. It noted that adoption of such a structure was likely to result in some substitution of shorter consultations by longer consultations, which would impact on either the total hours a general practitioner worked or the total number of services they could supply. The Working Group also noted that there was some evidence that longer consultations and better quality primary care could result in fewer general practitioner visits on average being required.

There were some issues that were not resolved by the Working Group, such as overall funding levels to accompany an item restructure. The Working Group therefore concluded that the Government and general practitioner organisations continue to engage in constructive dialogue about implementability of the findings of the report.

Original terms of reference for the Working Group included consideration of other non-referred general practitioner items, for example, after hours care and residential aged care facilities visits. The Working Group therefore concluded the work of the Working Group continue to consider these items and the issue of indexation.

Conclusions

The Working Group concludes that:

- 1. appropriate implementation of a 7 tier item structure in place of the current 4 tier item structure would improve the quality of health care in Australia.**
- 2. to ensure patient access is not compromised there are a number of issues, which include funding levels and workforce impact, that would need to be resolved between government and the GP representative groups prior to implementation.**
- 3. this 7 tier item structure appropriately includes relativities that reflect efficacy, the pattern of non-face-to-face time and a fixed modest flagfall.**
- 4. the Department and general practitioner organisations agree that there is value in continuing to engage in constructive dialogue about possible implementation of the findings of this report.**
- 5. the differences of the view between the department and the GP groups of basing the item descriptors on fixed time bands or content and indicative time needs to be resolved.**

- 6. the Working Group should complete the terms of reference in relation to indexation, after hours and residential care visits.**
- 7. further research on non-face-to-face time needs to be completed as a matter of priority.**

1. Introduction

The Attendance Item Restructure Working Group was formed in February 2002 to develop proposals for reform of the Medicare Benefits Schedule (MBS) attendance item structure to improve incentives for the provision of quality care. This Report considers in surgery general practice consultations (unreferred attendances). The Report does not address indexation or other unreferred General Practitioner (GP) items such as after hours care and residential aged care facilities visits.

Terms of Reference for the Working Group are at Attachment A.

The Working Group comprised representatives and observers from the Australian Divisions of General Practice (ADGP), the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), the Rural Doctors Association of Australia (RDAA), the Department of Health and Ageing (DHA), an independent chair and two technical experts (details at Attachment B). Secretariat support for the Working Group was provided by the DHA. The Working Group met from June 2002 to March 2003 on an approximately monthly basis.

This Report presents the findings of the Working Group. While individual members may not support all of the findings, this report is endorsed by all members of the Working Group as a reasoned technical discussion to the degree possible with existing information.

2. Current Medicare Benefit Schedule Arrangements for GP Attendances

In surgery general practice consultations (unreferred attendances) account for over 90 per cent of general practice patient rebates funded under the MBS, with the remainder of GP activity relating to procedures and other attendance items such as aged and after hours care items.

The current MBS schedule for Vocationally Registered (VR) GPs unreferred attendances comprises four major items as shown in the table below.

Table 1: Current MBS Attendance Items

Item	Nov 2002 Schedule Rebate	Nov 2001 Schedule Rebate	Percentage of all VR GP services 2001-02
Level A* Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.	\$11.45	\$11.15	1.57%
Level B** Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38,	\$25.05	\$24.45	86.25%

40, 43, 44, 47, 48, 50 or 51 applies.			
Level C Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies.	\$47.60	\$46.45	11.13%
Level D Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan.	\$70.05	\$68.35	1.06%
<i>Total*</i>			<i>100.00</i>

* Level A does not currently have a minimum time or maximum indicative time.

**Level B does not currently have a minimum time.

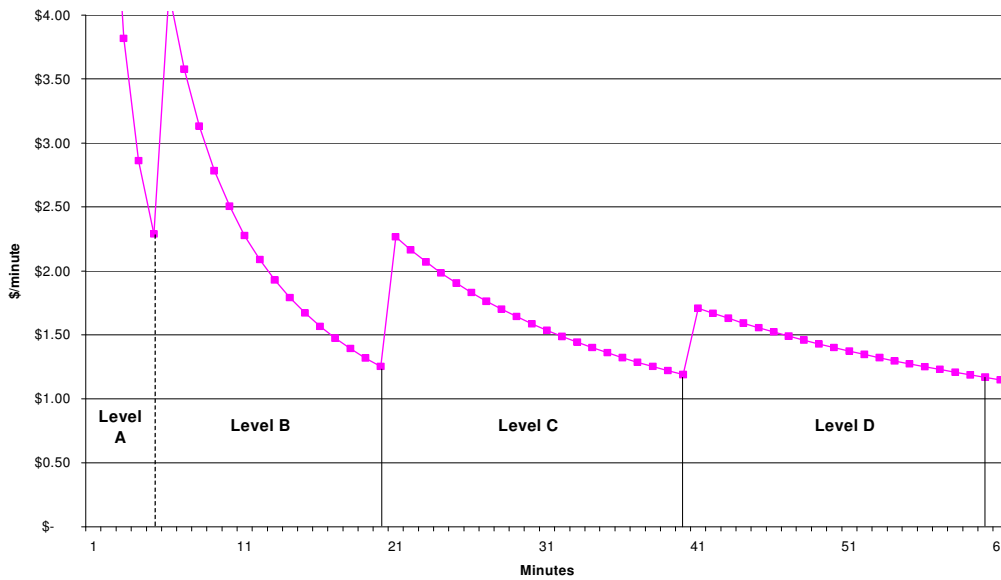
*** Total includes all in surgery items.

Patients of Other Medical Practitioners (OMPs) currently receive a different (lower) set of patient rebates for similar short to prolonged in surgery consultations. OMPs have a service pattern that closely parallels the service pattern of VR GPs, with over 80 percent of OMP consultations similarly being billed as a 5 to 25 minute standard consultation. For modelling purposes the analysis in this report is focused on VR GPs only.

The current item structure provides significantly different financial incentives (in terms of rebate dollars per minute) within individual items and between the different consultation items. Chart 1 shows the implied total gross patient rebates per minute before costs for consultations of different lengths under the current MBS attendance item structure.

Financial incentives under the current structure favour short consultations. The broad time bands implied by the current structure also mean that, for example, a GP who direct bills (bulk bills) a Level B consultation item, which can be up to 20 minutes long, receives the same rebate whether the consultation finishes at 6 minutes or 20 minutes, with the greatest per-minute financial return being for 6 minute consultations. The level of patient rebates for longer consultations means that patients of GPs performing these consultations generally receive lower rebates for the same number of hours worked than those focussing on shorter consultations.

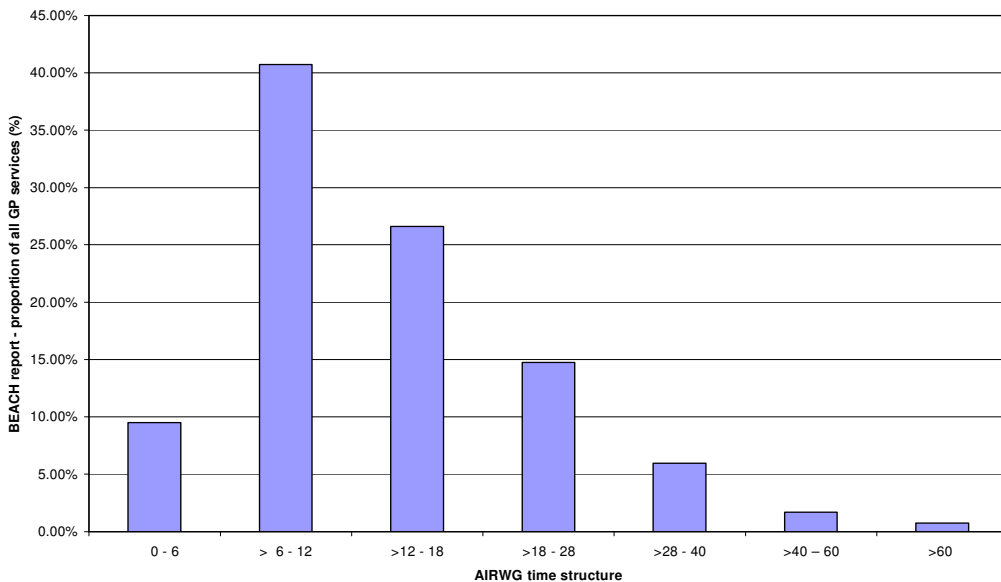
Chart 1: Rebate per minute for the current attendance item structure



Information on the time patterns of GP consultations is available from the Bettering the Evaluation and Care of Health (BEACH) survey. The BEACH survey of GP activity, a product of collaboration between the Australian Institute of Health and Welfare (AIHW) and the Family Medicine Research Centre at the University of Sydney, collects detailed information on GP-patient “encounters” (consultations) not readily available in other data collections or from MBS data.

As part of the BEACH survey 1999-2000 a Supplementary Analysis of Nominated Data (SAND) question required GPs to record the start and finish time for each encounter, giving the consultation time in minutes. It therefore shows the service actually provided. Data from BEACH provides details of the actual length of encounters, as reported by sampled practitioners, giving the consultation time in minutes. The distribution of GP consultations (based on BEACH data) across different time bands is shown in Chart 2 below.

Chart 2: 1999-2000 BEACH data in surgery GP consultations in broad time categories



While the financial incentives within the current item structure support short consultations - with the highest fee per minute (apart from extremely short Level A consults which are rarely used) occurring less than 6 minutes, BEACH data suggests this is not the most prevalent consultation length. Based on the BEACH data, the most prevalent consultation length is 10 minutes. This data does not include non-face-to-face time.

A later sub-study¹ of 2000-2001 BEACH data reports a mean (not modal) consultation length of 14.8 minutes with a median length of 12 minutes, and a range of 1-106 minutes. Using the GP as the unit of analysis, the modal consultation length was 15 minutes.

Under the current item structure the absence of a time barrier on the Level A – short consultation or lower bound on Level B sees many short consultations (<5 minutes) claimed as a Level B. BEACH data also suggests a significant number of consultations being billed to the MBS as a shorter consultation than the reported time would indicate. In particular it appears many consults of over 20 minutes which could have been billed as a Level C or D are in fact charged as a Level B.

3. Why Consider Change?

The Working Group identified a number of issues with the existing item structure.

The question of whether or not the existing item structure supported/rewarded the provision of high quality care was an issue. GP groups, particularly, felt that the existing item structure may not be optimal for this purpose, and that any change should increase the support/reward for high quality care if possible.

To examine this question, the Working Group, through the RACGP, undertook an extensive review of available evidence on the relationship between quality and length of consultation (refer to Attachment C), while recognising that length of consultation was not the sole determinant of quality

The conclusion of this work was that an increasing body of evidence from around the world suggests that ‘longer’ consultation times are associated with better health outcomes.

A ‘longer’ consultation creates an opportunity for more patient centred approaches, better communication, and better management of chronic conditions, of more complex consultations and of patients with psychosocial problems. Insufficient time will create various problems including compromised shared decision making (SDM), compromised interpersonal or technical aspects of care which may ultimately lead to greater patient dissatisfaction, communication problems, higher rates of litigation and malpractice suits. Insufficient time also raises levels of stress in doctors and is associated with reduction in quality of service.

The evidence examined was principally based on qualitative rather than quantitative data. There is limited quantitative data available regarding the link between consultation length and health outcomes.

¹ Britt, H., Valenti, L. & Miller, G. *Time for Care: Length of General Practice Consultations in Australia*. Australian Family Physician 2002, Vol 31, No. 9, pp 876-880.

“Long” and “longer”, as they apply to general practice consultations, are relative terms. The research showed substantial variation in the use of the terms, dependent on the setting of the research (eg. the country in which the research is undertaken). The activities included in the ‘consultation’ also appeared to vary across the research, with some studies appearing to include some non-face-to-face activities while others did not. As a result, the definition of “longer” and its relationship to quality needs to be context-specific.

Based on available evidence, the Working Group concluded that there is evidence that the relationship between time and quality of consultations has an upward gradient flattening over a certain point, but the evidence tends to be qualitative rather than quantitative. The upward slope appears to be positive up to around 20 minutes in the Australian context. This upward slope seems feasible up to around 30 minutes but may decline after that. The GP/patient interaction is evolving towards longer consultation times due in part to increasing complexity of illness and treatment, the ageing population and an increase in patient expectations. There is some indication that effective longer consultations may mean that fewer consultations per capita are required.

The broad banding (limited number of items) of the current MBS GP attendance item structure and the relativities between items in the current structure results in substantial variation in rebate remuneration (rebate \$ per minute) for consultations of differing length (as evidenced by the sharp ‘saw tooth’ pattern of Chart 1). Within the current structure, the 15 to 20 minute band was seen as a particular issue. As reflected in the research undertaken for the Working Group, consultations of this length are viewed as important in the provision of quality care for patients with chronic or complex conditions. These consultations are considered “high” effort compared with other consultation lengths, account for over 20 per cent of consultations and are relatively poorly remunerated in terms of rebate dollars per minute.

The Working Group agreed that the research had established a strong case for the removal of undue incentives for very short consultations but provided insufficient evidence for the provision of incentives for very long consultations. The implication of this decision was that a ‘flatter’ structure, in terms of the rebate dollar per minute, was considered more appropriate than the current structure.

4. Designing a New Attendance Item Structure

4.1 Introduction

Defining a new attendance item structure requires two elements:

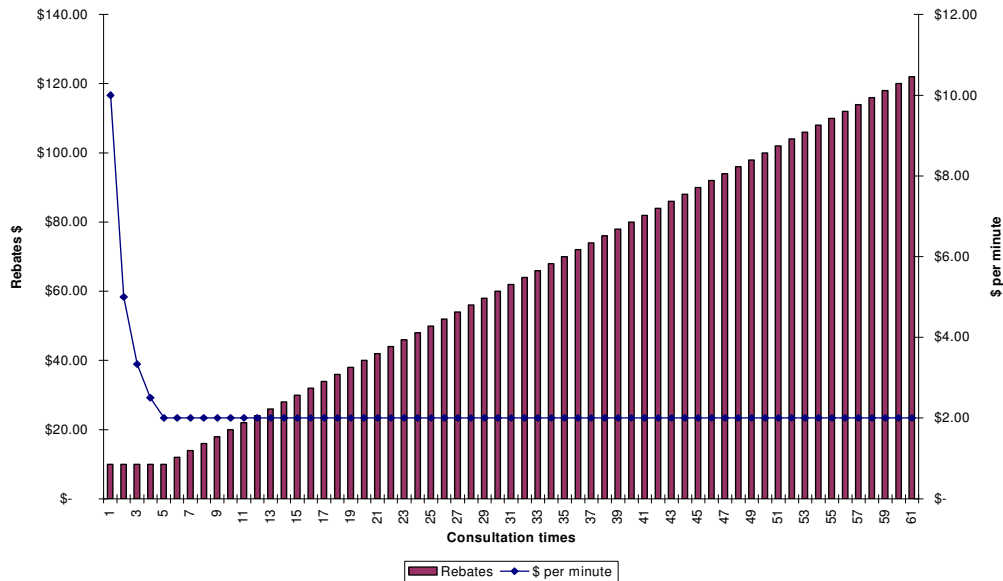
- (i) A definition of item structure, namely the number of items and a description of their parameters; and
- (ii) A definition of fee relativities of items in the new structure. Fee relativities refer to the relative value of each item in the attendance item structure compared to that of other items.

4.2 Definition of Item Structure

Clearly a trade off exists between the number of items in a schedule, its administrative complexity and the smoothness of the resulting dollar per minute function or absence of ‘saw tooth’ of the rebate schedule.

At one extreme, an item structure involving a fixed rebate amount per minute of consultation length, eliminates the peaks and troughs associated with a banded or grouped structure. For example, Chart 3 below, illustrates a hypothetical model with a flat rebate of \$10 for consultations up to 5 minutes and a rebate of \$2 per minute thereafter.

Chart 3: Hypothetical Item Structure and Rebate per minute



However, there are clearly practical administrative issues associated with the large number of individual items implied by this approach. There is a trade-off between increasing administrative complexity and resulting “smoothness” of the rebate structure in terms of number of items in any structure. The RACGP paper at Attachment E concludes that there should be a simple schedule.

In determining an appropriate item structure for GP attendance items, the Working Group examined a range of options, including the structure proposed by the Medical Services Review Board (MSRB) in the Relative Value Study (RVS) and various options involving splits within the current structure.

The Stage 1 RVS draft attendance item structure established eight core items for in surgery consultations. This revised structure was proposed for attendance items across all specialty groups and was developed on the basis of three principles: content, time and maintenance of clinical record, with content supported by time. These factors described below are based on the concept of a ‘reasonably efficient’ practitioner:

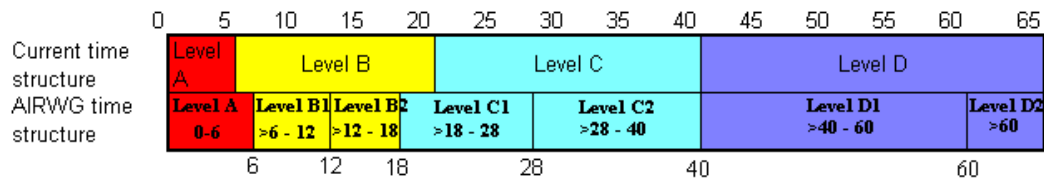
- Content – each item descriptor explains the nature of the work which must be undertaken before benefits are payable in respect of that service.
- Time – each item descriptor specifies the approximate time each service should take.
- Clinical records – the maintenance of clinical records as an essential element of a revised structure.

The concept of a ‘reasonably efficient practitioner’ is important. As reflected in the research undertaken by the RACGP for the Working Group, there are a number of limitations to the

studies available to inform the issue. The limitations include the fact that the studies only measure resource inputs – differences in the quality of care are not incorporated. The research suggests that a fair payment system should reflect differences in the quality of a service, particularly when it requires more resources to produce a higher-quality product. If some doctors routinely provide better quality services, then the research to date does not provide evidence about the extent of this, nor provide clear direction as to ways in which this could be reflected in a payment schedule. As a result, one of the limitations of taking the ‘reasonably efficient practitioner’ approach is that it may not provide the same incentives for highly skilled practitioners (who use less time in the context of a schedule based on fixed times for items, for example), or for practitioners who use different inputs and produce better outcomes.

The preferred structure adopted by the Working Group in its modelling work involved seven items. These are illustrated in Chart 4 below.

Chart 4: AIRWG Preferred Time Structure



These items differentiate within the current Level B, C and D items and seek to strike a balance between minimising the administrative burden and providing more balanced incentives to maximise quality patient care. The proposed additional items provide the capacity to reduce the disincentives to the provision of longer consultations by flattening the remuneration structure, reducing the variation in fee-per-minute across the current structure. The proposed time structure has also been designed to reflect current practice in the ‘real world’, namely, by catering for bookings which tend to be made at 10, 15, 20 etc minute intervals. The proposed structure also reflects what GPs see as the increasing complexity of consultations.

Schedule Items – Fixed or Indicative Time Structures

A major issue in defining a new item structure is whether the time banding is:

- Indicative with content descriptors defining the activity associated with each item – the position advocated by GP groups; or
- Fixed time bands – the position preferred by DHA

The position of the GP groups is that:

- The revised structure does not change the nature of consultative medical practice but more accurately describes and differentiates between the services provided by doctors. The items are based on content (not time-tiering): each item descriptor explains the nature of the work which must be undertaken for benefits to be payable in respect of that service.
- Content based descriptors enhance quality, and efficiency:

- They enhance quality by delineating the requisite minimal parameters of the consultation;
- They encourage efficient completion of episodes of care without undue clock-watching;
- They enhance doctor – patient rapport by reducing the potential for argument over differing views on time spent;
- They reward experience/expertise where it enables more rapid problem solving.
- Any times must be indicative and not proscriptive if GPs are to accept the complexity and administration hardships a multi-tiered system would present.
- Where a time is indicated it is only used to specify the approximate time for the service.
- The maintenance of accurate contemporaneous clinical records is an essential element.

For audit purposes, maintenance of accurate clinical records ensures that the appropriate service for item claimed has been provided.

Attachment **D** outlines the key principles of item descriptors for a new item structure. Detailed content descriptors have not yet been developed.

The position of the Department is that:

- a new and more detailed structure should have fixed time bands (eg GPs should claim item B1 if the time spent with the patient was more than 6 minutes and up to 12 minutes).
- this is likely to be easier for both GPs and patients in being more explicit.
- this approach avoids the necessarily subjective judgements of content by doctors, and the possibility of upbilling in claiming from the MBS and billing of patients by some GPs.
- fixed time banding has been used for psychiatrists for many years, has recently been introduced for anaesthetists, and in fact, except for the level A/B boundary is now in place for GPs.

Fixed time bands allow Commonwealth expenditure to be more accurately forecast and allow for auditable service provision.

4.3 Determining Item Relativities in a New Structure

Item fee relativities refer to the relationship between items – specifically the relative value of each item in the attendance item structure compared to that of other items.

The construction of the patient rebate/fee reflects two components, namely a professional remuneration component and a practice cost component.

Developing the overall relativities for an alternative item structure requires:

- The relative component of practice costs for the respective items;
- The relative component of professional remuneration for respective items; and
- The relative weight given to practice costs and professional remuneration components.

Item relativities could have been constructed so that the implied per minute rebate for different items was constant. This would remove any financial incentives or disincentives to perform any length consultation over another. It would not recognise the variation between consultation times of different length in terms of intensity or complexity, costs associated with patient throughput and non-face-to-face time, or the weighting between practice costs

and professional components. Arguably a flat rate structure could also reduce incentives for patient throughput and provide financial incentives for unnecessarily long consultations.

Issues in determining the approximate relativities between different items were a significant component of the RVS work. The RVS methodology involved determining the relative intensity of the professional contribution to different attendance items, the relative share of practice costs and professional remuneration in any fee and the time implied by each attendance item.

After the core attendance items were agreed in the RVS, the MSRB agreed on a set of working assumptions for intensity variations between the RVS attendance items. These assumptions recognised the impact of the relationship between time (and associated content) and intensity of work for the professional component. The RVS identified items in the 15 and 20 minute time lengths as having a higher intensity loading than longer or shorter consultations.

The Working Group in assessing appropriate relativities for a new item structure looked at previous work by the RVS and a range of issues potentially impacting relativities, including:

- possible variations in intensity and complexity of professional services of different lengths;
- possible differences in quality of the outcomes between services of different lengths;
- the relationship between face to face and non-face-to-face consultation time;
- flagfall; and
- practice costs.

Intensity and Complexity of General Practice Consultations

A review of available literature undertaken by RACGP for the Working Group concluded that for medical (not procedural) consultations:

- the available studies have some limits as differences in the quality of care are not studied and these studies do not provide clear direction as to the ways in which the ability of some doctors to provide better quality services could be reflected in a payment schedule;
- time is likely to be the most important factor indicating total workload for medical activities;
- it is recognised that mental effort and judgement, technical skill required and physical effort and stress due to risk contribute to the total workload at the margins; and
- other factors such as the differences in complexity associated with consultations involving new compared to existing patients are also marginal.

Details of the RACGP literature search are provided at Attachment E.

Although the RVS proposals recommended differentiating new (not seen in the last six months) and existing patients, the Working Group were of the view that this was not appropriate for GPs at present, based on available evidence.

While available research did not support or refute differential weightings, the Working Group agreed that differential weightings, which the Working group termed “efficacy” weightings could be justified. In this context, efficacy weightings reflect both intensity and quality, which are likely to have the same sorts of effects on the attendance item structure, based on the medical opinion and experience of doctors in the Working Group. This reflected a

consensus view of the group that at the identified consultation lengths, a loading for GP inputs (intensity/complexity) and health outcomes (quality) was warranted. These weightings are shown in Table 2 below and place a higher weight for consultations in the 12-28 minute bands than other time bands. The Working Group concluded that non-emergency consultations taking longer than 60 minutes warranted a marginally lower weighting as they were generally less “efficacious”.

Face to Face and Non Face to Face Time

The relationship between face to face consultation time and non-face-to-face time spent on activities directly related to a consultation was an issue the Working group considered in examining item relativities.

The non-face-to-face consultation time is important as the relative cost of any consultation should depend on the total time (face to face and non-face-to-face) involved, but the items have historically been based only on the face-to-face time of the consultation.

If the ratio of non-face-to-face time to total consultation time is constant the relativities between different items are unaffected. For example as long as the proportion of non-face-to-face time (eg 15% or 25%) of the total consultation time is constant for all of the consultation items/times it will make no difference to the relativities between different items and therefore the rebate amounts applying to those items.

The Working group considered that indirect consultation time is a significant proportion of total consultation time that may possibly vary with consultation length and thus impact on the relativities between items.

For the purposes of modelling, the Working Group has relied on the outcomes of a study by Secolo², which indicates that indirect consultation time represents a smaller proportion of longer consultations than of shorter consultations. This study is limited and dated but the modelling has adapted the outcomes of this study as the most relevant available source. Modelling of alternative scenarios was based on Secolo findings of an average of 4.6 minutes per consultation and a diminishing proportion of indirect consultation time as total consultation length increases. For modelling purposes, the Working Group decided on 20 per cent non-face-to-face time for items A to C1 and 4.6 minutes for items C2 to D2.

The lack of any robust and current evidence around indirect consultation time significantly constrained the work of the Working Group and all GP workforce planning. The GP Groups on the Working Group strongly recommend that further research in this area is a priority for 2003-04.

Flag fall and Practice Costs

In the modelling of alternative item structures practice costs were assumed to absorb 50 per cent of the rebate amount, with 50 per cent for professional remuneration. To reflect the practice cost component 50 percent of each item relativity is calculated at a flat rate per minute across different consultation lengths. This 50 per cent assumption is based on

² *Evaluation of ratio of face-to-face consultation time as a proportion of total clinical work in Australian General Practice (2000)*. Conducted by Secolo Consulting Pty Ltd for the Australian Medical Association as part of the RVS.

evidence such as the RACGP Interpractice comparison³, the 2001 AMA GP survey⁴ and the RVS.⁵

In this context, a flagfall is a component of the patient rebate for each schedule item that recognises costs associated with seeing each individual patient (eg record storage and retrieval, accounting time etc) which are not reimbursed through the practice cost component of the rebate in shorter consultations.

While evidence on an appropriate level for flagfall is limited, the overall consensus of the group was that a modest, constant dollar flagfall should be included to support the shorter consultations. It was agreed that a \$2 flagfall be incorporated in the modelling.

Depending on the size of the flagfall chosen, the flagfall will increase the relative gross value of shorter consultations compared with longer consultations.

Relativities for Modelling of Preferred Structure

For modelling purposes, the Working Group adopted a relativity structure based on the assumptions shown in Table 2 below.

Table 2: Relativity Assumptions (based on Model 1)

A	B	C	D	E	F	G	H	I	J**
Item	Indicative Band (minutes)	Indicative Average time	Non face-to-face time	Indicative time: Avg time + Non face-to-face time	Practice cost relativity (ie ratio of indicative time)	Efficacies	Professional component relativity (F x G)	Flagfall	Overall relativity using 50% professional and 50% practice costs + flagfall*
A	0 - 6	5	20% x 5=1	6	1.0	1	1.0	\$2	1.2
B1	> 6 - 12	10	20% x 10= 2	12	2.0	1	2.0	\$2	2.2
B2	>12 - 18	15	20% x 15= 3	18	3.0	1.1	3.3	\$2	3.4
C1	>18 - 28	23	20% x 23= 4.6	27.6	4.6	1.1	5.1	\$2	5.1
C2	>28 - 40	34	4.6 minutes	38.6	6.4	1	6.4	\$2	6.7
D1	>40 - 60	45	4.6 minutes	49.6	8.3	1	8.3	\$2	8.5
D2	>60	75	4.6 minutes	79.6	13.3	0.9	11.9	\$2	12.1

* \$2 Flagfall is equivalent to a relativity of 0.24 for Model 1

** The final relativities in column J are based on Model 1, dependent on the assumptions made in the preceding columns.

Where:

Column **A** shows the AIRWG preferred item structure, which as discussed earlier roughly divides the current level B, C and D consultation items.

Column **B** shows the respective items' equivalent time frames.

Column **C** shows the average time for each of the time frames indicated in column B, which represents the total face to face time for each consultation item.

Column **D** shows the amount of non-face-to-face or indirect consultation time. As indicated earlier it is 20% of the face to face or direct consultation time until 20% is the equivalent of

³ *Interpractice Comparison Survey (2001)*. Royal Australian College of General Practitioners.

⁴ *GP Workforce Survey (2001)*. Conducted by Access Economics for the Australian Medical Association.

⁵ *A resource based model of private medical practice in Australia The practice cost study – final report (2000)*. Conducted by Price Waterhouse Coopers for the Medicare Schedule Review Board.

4.6 minutes. From this point onwards, for the remainder of the items a constant non-face-to-face time of 4.6 minutes is modelled.

Column **E** shows the total indicative time, calculated as the sum of Column C (the average time for each of the time frames) and D (the amount of non-face-to-face or indirect consultation time).

Column **F** shows the Practice cost component of the total item relativities between items, which is calculated at a flat rate.

Column **G** shows the “efficacies” or differential weightings for complexity/intensity and quality for different consultations, applied to the professional component of the total item relativities.

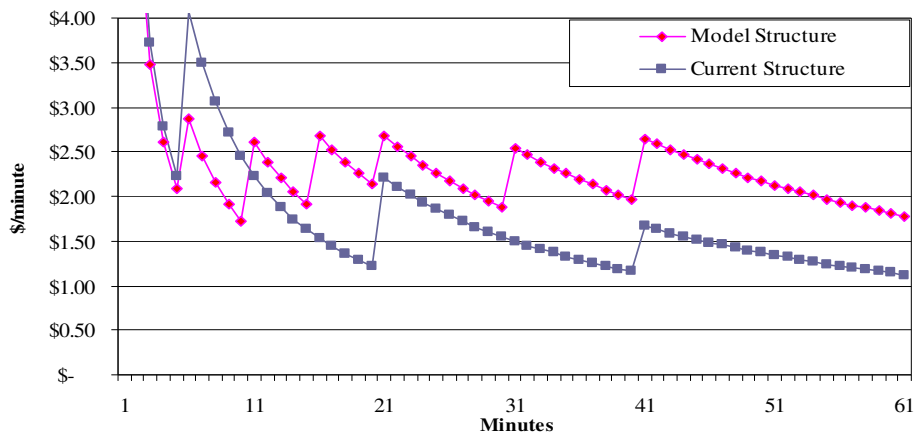
Column **H** shows the professional relativity component of the total item relativities, which is calculated as Column F (the total indicative time) multiplied by Column G (the “efficacies”).

Column **I** shows the flagfall amount agreed to by the group for the purposes of modelling. As a component of the final total item relativities, the equivalent percentage of the rebate dollar amount for the first consultation item equal to \$2 is added.

Column **J** shows the final total item relativity for each of the respective consultation items. The final figure is calculated firstly, as discussed earlier, as 50% of the practice component relativity plus 50% of the professional component relativity. Added to this result is the flagfall. For example for a Model 1 scenario without a flagfall the rebate dollar amount for the first consultation item is \$8.45. With this rebate amount a \$2 flagfall is equal to 24% or 0.24. This 0.24 is then added to the 50% of the practice component relativity plus 50% of the professional component relativity to give the final total item relativity for each of the respective consultation items.

The proposed relativities shown in Table 2 reduce the disincentives to the provision of quality care by flattening the remuneration structure, reducing the variation in fee-per-minute across the current structure. This is illustrated in Chart 5 below, which shows the rebate fee per minute for a Model 1 scenario based on the Working Group’s preferred model, the combination of the preferred item structure and relativities between items discussed above compared to the current structure. It is noteworthy that the new structure as modelled shows that, with the same overall budget, the rebate per minute for all items generally ranges from \$2 to \$2.50, whereas for the current (old) structure, the rebate per minute ranges from \$2 to \$4 for consultations less than ten minutes but only \$1 to \$2 for consultations greater than ten minutes. As such, the new structure removes possibly distorted incentives towards consultations less than ten minutes inherent in the current structure.

Chart 5: Rebate per minute for the preferred item structure with Model 1 and relativities assumptions and the current attendance item structure



5. Impact of a New Item Structure – 3 Models

The primary purpose of a redesigned attendance item structure is to provide a fairer structure of patient rebate remuneration for the GP and to provide incentives for GPs to practice quality medicine and no longer disadvantaging those patients needing longer consultations. By removing the financial disincentive for a GP to perform longer consultations, it would be expected that there would be some substitution of shorter consultations with longer consultations. The Working Group has examined in detail 3 Models:

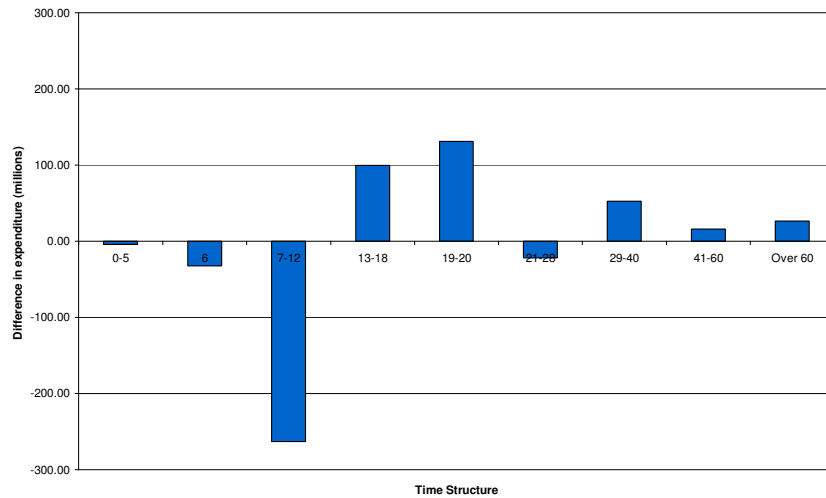
- Model 1 – Budget Neutral
- Model 2 – Income neutral outcome for particular GP groupings
- Model 3 - At Level B1 rebate based on Level B rebate (as at 1 November 2001)

5.1 Model 1 – Budget Neutral

Should a revised structure be introduced using Model 1, the immediate impact of a new item structure is to redistribute existing funding between consultations of different lengths, that is, from shorter to longer consultations.

Using Model 1, Chart 6a below shows the impact of the Working Group’s modelling of the preferred structure on the distribution of Commonwealth funding between items of different lengths (The 6th minute and the 19-20 minute bracket have been separated from the AIRWG time structure to allow comparison with the current time structure).

Chart 6a: Redistribution of Commonwealth Funding – Model 1



The Working Group noted that, based on current patterns of service delivery and the modelled item structure under Model 1, there would be a substantial redistribution of funds away from consultations in the >6 – 12 minute time band to consultations in the >12 - 20 minute time band.

The rebate for a patient receiving a consultation in the >6 - 12 minute time band would be reduced from \$24.45 to \$17.20 based on the November 2001 Schedule. The rebate for a patient receiving a consultation in the >12 – 18 minute time band would increase from \$24.45 to \$28.65 based on the November 2001 Schedule.

A direct billing general practitioner providing a large proportion of services in the >6 - 12 minute time band would face a substantial loss of income. This would also increase the gap for privately billed patients.

It was emphasised that GPs working in an area of under supply may be forced by demand pressures to limit consultations to the shorter time bands and therefore any changes to the item structure will have a disproportionate impact.

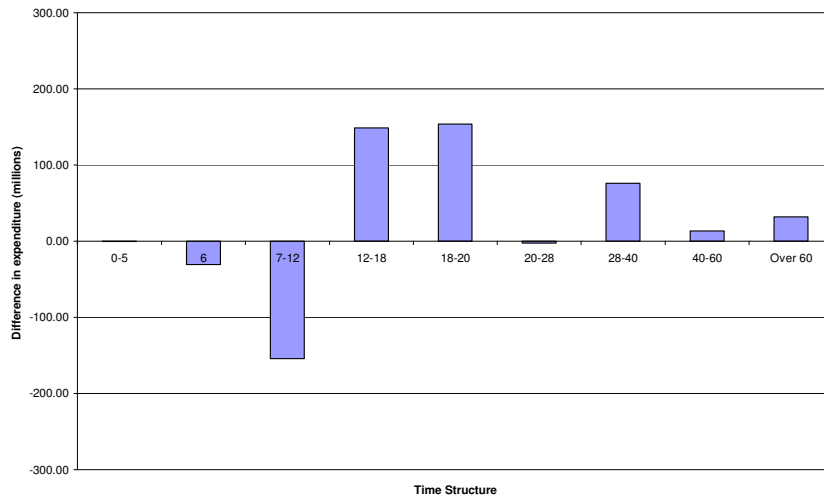
The GP representatives on the Working Group unanimously declared such a scenario to be totally unacceptable on access and equity grounds. Given this redistributive impact and the likely impact on incomes of individual GPs, the GP members of the Working Group have concluded that implementation of a revised item structure, without additional Commonwealth funding is not acceptable.

5.2 Model 2 – Income neutral outcome for particular GP groupings

Model 2 is based on particular GP groupings (separated by age, gender and RRMA) with an aggregate reduction in income (based on aggregate service patterns for each cohort) as the result of the implementation of a new structure based on the preferred model, the first full year aggregate Commonwealth static financial impact would be a cost in the order of \$240m.

Chart 6b below shows the equivalent distribution of Commonwealth funding between items of different lengths, as illustrated in Chart 6a, for Model 2.

Chart 6b: Redistribution of Commonwealth Funding – Model 2

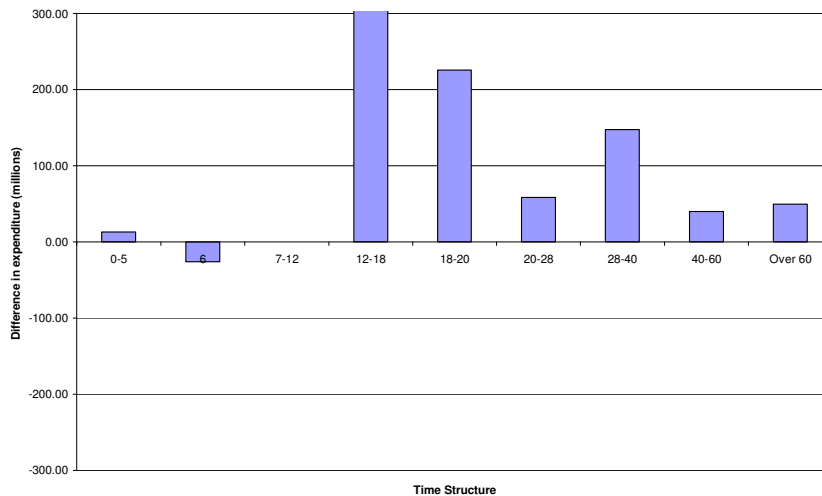


5.3 Model 3 - At Level B1 rebate based on Level B rebate (as at 1 November 2001)

For Model 3 the first full year aggregate Commonwealth static financial impact would cost in the order of \$820m

Chart 6c below shows the equivalent distribution of Commonwealth funding between items of different lengths, as illustrated in both Chart 6a and 6b, for Model 3.

Chart 6c: Redistribution of Commonwealth Funding – Model 3



The table below shows the resulting rebates for Model 1, Model 2 and Model 3.,

Table 3: Rebates and first full year aggregate static Commonwealth financial impact.

Time Structure	1 November			
	2001 Rebates	Model 1	Model 2	Model 3
0 - 6	\$11.15	\$10.25	\$11.10	\$13.25
> 6 - 12	\$24.45	\$18.50	\$20.20	\$24.45
>12 - 18	\$24.45	\$28.00	\$30.70	\$37.35
>18 - 28	\$46.45	\$41.85	\$46.00	\$56.15
>28 - 40	\$46.45	\$55.10	\$60.55	\$74.15
>40 – 60	\$68.35	\$70.20	\$77.25	\$94.70
>60	\$68.35	\$106.00	\$116.70	\$143.30
First full year aggregate static Commonwealth financial impact (\$' 000)		Nil	\$236,413	\$824,102

6. Behavioural Response to a New Structure

This simple static analysis, however, is an incomplete analysis of the likely impact of an altered rebate structure on GP service delivery and billing patterns. As the primary purpose of this change is to alter the incentives and hence behaviour in order to enhance quality, further dynamic modelling is needed to reflect the potential impact on GP and patient behaviour.

The impact of any change will depend on a wide range of factors including:

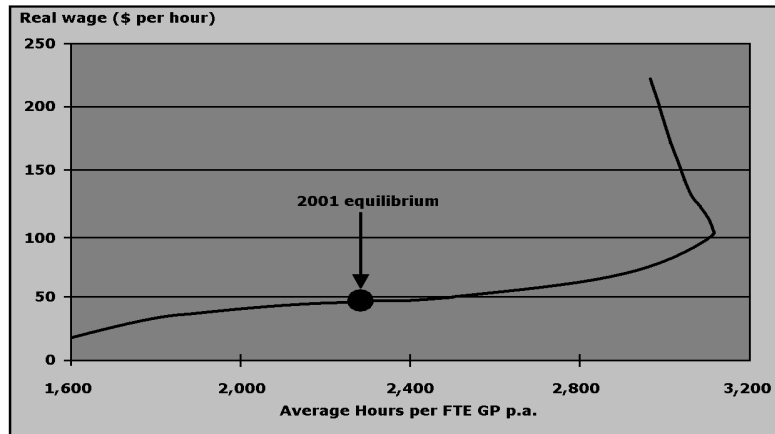
- (i) The responsiveness of GP behaviour to changes in price signals from the altered schedule items. For individual GPs, this may depend on:
 - their current service patterns;
 - their level of patient charging;
 - their hours of work;
 - their capacity to change current service patterns eg to provide a larger number of longer consultations and less short consultations;
 - the impact of changes on their aggregate income.
- (ii) The extent that clinical need and patient demand factors moderate or override GP supply responses to altered price signals. These supply responses are likely to vary both for individual GPs and for different parts of the schedule, for example the number of attendances of greater than 60 minutes could be assumed to be determined largely by clinical need and demand side factors.

The Working Group considered two alternative approaches to providing quantitative assessment of the impact of a new item structure. Both involved a measurement of the likely ‘price’ response of GPs to altered rebate structures which was subsequently modified by assumptions about the likely impact of patient demand and clinical factors on GP service patterns.

The first approach was based on a GP supply curve developed by Access Economics for the AMA⁶. This supply curve was developed from data collected from a survey of GPs on their likely responses (in terms of hours of work) to changed hourly earnings (total including non MBS sources). The supply curve provides a relationship between supply of hours per annum and hourly remuneration rates (total MBS and non-MBS incomes).

⁶ *An Analysis of the Widening Gap between Community Need and the Availability of GP Services* (2002). A report to the Australian Medical Association by Access Economics Pty Ltd. Canberra ACT.

Chart 7: Long-term supply of GP services, 2001



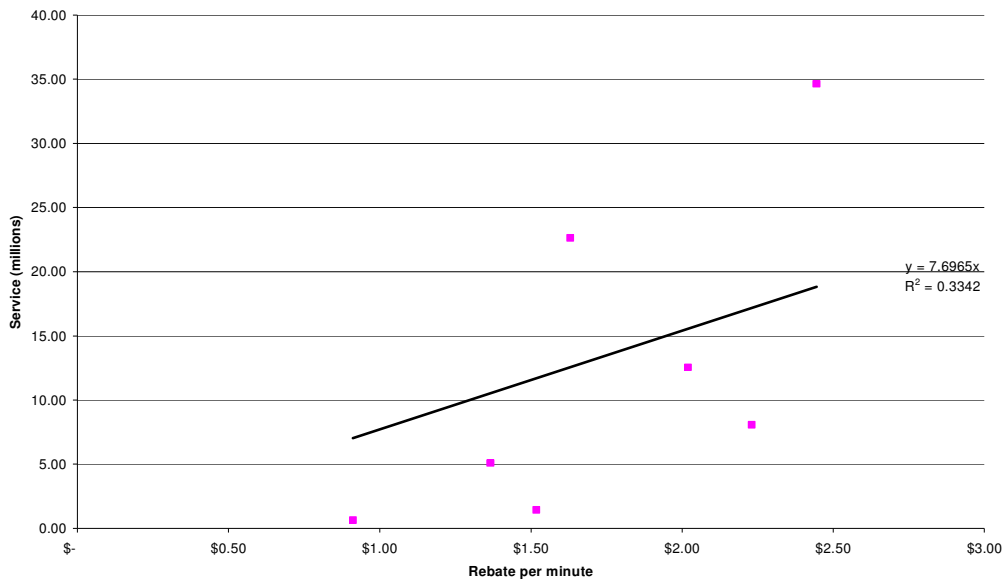
Source: Access Economics

Using this relationship to assess the likely response to changes in the MBS schedule for individual items required significant simplifying assumptions about:

- The service patterns of GPs – namely that all services were of a constant length, that is that the per minute change in total patient rebates for a given consultation length can be converted to an hourly rate to determine the likely impact on hours worked.
- The constancy of other sources of income.

The second approach uses an estimated relationship between number of services of different lengths from BEACH data and the total patient rebates per minute from the current attendance item structure.

Chart 8: All GPs Correlation between service frequency and per-minute rebate



Source: BEACH data for 1999-2000

Using this estimated relationship the change in per minute rebates as the result of implementing a new item structure is used to predict the new service volume for each item in a new structure for different cohorts of GPs.

For both these relationships it is possible to forecast a “price” response by GPs to an altered rebate structure. This requires assumptions, about not only item structures and relativities but also the actual level of rebates applying.

Both these approaches provide an estimate of the “price” response to a new item structure and changed rebate levels. In practice as stated above actual outcomes will depend, not only on this but also a range of other factors.

The pure price responses quantified in the two methods mentioned above are concerned solely with the GP supply of services in response to changed price signals and are not constrained by demand eg other patients requesting access to the GP or the impact on aggregate income. To gauge the likely response, including the impact of demand and clinical need, the Working group assumed adjustment factors or behavioural change constraints, which were used to modify the price responses derived under the two methods above. The demand column in Table 4 shows a demand constraint assumed in modelling. This was set at a constant of 0.5, in response to the lack of evidence on the elasticity of demand and supply. Clinical need is another important factor, which will constrain a pure price response to GP supply of services. As shown in the final column of Table 3, for longer consultations, it was felt by the Working group that there was a need to constrain the price response at the very long consultation end (items C2, D1 and D2) given the view that these consultations are much more likely to be affected by clinical need than price.

Further modelling work, using the limitations in Table 4 below, therefore modified the pure price effect for the estimated impact of these factors. These factors (Table 4) were applied multiplicatively to the estimated price response derived above and therefore resulted in a reduction of the pure price effect.

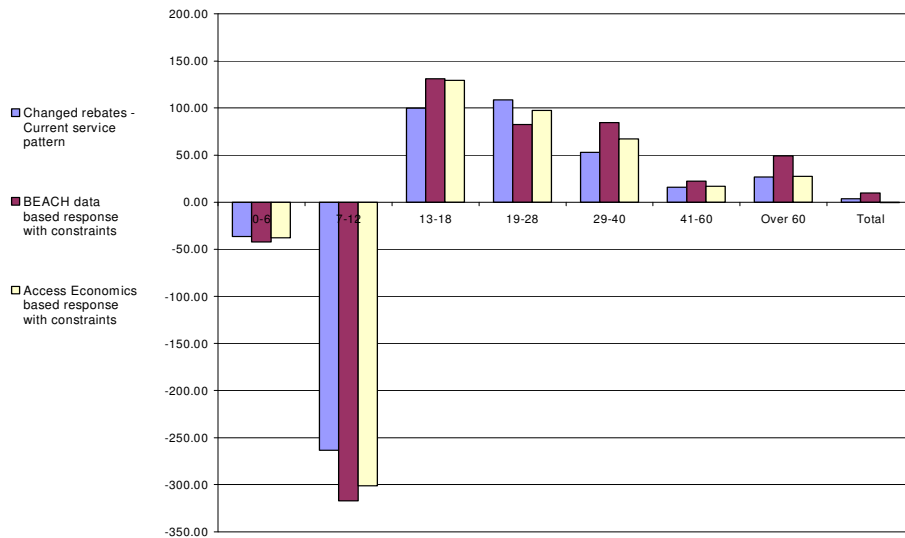
Table 4: Behavioural change constraints

Item	Item (minutes)	Demand	Clinical need/ Price
A	0 – 6	0.5	1.0
B1	> 6 – 12	0.5	1.0
B2	>12 – 18	0.5	1.0
C1	>18 – 28	0.5	1.0
C2	>28 – 40	0.5	0.5
D1	>40 – 60	0.5	0.1
D2	>60	0.5	0.1

Incorporating these adjustments, the estimated impact for both approaches would be a reduction in the total number of services as GPs increase the average length of consultation, unless GPs worked longer hours. This outcome reflected a reduction in number of services in the <12 minute categories and increases in all other categories except the 19-28 minute time band. The major impact of demand and clinical need adjustments was a reduction in the estimated price response for long consultation items.

Chart 9a shows the Commonwealth rebate expenditure from application of the new rebates, under Model 1, to current service levels. It compares this with the expenditure that would eventuate as a result of a change in behaviour for all GPs in response to the new rebates, using the two alternative models of behaviour change. As noted previously, the “pure price” responses obtained from the models of behaviour change have been moderated by the inclusion of demand and clinical need factors.

Chart 9a: Estimated change in Commonwealth rebate expenditure of current structure – Model 1



The Working Group also investigated the impact of the rebate change on different cohorts of GPs, that is, male, female, urban and rural GPs. Chart 9b shows the Commonwealth rebate expenditure from application of the new rebates, under Model 1, to current service levels for urban GPs only. It compares this with the expenditure that would eventuate as a result of a change in behaviour in response to the new rebates for all urban GPs, using the two alternative models of behaviour change. The equivalent charts for the three remaining cohorts are at Attachment F.

Chart 9b: Estimated change in Commonwealth rebate expenditure of current structure – Model 1, Urban only

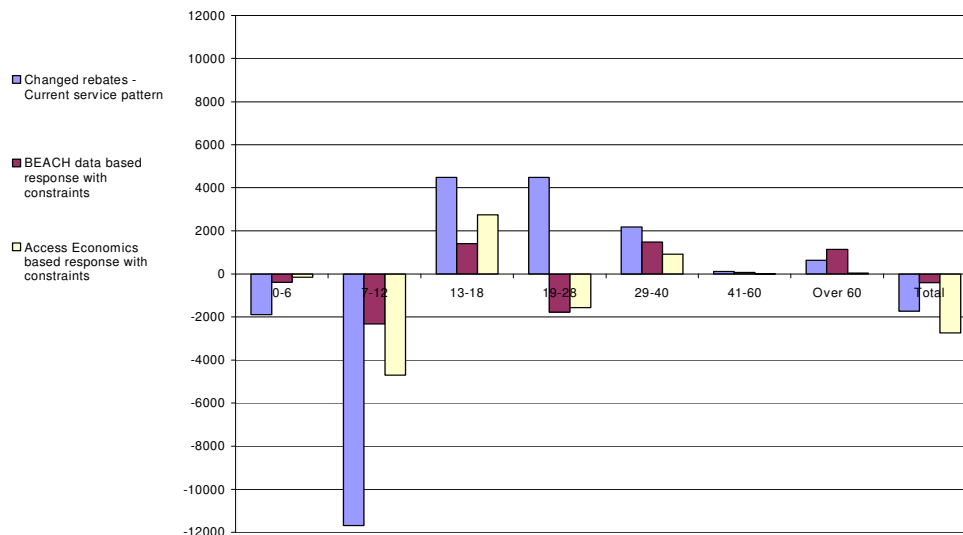


Chart 9c shows the Commonwealth rebate expenditure from application of the new rebates, under Model 2, rather than Model 1, to current service levels. The Model 2 scenario is one in which additional funding is provided so that no GP cohort loses income as a result of the change in rebate levels. The Chart compares this scenario with the expenditure that would eventuate as a result of a change in behaviour in response, for all GPs, to the new rebates, using the two alternative models of behaviour change.

Chart 9c: Estimated change in Commonwealth rebate expenditure of current structure – Model 2

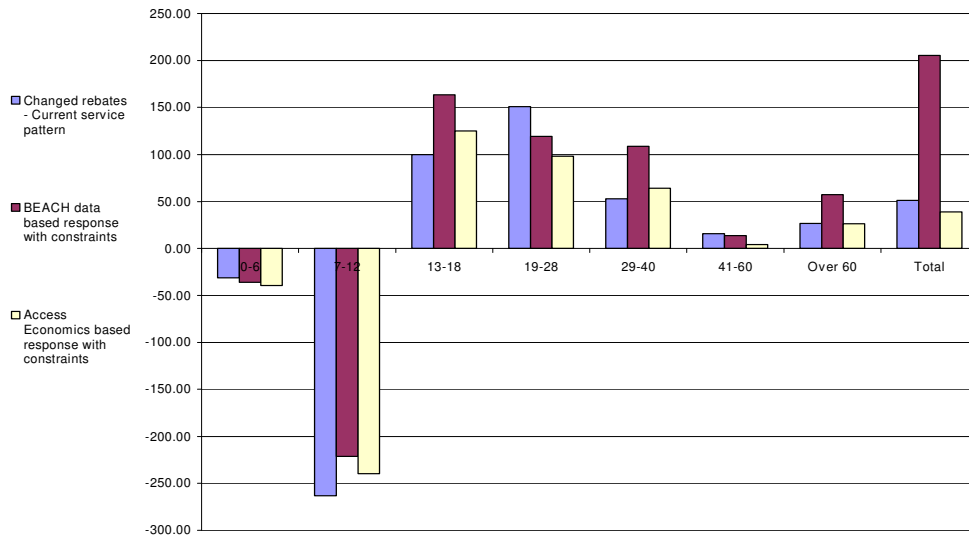


Chart 9d shows the Commonwealth rebate expenditure from application of the new rebates, under Model 2, to current service levels for urban GPs only. It compares this with the expenditure that would eventuate as a result of a change in behaviour in response to the new rebates for urban GPs, using the two alternative models of behaviour change. The equivalent charts for the three remaining cohorts, male, female, and rural GPs, are at Attachment F.

Chart 9d: Estimated change in Commonwealth rebate expenditure of current structure –Model 2, Urban only

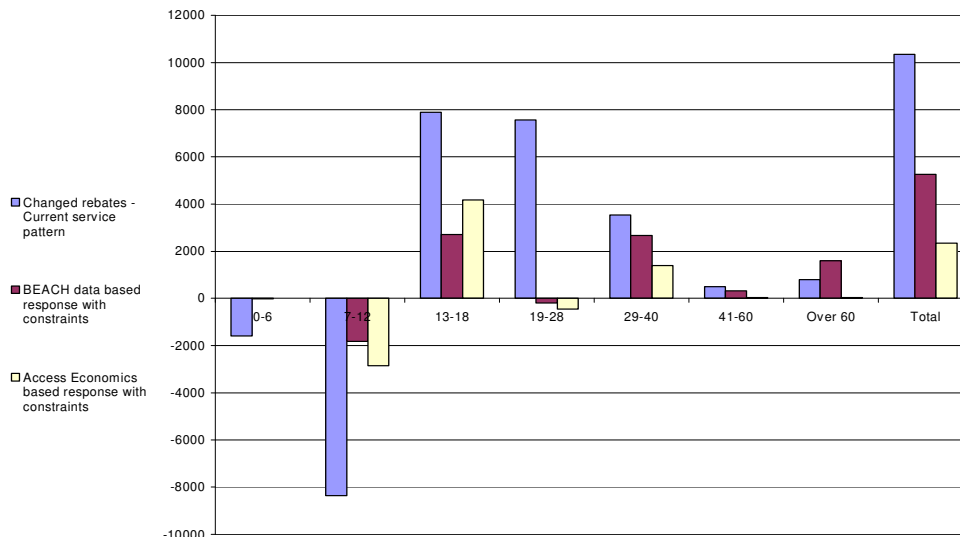


Chart 9e shows the Commonwealth rebate expenditure from application of the new rebates, under a Model 3 scenario rather than a Model 2, or Model 1 framework, to current service levels. The Chart compares this scenario with the expenditure that would eventuate as a result of a change in behaviour in response, for all GPs, to the new rebates, using the two alternative models of behaviour change.

Chart 9e: Estimated change in Commonwealth rebate expenditure of current structure – Model 3

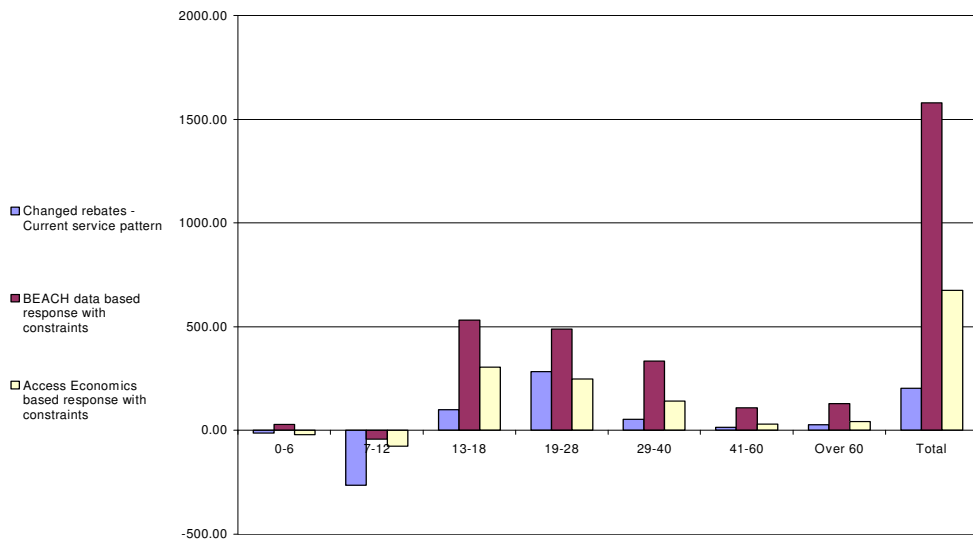
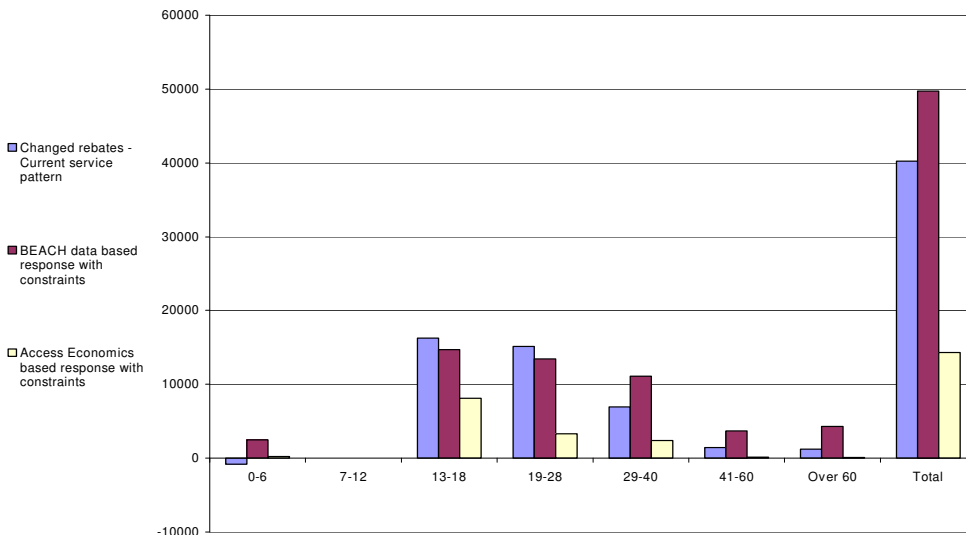


Chart 9d shows the Commonwealth rebate expenditure from application of the new rebates, under for a Model 3 scenario, to current service levels for urban GPs only. It compares this with the expenditure that would eventuate as a result of a change in behaviour in response to the new rebates for urban GPs, using the two alternative models of behaviour change. The equivalent charts for the three remaining cohorts, male, female, and rural GPs, are at Attachment F.

Chart 9f: Estimated change in Commonwealth rebate expenditure of current structure – Model 3, Urban only



The assumptions underlying both behaviour change methodologies and the adjustment for demand and clinical need factors imply that results can be regarded as indicative only. In addition, the methodologies dealt with the likely response of GPs as a whole to changes in the rebate structure and did not explicitly take into account the possible response of individual GPs to changes in their total patient rebates.

7. Other Issues

7.1 Impact on Aggregate Workforce Supply

The potential impact of a new structure on GP workforce supply is critical. By removing the financial disincentive for a GP to perform longer consultations, it would be expected that there would be some substitution of shorter consultations with longer consultations. This will inevitably have an impact on either the total hours a GP works or the total number of services they can supply, or both.

If a GP substitutes shorter consultations with longer consultations and still maintains the same number of services that they provide then they must increase the total number of hours that they work. Alternatively if the hours a GP works remain fixed then by replacing shorter consultations with longer consultations the total number of services a GP is able to supply will have to be reduced. This may mean that a GP is unable to see as many patients as previously, which could have a negative impact on patient access to GPs. Counter to this there is some evidence that longer consultations and a higher quality primary care may result in fewer GP visits on average being required.

7.2 Aggregate Commonwealth Budget Implications

As a technical group the AIRWG has only been concerned with the structure of the current attendance items and any possible alternatives. In this context the focus of the group has mainly been on the item structure and relativities between items. While a variety of rebate dollar amounts have been used in the modelling of various scenarios their purpose has been to illustrate the impact on the current attendance item structure of the various alternatives explored in terms of item structures and relativities between items. Examples of rebate dollar amounts have also been necessary in deriving the best methodology for costing any impact of a new attendance item structure. What these rebate dollar amounts would be in a new structure is, however, a policy issue which was considered outside the scope of this working group. For modelling purposes, the working group used a number of simplifying assumptions:

- The year 1 volume of services are based on a November 2002 implementation date.
- Growth in services is 0% before behavioural change.
- Fee drift is 0%.
- No “upbilling” / “downbilling” is assumed.
- Percentage of payment that is practice costs and the percentage of total patient rebates that is professional service is 50%.

In determining the final budgetary implications of a new structure it would be necessary to review these assumptions.

7.3 Indexation

One issue that could not be resolved by the Working Group was the approach to indexation.

Part of the Working Group's second term of reference was that:

Proposals will include consideration of indexation as a mechanism for examining options for transition to a new fee structure and include the flexibility to include indexation options in a modelling context.

The Department's approach was that this constrained indexation to being one factor among many for the purposes of modelling an alternative item structure (in the modelling, indexation was generally included at a level of 2.1 per cent in estimating expenditure in the second and subsequent years of implementation). In addition, the Department's view was that differential indexation of items could assist in the gradual implementation of an alternative structure, although this was not considered formally by the Working Group.

GP groups argued strongly that consideration of indexation should not be constrained to these technical applications. They identified the level of indexation applied to GP attendance items (attendance items are currently indexed using the Wage Cost Index 5) as a significant issue and argued that inappropriate indexation arrangements had the potential to undermine the integrity of any fee structure.

GP groups identified addressing structural problems with WCI5 as essential in implementation of a new structure and concluded that the work of the Working Group be extended to review and provide recommendations on indexation.

A full discussion of the GP groups' view is at Attachment G.

8 Conclusions

This report presents the outcomes of the investigations of the Working group into alternatives to the current attendance item structure for in surgery general practice consultation items.

The Working Group identified that both the current MBS GP attendance items time structure (with broad time bands) and relativities between items, result in a substantial variation in rebate remuneration (rebate dollars per minute) for consultations of differing lengths. As a result within the current structure there exist financial incentives that favour shorter consultations and subsequent financial disincentives for GPs to perform longer consultations. Longer consultations are viewed as important in the provision of quality care for patients with chronic or complex conditions, are considered "high" effort compared with other consultation lengths and account for over 20 per cent of consultations.

The Working group agreed that the body of evidence was sufficient to support a link between longer consultations (when appropriate) and quality and therefore justify the removal of financial disincentives inherent in the existing structure that mitigate against the provision of these consultations. This was achieved by altering both the item structure and relativities between items.

The proposed new items broadly split the current Level B, C and D items. The proposed additional items reduce the disincentives to the provision of quality care by flattening the remuneration structure, ie reducing the variation in fee-per-minute across the current structure. The proposed time structure has also been designed to reflect current practice in the 'real world'. The preferred model's relativities between items similarly seek to flatten the remuneration structure and reduce the variation in fee-per-minute across the current structure, as well as rewarding "efficacy", recognising the pattern of non-face-to-face time and providing an allowance for flagfall.

In implementing any revision to the current structure, there remain issues for resolution which are outside the terms of reference of the Working group, primarily those relating to the level of rebates applying to a revised structure. On this, the view of the GP groups is clear that additional funding must accompany a restructure. There is also a different view between GP groups and the DHA on the treatment of time bands in a new structure.

In undertaking their investigation GP groups found the evidence on which decisions needed to be based, to be limited. They suggested that a more conclusive and comprehensive body of evidence be gathered regarding the relationship between quality and length of consultations, the complexity and 'intensity' of general practice consultations and the proportion of indirect to total consultation time. These issues should be the subject of urgent further research.

The Working Group provides this report for consideration by the Minister and GP groups, and concludes that:

- 1. appropriate implementation of a 7 tier item structure in place of the current 4 tier item structure would improve the quality of health care in Australia.**
- 2. to ensure patient access is not compromised there are a number of issues, which include funding levels and workforce impact, that would need to be resolved between government and the GP representative groups prior to implementation.**
- 3. this 7 tier item structure appropriately includes relativities that reflect efficacy, the pattern of non-face-to-face time and a fixed modest flagfall.**
- 4. the Department and general practitioner organisations agree that there is value in continuing to engage in constructive dialogue about possible implementation of the findings of this report.**
- 5. the differences of the view between the department and the GP groups of basing the item descriptors on fixed time bands or content and indicative time needs to be resolved.**
- 6. the Working Group should complete the terms of reference in relation to indexation, after hours and residential care visits.**
- 7. further research on non-face-to-face time needs to be completed as a matter of priority.**

Terms of Reference

1. To develop proposals for reform of the attendance item structure for in-surgery General Practice consultations to improve incentives for provision of quality care.
2. To cost such proposals and provide advice on financial options for attendance item reform:
 - Financial modelling to be ‘without prejudice’ as to the need for additional investment by the Government on rebates;
 - All the results of the modelling must be available to the groups participating, for discussion with the GP profession;
 - Proposals will include consideration of indexation as a mechanism for examining options for transition to a new fee structure and include the flexibility to include indexation options in a modelling context.
3. Following modelling of standard GP in-surgery items, to consider other non-referred GP items, for example, after hours care and residential aged care facilities visits.
4. To provide advice to the Minister for Health, the AMA, the RDAA, the RACGP and the ADGP on options for an attendance item restructure. These options will be prioritised by consensus if possible.

Attendance Item Restructure Working Group

Organisation/Role	Name
Chair	Professor Justin Beilby Head Department of General Practice Adelaide University
Technical Expert	Dr Jim Butler Deputy Director National Centre for Epidemiology and Population Health Australian National University
Technical Expert	Ms Lynne Pezzullo Senior Economist, Health Access Economics
Representatives	
RACGP	Associate Professor Philip Hegarty Royal Melbourne Hospital Staff Health Service
ADGP	Dr Michael Nolan Director Central Bayside Division of General Practice
AMA	Dr David Rivett Chair AMA Council of General Practice Australian Medical Association
RDAA	Dr Geoff White Past President Rural Doctors Association of Australia Rural Doctors Association of Australia representative to the General Practice Reference Group
DHA	Ms Judy Daniel Director General Practice Financing Section Department of Health and Ageing

DHA
Ms Kim Farrant
Director
General Practice Financing Section
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Ms Leonie Smith
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General Practice Access Branch

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RACGP
Mr Ian Watts
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AMA
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Mr Brian Curren
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Mr Rob Janssens
Policy Officer
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Ms Adriane Dyke
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General Practice Financing Section
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DHA Secretariat
Mr Adrian Davies
Policy Officer
General Practice Financing Section
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Literature on the relationship between quality and length of consultations

Introduction:

An increasing body of evidence from around the world suggests that “longer” consultation times are associated with better health outcomes (e.g. Bolton et al., 1998; Campbell et al., 2001; Charlton & Charlton, 1993; Coulter & Dunn, 2002; Elwyn et al., 1999; Goedhuys & Rethans, 2001; Gotler et al., 2000; Howie et al., 1989, 1991, 1999, 2000; Kaplan et al. 1995; Martin et al., 1999; Morrell et al., 1986; Stirling et al., 2001; Van Berkestijn et al., 1999; Wilson, 1991).

A “long” consultation creates an opportunity for more patient centred approaches, better communication, and better management of chronic conditions, more complex consultations and of patients with psychosocial problems. Insufficient time will present various problems including compromised shared decision making (SDM), compromised interpersonal or technical aspects of care which may ultimately lead to greater patient dissatisfaction, communication problems, higher rates of litigation and malpractice suits.

Overall, for the Australian context, the evidence supports the approach of rewarding doctors for “longer” consultation times (approx 20 minutes); particularly for those consultations associated with the management of chronic illnesses.

This paper seeks to provide a very brief summary of relevant research.

Background:

Research literature on a relationship between quality or positive health outcomes, and consultation length in an Australian context is limited.

Suggestions that consultations need to be “longer” needs to be seen within the setting of the research. In the British research, consultations are around 5 -10 mins (e.g. Howie et al., 1991, 1999, 2000; Morrell et al., 1986; Stirling et al., 2001). Scandinavian research refers to average consultation times of 15 mins (Van Berkestijn et al., 1999) and 20-23 mins (Andersson & Mattsson, 1994). North American research quotes average times of first consultation 26.1 minutes (Barnsley et al., 1999), an average consultation time of 19-23 mins (Cegala et al., 2001) or refers to consultations with participatory decision making (PDM) as being in 21-30 minute brackets. New Zealand consultation booking times average 15 minutes (Charlton & Charlton, 1993). Research in the Australian context reports an average consultation time of 15 mins (Sturmberg, 2001) and spans times from 5-10 mins to greater than 20 mins (Martin et al., 1999).

There is some contrasting evidence regarding the relationship between quality and length of consultation, and possibly other factors involved. Adequate time is necessary for better outcomes, but is not necessarily all that is required. Research relevant to these issues is discussed toward the end of this paper.

Quality and consultation length related research:

Coulter and Dunn (2002) argue that quality of outcome is related to the quality of communication. Better communication results in better understanding and incorporation of patient preferences, better patient adherence, and that patients will be less likely to accept risky/ineffective procedures if well informed. However, they advise this requires longer consultation times.

Elwyn et al. (1999) note that, while requiring more time with the patient, the patient centred approach (participatory decision making/shared decision making) leads to a more active doctor-patient relationship. This is desirable as it leads to improved short term outcomes (higher patient satisfaction and understanding), to better adherence and to less use of other services (e.g. Greenfield & Kaplan, 1997, 1998, 1999, all cited in Elwyn et al., 1999).

Freeman et al. (2002), in reviewing papers on the subject note that longer consultations lead to doctors prescribing less, offering more lifestyle and health advice, better recognising and addressing of psychosocial problems, better enablement of patients, and better chronic illness care.

Howie and colleagues (1989, 1991, 1999, & 2001) also noted longer consultations allowed for better recognition and handling of psychological, psychosocial and social problems, and of other long term health problems (1989) and that attending to psychological problems resulted in fewer prescriptions of antibiotics and greater patient satisfaction. Howie et al. (1999, 2000) also argue that longer consultations result in better patient enablement.

Stirling et al. (2001) found that recognition of distress is greater in longer consultations, and that socioeconomic need is associated with shorter consultation times. This indicated that time is critical to quality care – even more so in areas of need.

Campbell et al. (2001) concluded that longer consultations were essential for providing high quality care, especially with respect to managing patients with chronic illness.

In one Australian study, Martin et al. (1999) also found that longer consultations allow for better outcomes for patients with chronic illness. Short consultations may be appropriate for simple, acute conditions, but for multiple chronic conditions, more time is needed to review illness and treatment options, and for patients to discuss their issues regarding the illness, its impact on their life and management issues.

Morrell and colleagues (1986) found that the 5 minute consultations made it less likely that doctors would identify all patients' problems, would undertake fewer examinations, and would result in lower patient satisfaction. Furthermore, the authors found that doctors would be constantly running behind the clock and would have less time for good record keeping.

Bolton et al. (1998) found longer consultations were associated with higher patient satisfaction and with greater diagnostic complexity in an Australian context. This study concluded that diagnostic complexity and aspects of holistic care (e.g. counseling) are the major determinants of long consultations.

Wilson (1991) found that longer consultation times were associated with higher levels of patient satisfaction, and more health education/prevention measures.

Charlton and Charlton (1993), in their commentary on general practice in New Zealand, noted that consultation booking times averaged 15 minutes, and that this longer time benefited both doctors and patients with more time to explore patients problems in more depth.

Also, in a study looking at general practice consultation length in Singapore, Voo (1999) observed marked differences in mean (9.3 mins), median (6.0 mins) and mode times (3.0 mins) for consultations. Consultation length also varied according to case mix; mean consultation times for acute consultations was 7.1 minutes, for chronic conditions was 7.6 minutes and chronic relapsing at 9.9 minutes.

Other factors related to quality:

Some of the literature argues that longer consultation time alone, may not necessarily lead to better quality outcomes; that various patient, doctor, and consultation characteristics are also involved. Barnsley et al. (1999) found that characteristics of the physician-patient relationship influence outcomes (e.g. communication style).

Hickson et al. (2002) found that communication was essential to patients' perception of quality care, and that failure to communicate effectively was often at the heart of malpractice suits. In terms of quality and time, this study found that high numbers of relative value units may lead to decreased time with patients, and thus, less attention to interpersonal and technical aspects of care, which could lead to increased risk of malpractice suits.

Cegala et al. (2001) found that patient communication training improved outcomes by increasing the level of active participation and the amount of information exchanged during the consultation. This did not involve additional consultation time with the doctor, although the average consultation time was 19-23 minutes. Outcomes of this research suggest support for the use of structured self-management and other ways of improving patient communication as a means of managing overall consultation time.

Gotler et al. (2000) found that PDM was employed at highly variable rates – with a focus on patients with the most need (i.e. most complex decisions) and concluded that use of PDM is an issue of physician style, communication skills and also an issue of competing time demands. Similarly, Goedhuys et al. (2001) found that PDM approach seems useful where legitimate patient choices exist (e.g. complex presentations; chronic conditions) but that a more directive approach may be useful elsewhere (e.g. uptake of screening procedures).

Patient characteristics also play a role in outcomes. Kaplan et al. (1995) found that patients who were younger than 30 years, older than 75 years, from ethnic minorities, or who were male had the least participatory consultations with doctors, and as such, had poorer outcomes. They also noted that shorter consultations, and consultations where doctor-patient tenure was shorter were also associated with less PDM. Similarly, McKinstry (2000) found that patients who were older, less educated, non-smokers or patients with simple complaints had less desire for a PDM approach to their consultation.

Wilson (1991) found that consultation length was determined by patient and doctor variables, and that many of the studies reporting associations between consultation length and process and outcomes were confounded by activities of the doctors, such as prescribing, investigations, referrals and request for follow up consultations.

Wilson and colleagues (2002) and Sturmberg (2002), in response to Freeman et al. (2002) also note time is not the only critical factor to improve quality. Wilson found that merely booking longer appointments did not result in doctors having longer consultations, nor did it decrease the number of prescriptions, number of exams carried out, nor reduce the number of referrals made. They also observed more repeat appointments, a greater numbers of investigations arising from the longer consultations and found no difference in identification of psychological distress.

In response to Wilson et al. (2002), Sturmberg (2002) argued that not only is sufficient time critical, but also that attitudes and expectations of doctors and patients are also a factor. The author suggests that in a short trial (referring to Wilson et al. 2002), it would not be likely to see an overall change in doctor focus and behavior and that longer consultations would not necessarily lead to increased diagnosis and dealing with more psychological problems.

Conclusion:

There is a strong and consistent tie between adequate consultation time and positive health outcome for the patient. In the Australian context, it would appear that adequate time will approximate 20 minutes. There is, however, evidence that time alone is not sufficient; patient characteristics such as age, GP characteristics such as communication style, and consultation characteristics such as complexity of the reason for the consultation all play a part.

Studies that tend to find that time is not such a strong influence have longer consultation times; usually around the 20 minute mark (e.g. Andersson & Mattsson, 1994; Barnsley et al., 1999; Cegala et al., 2001; Kaplan et al., 1995). This suggests that while an adequate amount of time is required, once this time has been achieved (eg approx 20 minutes), other factors such as communication style, whether or not patient centred approaches are employed, continuity of care, and various patient attitudes/preferences, for example, become factors in obtaining quality health outcomes.

As Wilson (1991) suggests, however, a change to “longer” consultation times is not without cost. The workforce and patient access impacts of the change, for example, would need consideration.

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GP GROUPS PAPER

Principles for the consultation item structure descriptors

- 1) The simplicity of the payment schedule should be maximised for the benefit of GPs and their patients. Further differentiation beyond the seven-tiered schedule as proposed will impose an increased administrative and compliance burden for GPs in an already difficult climate of red-tape overload.
- 2) The revised structure does not change the nature of consultative medical practice but more accurately describes and differentiates between the services provided by doctors. The items are based on content (not time-tiering): each item descriptor explains the nature of the work which must be undertaken for benefits to be payable in respect of that service.
- 3) Content based descriptors enhance quality, and efficiency:
 - They enhance quality by delineating the requisite minimal parameters of the consultation;
 - They encourage efficient completion of episodes of care without undue clock-watching;
 - They enhance doctor – patient rapport by reducing the potential for argument over differing views on time spent;
 - They reward experience/expertise where it enables more rapid problem solving.
- 4) Any times must be indicative to provide the flexibility to accommodate differing levels of GP skills.
- 5) Where a time is indicated it is only used to specify the approximate time for the service.
- 6) The maintenance of accurate contemporaneous clinical records is an essential element.
- 7) Reform of the GP Attendance Item Structure will not be supported by GP organisations (AMA, RACGP, RDAA & ADGP) unless it is subject to additional Commonwealth investment to 1) substantially redress of the current underfunding of the GP attendance item numbers and 2) ensure ongoing sustainability through indexation which recognises practice costs. WCI 5 is unacceptable as an indexation mechanism.
- 8) The diminution of patient access in a situation of GP undersupply must be balanced with any benefits from a change to a system rewarding longer consultation times.
- 9) Subject to the above caveats, the reform of the GP Attendance Item Structure should proceed as a discrete exercise that previous policy (adopted by the GP Remuneration Taskforce) linking Attendance item Structural reform with specialist items is no longer applicable.

The complexity and ‘intensity’ of general practice consultations – the research and its implications for the structure of fee-for-service payment systems

“... I was reminded of the Gary Larson cartoon in which, after covering a blackboard with sophisticated and arcane mathematical equations, Einstein discovers that time equals money.” (Gulya, 1999)

Introduction:

A previous paper prepared for the Attendance Item Restructure Working Group reviewed the increasing body of evidence from around the world, suggesting that “longer” consultation times with General Practitioners (GPs) are associated with better health outcomes. As that paper outlined, however, time is not the only variable of importance in achieving excellent care.

This paper aims to summarise available literature on ‘intensity/complexity’ of general practice encounters, and to outline the implications for developing a payment schedule that appropriately recognises and rewards the work of GPs.

Clinical consultations with GPs also vary in complexity, and in how ‘intense’ they are. The mental effort and judgement required of a GP, the technical skill and physical effort used, and the stress experienced by a GP due to medico-legal risk, can all vary in clinical consultations. These factors define and determine the complexity and ‘intensity’ of General Practice consultations.

The principal evidence about differentiating the intensity and complexity of the work undertaken by doctors comes from a 6 year study by WC Hsiao and colleagues undertaken in the USA through the 1980s. Robust research in Australia (and elsewhere) is very limited.

The available research suggests that it would be possible to develop robust measures of the intensity and complexity of simple encounters (e.g. encounters where one problem is presented). It is more difficult to develop measures that reflect the heterogeneity of clinical consultations experienced by Australian GPs and their patients.

However, time is likely to be the most important factor in indicating total workload for medical activities (though not for surgical activities), predicting as much as 90% of the variation. As a result, any payment schedule needs to build on time as the starting point for differentiating remuneration for consultations.

The fact that a patient is new, or that an existing patient presents with a new problem; and/or the presence or absence of some core activities (such as physical examination or history taking), may be appropriate as differentiating characteristics beyond time. If this were to be the case, then it is likely that the weighting for these characteristics would be small, reflecting the relative importance of the factors. Potentially, descriptors of the items in the (revised) schedule could assist to delineate these differences.

In theory, there is merit in bundling activities together (e.g. opportunistic screening for some diseases with some clinical consultations), as this may reduce both workload and time. However, the appropriateness of bundling activities together is probably specific to the clinical encounter, making it difficult to construct a schedule that included appropriate incentives for ‘bundling’ activities together.

Any changes, however, must be considered in the context of a growing administrative and compliance burden associated with a differentiated schedule. The recommendations of respected authors are that the simplicity of the payment schedule should be maximised, as the benefits of a complex system (e.g. in the reduction of fraud) may not be high.

There are a number of limitations to the studies available, including the fact that the studies only measure resource inputs; differences in the quality of care are not incorporated. A fair payment system should reflect differences in the quality of a service, particularly when it requires more resources to produce a higher-quality product. If some doctors routinely provide better quality services, then the research to date does not provide evidence about the extent of this, nor provide clear direction as to ways in which this could be reflected in a payment schedule.

Relevant research:

Mental and physical effort, judgement, technical skill and stress

The principal research evidence comes from a major study (or group of studies) undertaken by WC Hsiao and colleagues over a 6 year period in the 1980s, in the USA. As one part of this large study, Hsiao, Ynterma, Braun, Dunn and Spencer (1988) sought to understand, define and measure the intra-consultation work input of doctors' services. The authors found that the dimensions of this work input were:

- time
- mental effort and judgement
- technical skill and physical effort, and
- stress due to risk.

Hsiao et al found that the dimensions were rated similarly across a cohort of doctors. They found, in every specialty including family practice, that none of the four dimensions could be discarded without significantly impairing the description of work.

Time was a more important dimension in predicting 'work' for medical specialties than for surgical specialties (Hsiao, Braun, Dunn and Becker, 1998, p.2350). Braun, Dernburg, Dunn and Cohen (1992) report that their work (as part of the team with Hsiao) showed face-to-face time with the patient predicted 90% of the variation in the level of work. This finding was supported in research by Lasker and Marquis (1999).

Hsiao and his colleagues used a magnitude estimation method to measure subjective perceptions and judgements (rating a vignette of one service in relation to a vignette of a reference service); and found reliable and valid ratings of work in performing services within specialties.

There are limitations to the methodology used by Hsiao et al, which are relevant to the work on a revised Medical Benefits Schedule. For example, it may be possible to make consistent predictions about the resource intensity of some events (e.g. procedures) especially when the content is known or the scope of the presenting problems limited (as is necessary in the vignette methodology). Lee and Ginsburg (1988) suggest that this might apply particularly to 'evaluation and management' activities that are common in general/family practice. Thus, it may be more difficult to make such assessments of complexity/intensity that can be used in a payment schedule in the context of heterogenous and unpredictable presentations, as are routine in Australian general practice.

The difficulty is illustrated in a letter to the Editor of the *New England Journal of Medicine*:

“How do I code for the visit of a patient who presents for periodic follow-up of diabetes, , and hyperlipidemia but who also wants me to evaluate a new skin lesion and a newly sore knee and to suggest a treatment for periodic constipation? Not uncommonly, this same patient will have contracted an upper respiratory infection two days before the visit and will expect me to evaluate and treat it , too ..”
(Reynolds, 1999)

Additionally, the work by Hsiao and his team does not include measurement of differences in quality or competence amongst physicians (Hsiao, Braun, Dunn and Becker, 1988, p.2348), nor does it address the impact of supply and demand factors on the provision of different services. (Roper 1988, p. 2444). A recent re-analysis of the BEACH data, commissioned by the RACGP, to explore potential differences in the quality of care provided by Fellows of the College, and non-Fellows, may illuminate some of these issues. The research does not, however, aim to provide direction as to the implications for a payment schedule.

New patients, new patient problems and familiarity with types of patient problems

Lasker and Marquis (1999) found that four characteristics of the visit were important in predicting the total amount of work. These were:

- Whether the patient was ‘new’ or ‘established’ (though these terms are not defined)
- Whether the physician was initiating or continuing care
- Whether the patient was referred by another physician
- Whether the physician was seeing the patient for a new or for a previously existing problem.

They report, for example:

“among visits involving 15-minute (face-to-face time), the total work was 23 percent greater for office visits with new patients than for office visits with established patients, ... 36 percent greater for initial than for follow-up consultations, ... and 10 percent greater for office visits with established patients in which new rather than previously existing problems were addressed.” (pp. 339-340)

This work is in contrast to the work of Braun et al (1992, p.NS20). They reported that the site/type of service, patient status and referral status account for 15% of the variance remaining *after time has been accounted for* (emphasis added).

Bertram, Opila, Brown, Gallagher, Schifeling, Snow, and Hershey (1992) suggest that, in their study, the extra time scheduled for new patients may have offset the extra demand involved, thus reducing the impact of new patients on mental workload in their study.

Bertram et al (1992) examined the reliability and validity of a brief instrument to measure the mental workload experienced by some doctors in an ambulatory care setting. Their study had a number of methodological limitations, including sample size and the fact that the doctors studied were residents. Despite that, some of the concepts discussed are germane.

Bertram et al define mental workload as:

“a subjective experience of the costs incurred by a physician in performing patient care tasks and reflects the totality of physician skill, experience, effort exerted, emotional responses, tasks requirements, and the environmental setting” (p.96)

They hypothesised that mental workload would increase if:

- Physician fatigue increased
- The total number of patients seen in a clinic session increased
- The proportion of new, as opposed to return visits was higher
- Complexity of individual patients (e.g. number of problems presented at the consultation) was higher

They hypothesise that mental workload would decrease if:

- Physician familiarity with the type of problems presented by the patient increased.

The authors found that the strongest determinant of mental workload was familiarity and experience with the types of problems presented by patients.

In this aspect of the research, Bertram et al's work contrasts with the research of Hsiao et al (1998), which found that time was the key predictor of overall workload.

This difference may indicate that a group of doctors can estimate the likely intensity/complexity of a defined interaction (using a series of vignettes), but that in an individual, actual encounter, familiarity with the type of problem is also an important consideration. Even if familiarity with the type of problem is important in the individual consultation, the question in the context of restructuring a national payment schedule is whether is possible to the payment structure to accommodate this individual variation.

In Bertram et al's study, patient complexity had a positive correlation to increased mental workload, but was not statistically significant. The authors suggest a number of methodological limitations that might be relevant to this finding, including a possibility that they were unable to detect meaningful distinctions in patient complexity. The total number of patients seen in a clinic session did not have an effect on mental workload, possibly because of the low number of patients seen in the study context. The authors suggest that there may be a threshold level of patients in a session above which mental workload becomes a salient issue. It is also possible that the impact of patient 'new-ness' and/or the number of patients seen in a session may be less important than familiarity with the sort of problems presented by the patient.

Lasker and Marquis (1999) used data from a 1989 study on patient visits to urologists, rheumatologists and general internists to identify differences in the total work and work intensity for different types of visits. This work is on actual visits and suggests that intensity might be higher in shorter encounters, because the proportion of direct time is higher. Additionally, in this study, the difference in work activity was not related to a difference in the mix of services/activities within the consultation.

Although Lasker and Marquis (1999) found that the total amount of work increased with longer face-to-face time, the increase was not in direct proportion to the increase in face-to-face time. Braun et al (1992, p.NS21), in contrast, indicate that while they "began with the same *a priori* hypothesis (that indirect time was a declining fraction of the total time spent on a patient's care), (they did not see) any evidence in (their) data that pre- and post-service work is a declining fraction of the total."

Activities within the consultation

Some researchers have investigated the mix of activities undertaken within consultations.

Consideration of the activities undertaken within a consultation may be useful, as the number and type of core tasks undertaken within a consultation may have a relationship with its intensity/complexity.

Bryne and Long (1976, cited in Bergh, 1996) refers to a study published by the Royal College of General Practitioners in 1976, which outlines six core tasks in a consultation. These tasks were:

- Introduction
- Exploration of the patient's reason for visit
- Medical investigation
- Explanation of the diagnosis
- Treatment planning
- Termination of the visit.

This delineation of the core tasks is useful when reviewing research by authors who studied the range, mix and extent of activities within consultations.

Lasker and Marquis (1999) found that particular activities, such as taking a history or performing a physical examination accounted for the same proportion of total time, regardless of the length of the encounter. They suggest that this finding probably reflected certain fixed activities, such as review of charts or entry of information onto the chart. Bergh (1996, p.267) found that "times in opening and closing were brief and varied little".

Stange, Zyzanski, Jaen, Callahan, Kelly, Gillanders, Shank, Chao, Medalie, Miller, Crabtree, Flocke, Gilchrist, Langa and Goodwin (1998) studied both the content and context of family practice visits in Ohio. Their direct observation study measured the face-to-face time spent with the patient. The data show that patient history, including the assessment of family history is a major tool, representing a mean of 55.9% of time intervals recorded. Planning treatment represented a mean of 32% of time intervals recorded and physical examination represented a mean of 22.9% of time intervals recorded. This methodology allowed for multiple activities to be recorded at the same time (representing the ability of the doctors to undertake more than one task at a time – see the research by Hillsdon et al).

This information may be useful in exploring the content of short consultations, or the content/activity that might differentiate short consultations from longer consultations; as the presence/absence of a core activity might be an important differentiating factor. For example, descriptors might reflect that a consultation in which there is the absence of a medical examination or history taking is remunerated as a 'short' consultation.

Hillsdon, Feldman and Wingert (1992) look at issues of 'economies of scope' in payment for services by doctors. 'Economies of scope' arise when the resources needed to produce one product or service can be shared in the production of another.

"There could be an 'overhead' cost in initiating the patient encounter that does not need to be repeated when the first task is completed and the second is started at one visit. There may be the opportunity for performing some largely physical services (e.g. treatment of a wart) simultaneously with predominantly cognitive services (e.g. interval history regarding angina)." (p.828)

The results of Hillsdon et al's study suggested that 'economies of scope' may exist for both total work, and for time in certain circumstances (i.e. that both the total amount of time and total amount of work may be reduced in some situations, by undertaking a range of activities within the same consultation).

This has implications for payment structures. They suggest that a major goal of reimbursement mechanisms is that they be (financial) incentive-neutral – that is, doctors are paid in such a way that their decisions about patient care are not subject to financial incentives that might conflict with their goals for optimal patient care.

If multiple, but separately funded, services can be bundled into one encounter, then there is a financial incentive for the doctor to do this. The resulting effects on quality or patient satisfaction may vary, and not necessarily be positive. Completion of some services (e.g. screening or preventive services) at the same encounter as other direct care, may reduce the likelihood that these services would be missed because of an absence of follow-up visits. This ‘bundling’ might reduce total visits. It may also reduce total costs, if the payment is made for the encounter, not for each service element. The authors also comment that the appropriateness of ‘bundling’ activities together may be situation-specific, and reliant on decisions by the doctor and patient within the consultation. Thus, structuring a payment schedule to ensure maximum ‘economy of scope’ while maximising quality of care may not be possible.

As a final note, it may be relevant to record that in the consultations studied by Stange et al (1998), a relatively low priority was given to “community and public health”. The authors suggest that

“a fundamental change in the operational structure of most practices may be needed if family physicians are to focus less effort on acute care and more effort on chronic disease management, prevention, mental health, and population medicine” (p.386)

Other considerations in the design of a payment schedule:

One approach to addressing the issues of intensity/complexity, would be to establish a range of items with appropriate descriptions of the diverse intensity/complexity. The literature, however, raises concerns about the administrative and compliance costs of a payment schedule (Iezzoni, 1999; Robinson, 2001, Hsiao, Braun, Dunn, Becker, Yntema, Verrilli, Stamenovic and Chen, 1992). This is expressed by Kelly et al (1988, p.2384) as the “balance between the level of detail incorporated in each individual code and total number of codes”.

In his review of the theory and practice of providing financial incentives for doctors Robinson (2001) makes a strong case for simplicity in payment systems. He cites administrative/transaction costs as a major impediment to ensuring an efficient system focused on excellent patient care, and implies that there is an opportunity cost in direct patient care where the administrative burden is high. He suggests that transaction/administration costs increase significantly where the complexity of the funding system is increased, and that even the most sophisticated mechanisms for paying doctors merely attenuate, but do not eliminate perverse incentives and undesirable outcomes.

Lasker and Marquis (1999) reflected on the concern about a complex schedule in the USA in 1991, following an attempt to increase accountability through a differentiated schedule. They reported that their work demonstrated that face-to-face time was the single most important predictor of the total amount of work performed during a visit. The only other significant variables were differences such as new vs established and new problem vs existing problem. Even with this degree of simplicity, they suggest a matrix of five visit durations with four categories of visit (e.g. established patient with new problem).

Conclusion:

It is possible to reliably determine variation in intensity/complexity, though the literature offers little specific to general practice in Australia.

The length of time taken in a face-to-face encounter with a patient is a sound predictor of the total amount of work (including its complexity/intensity).

There is a small amount of support for distinguishing new patients and new problems of existing patients, but also some support for the view that additional time would mitigate the need for this. In any case, it is not clear that the variation in intensity/complexity is substantial.

In general practice there is probably clinical and economic value in the economies of scope. However, neither this, nor other relevant factors (e.g. a doctor's familiarity with the types of problems presented by a patient) are easily addressed within a national payment schedule.

This diversity of complexity, intensity and 'bundling of activity' may be addressed within a highly differentiated schedule. Suggestions of a differentiated schedule need to be viewed in the context of rapidly increasing administrative and compliance costs (and the degree to which a schedule can actually reduce fraud, or attenuate undesirable outcomes).

This argues for a simple schedule, based principally on time. Any 'loading' for characteristics of the consultation (e.g. new patient or new problem in existing patient) is likely to be small. Given the level of an appropriate loading, it would be important to consider the trade-off created by having to differentiate the schedule to accommodate the variety of consultations.

The suggestion that there may be a reasonably fixed element of pre- and post-consultation time may have relevance to the consideration of a 'flag-fall' in attendance items for General Practitioners in Australia.

It is also important to reflect on the limitations of the studies. They do not, for example, address the impact of supply and demand factors on the provision of different services, nor measure differences in quality or competence amongst physicians. If Fellows of the RACGP, for example, consistently provide higher quality care, then the research to date provides little that would assist in determining how this difference might be reflected in payment mechanisms.

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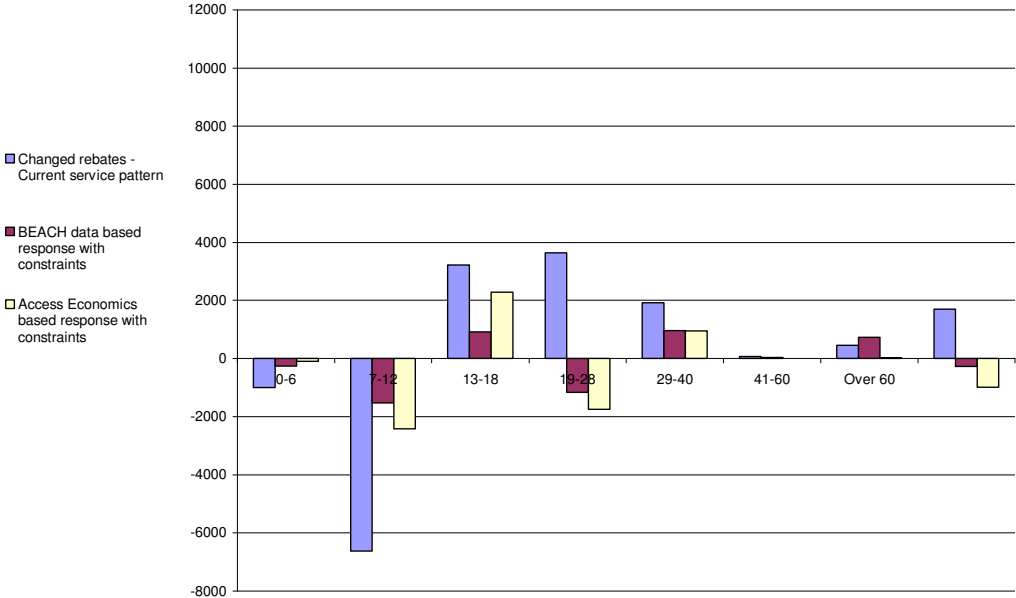
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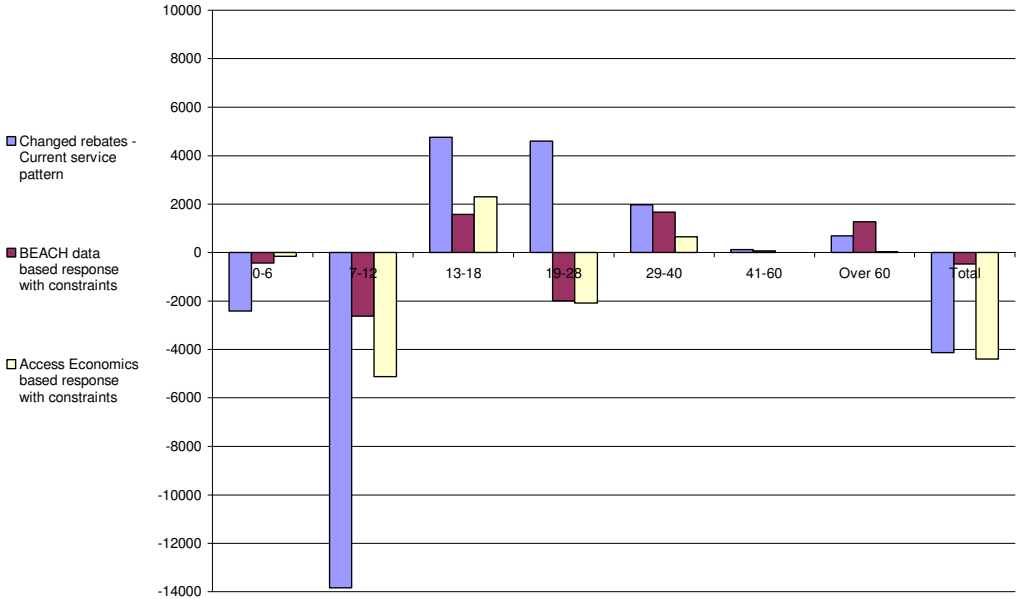
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Behavioural change response with constraints by GP cohort

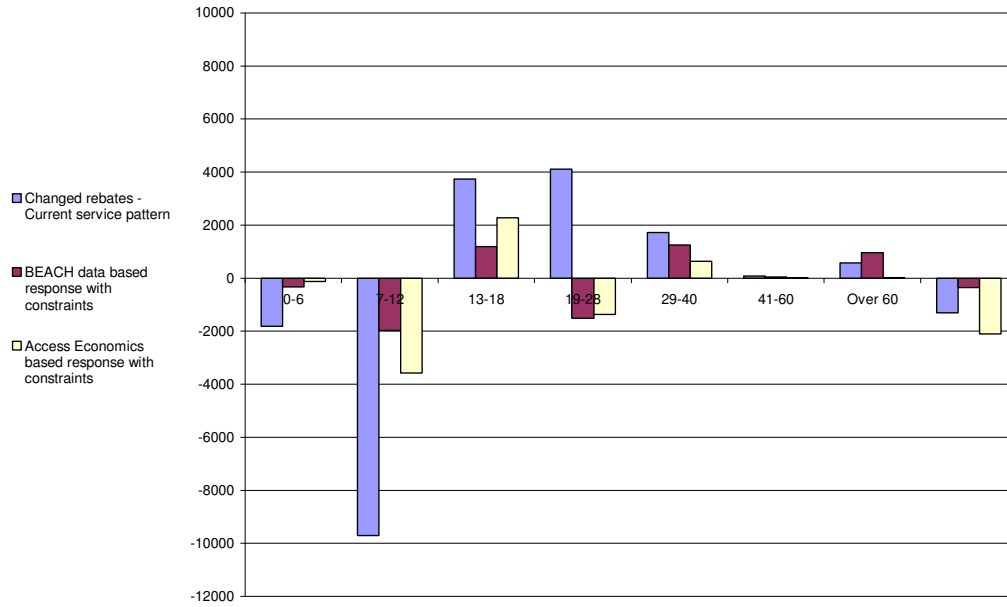
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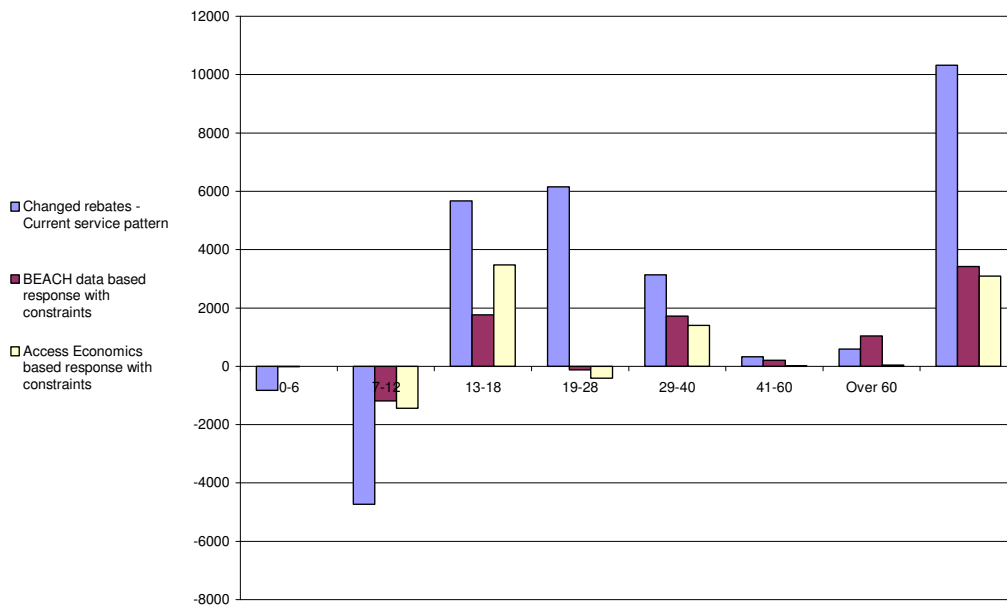
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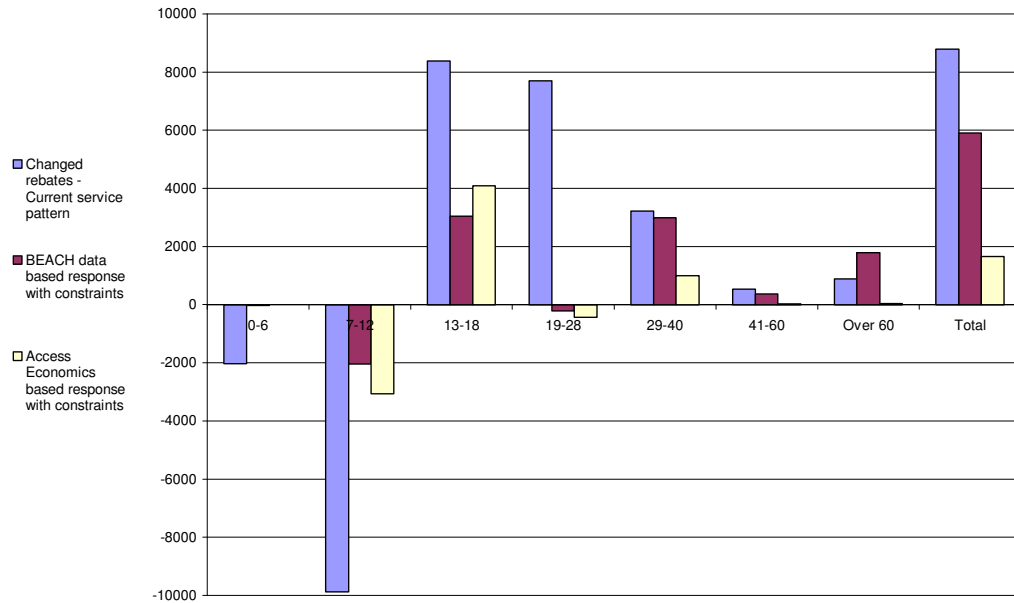
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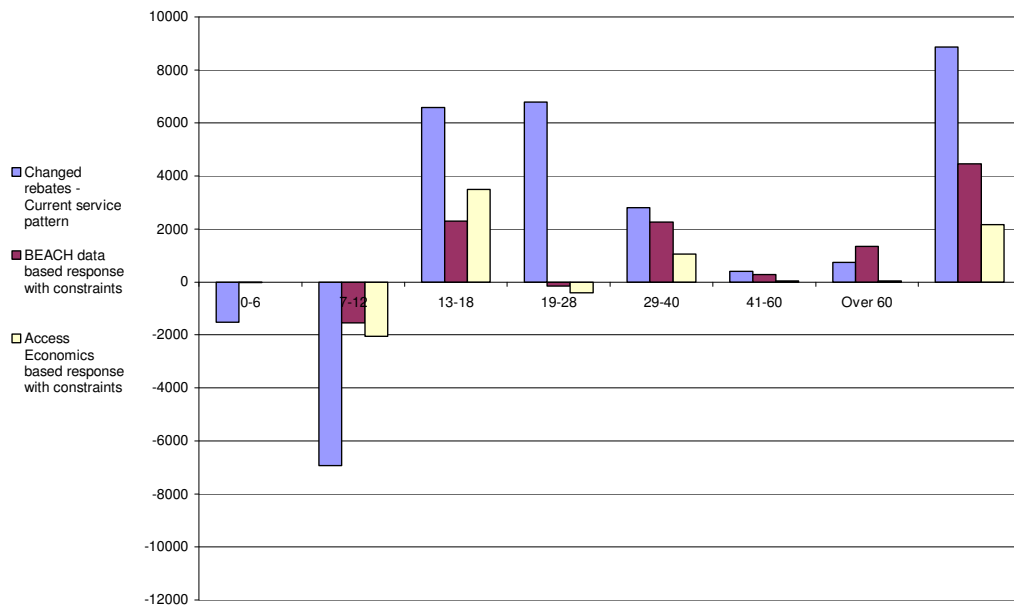
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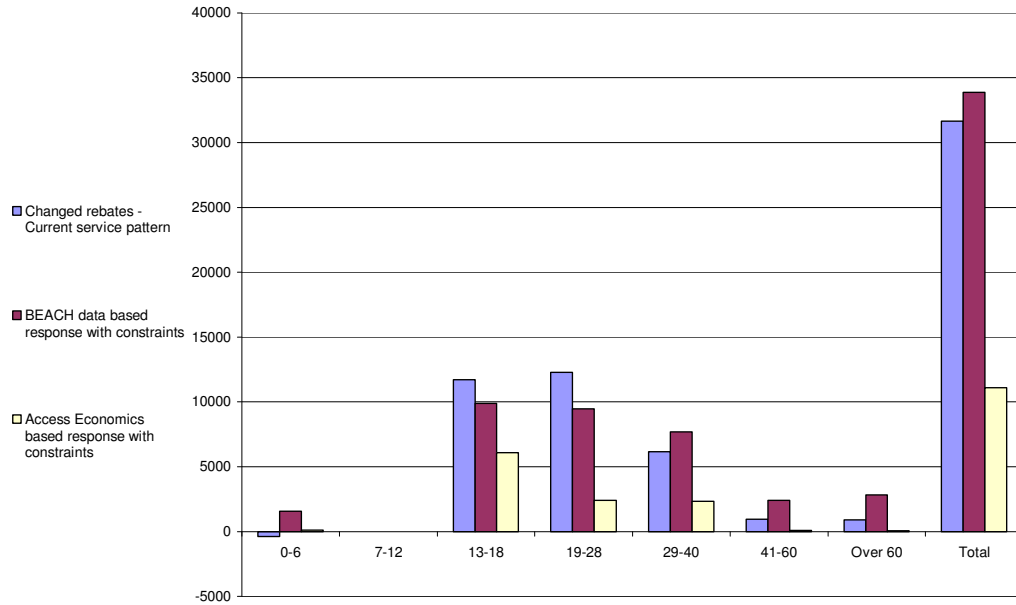
Estimated change in Commonwealth rebate expenditure of current structure – Model 2, Males GPs only.



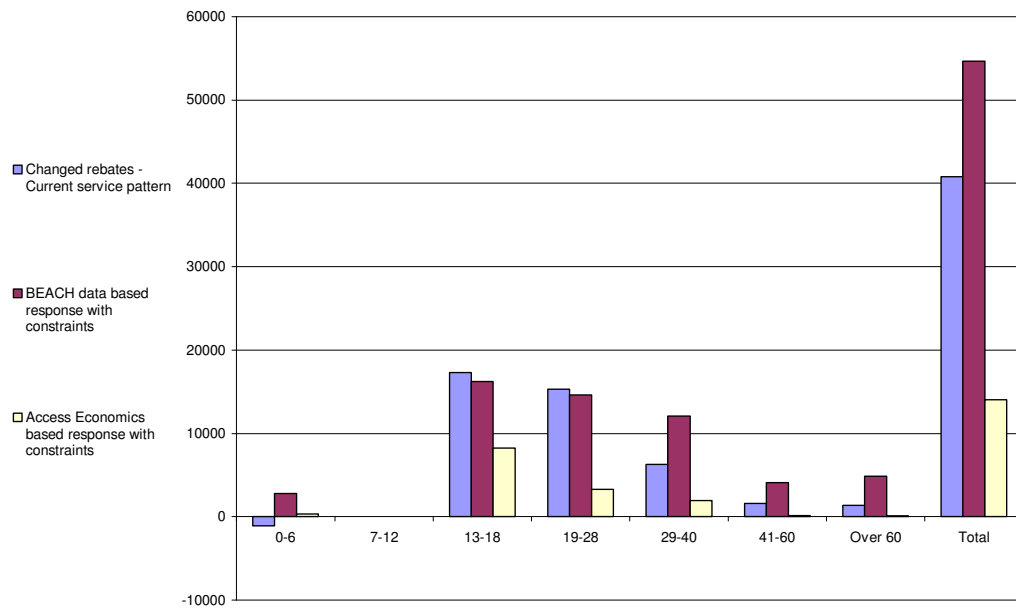
Estimated change in Commonwealth rebate expenditure of current structure – Model 2, Rural GPs only.



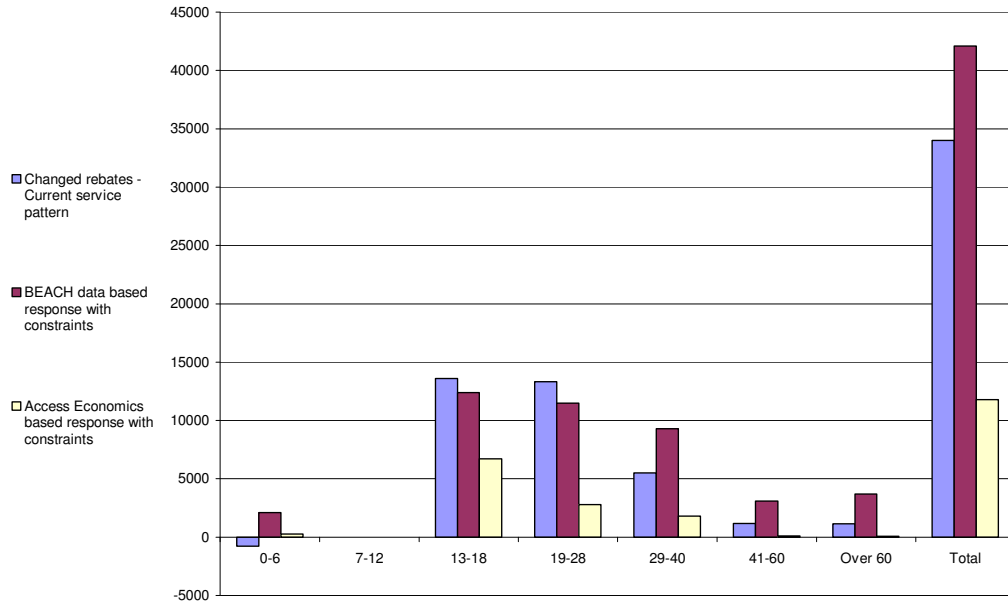
Estimated change in Commonwealth rebate expenditure of current structure – Model 3, Females only.



Estimated change in Commonwealth rebate expenditure of current structure –Model 3, Males only.



Estimated change in Commonwealth rebate expenditure of current structure – Model 3, Rural only.



**Model 1 - AIRWG “Efficacies” - \$2 Flagfall – 20% for A,B1,B2,C1 and 4.6 minutes thereafter
Change in volume of services**

Time structure	Male			Female			Urban			Rural		
	BEACH		Access	BEACH		Access	BEACH		Access	BEACH		Access
	Current	data	Economics	Current	data	Economics	Current	data	Economics	Current	data	Economics
0-6	448	405	433	206	181	197	360	322	345	348	316	337
6-12	2327	2185	2050	1112	1031	982	1966	1839	1711	1631	1524	1438
12-18	1341	1398	1423	907	940	989	1262	1312	1360	1053	1096	1135
18-28	749	701	698	604	577	563	745	703	708	646	610	614
28-40	228	258	240	222	240	240	251	278	267	199	222	211
40-60	60	61	60	37	37	37	55	56	55	45	46	46
Over 60	18	30	19	12	19	12	17	27	17	15	24	16
Totals	5171	5038	4923	3101	3024	3019	4655	4537	4463	3938	3838	3794

Change in MBS rebate remuneration

Time structure	Male			Female			Urban			Rural		
	BEACH		Access	BEACH		Access	BEACH		Access	BEACH		Access
	Current	data	Economics	Current	data	Economics	Current	data	Economics	Current	data	Economics
0-6	\$ 4,594	\$ 4,155	\$ 4,437	\$ 2,109	\$ 1,854	\$ 2,018	\$ 3,695	\$ 3,304	\$ 3,538	\$ 3,566	\$ 3,235	\$ 3,450
6-12	\$ 43,043	\$ 40,422	\$ 37,917	\$ 20,581	\$ 19,065	\$ 18,170	\$ 36,364	\$ 34,030	\$ 31,655	\$ 30,177	\$ 28,203	\$ 26,596
12-18	\$ 37,559	\$ 39,137	\$ 39,856	\$ 25,399	\$ 26,311	\$ 27,682	\$ 35,330	\$ 36,731	\$ 38,066	\$ 29,488	\$ 30,676	\$ 31,773
18-28	\$ 31,326	\$ 29,333	\$ 29,229	\$ 25,290	\$ 24,138	\$ 23,544	\$ 31,190	\$ 29,415	\$ 29,619	\$ 27,036	\$ 25,534	\$ 25,675
28-40	\$ 12,548	\$ 14,216	\$ 13,205	\$ 12,253	\$ 13,218	\$ 13,203	\$ 13,809	\$ 15,293	\$ 14,732	\$ 10,959	\$ 12,217	\$ 11,603
40-60	\$ 4,227	\$ 4,296	\$ 4,227	\$ 2,587	\$ 2,626	\$ 2,587	\$ 3,849	\$ 3,910	\$ 3,859	\$ 3,193	\$ 3,244	\$ 3,200
Over 60	\$ 1,937	\$ 3,204	\$ 1,969	\$ 1,291	\$ 2,023	\$ 1,320	\$ 1,770	\$ 2,897	\$ 1,800	\$ 1,626	\$ 2,581	\$ 1,653
Totals	\$ 135,233	\$ 134,762	\$ 130,839	\$ 89,509	\$ 89,236	\$ 88,524	\$ 126,006	\$ 125,579	\$ 123,270	\$ 106,045	\$ 105,690	\$ 103,950

Model 2 - AIRWG “Efficacies” - \$2 Flagfall – 20% for A,B1,B2,C1 and 4.6 minutes thereafter

Change in volume of services

Time structure	Male			Female			Urban			Rural		
	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access
		data	Economics		data	Economics		data	Economics		data	Economics
0-6	448	446	448	206	204	206	360	358	360	348	346	348
6-12	2327	2225	2175	1112	1054	1041	1966	1875	1824	1631	1555	1530
12-18	1341	1441	1475	907	964	1021	1262	1350	1398	1053	1128	1167
18-28	749	744	739	604	602	595	745	741	735	646	643	637
28-40	228	277	244	222	251	245	251	295	274	199	236	216
40-60	60	65	61	37	40	37	55	59	55	45	49	46
Over 60	18	34	19	12	21	13	17	30	17	15	27	16
Totals	5171	5231	5160	3101	3136	3158	4655	4709	4664	3938	3984	3960

Change in MBS rebate remuneration

Time structure	Male			Female			Urban			Rural		
	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access
		data	Economics		data	Economics		data	Economics		data	Economics
0-6	\$ 4,975	\$ 4,949	\$ 4,975	\$ 2,283	\$ 2,268	\$ 2,283	\$ 4,001	\$ 3,978	\$ 4,001	\$ 3,862	\$ 3,842	\$ 3,862
6-12	\$ 46,998	\$ 44,954	\$ 43,931	\$ 22,472	\$ 21,290	\$ 21,029	\$ 39,706	\$ 37,885	\$ 36,851	\$ 32,950	\$ 31,410	\$ 30,905
12-18	\$ 41,180	\$ 44,226	\$ 45,271	\$ 27,848	\$ 29,609	\$ 31,330	\$ 38,736	\$ 41,443	\$ 42,914	\$ 32,331	\$ 34,626	\$ 35,819
18-28	\$ 34,432	\$ 34,218	\$ 33,992	\$ 27,798	\$ 27,674	\$ 27,391	\$ 34,283	\$ 34,090	\$ 33,822	\$ 29,717	\$ 29,555	\$ 29,319
28-40	\$ 13,789	\$ 16,778	\$ 14,787	\$ 13,464	\$ 15,193	\$ 14,863	\$ 15,175	\$ 17,834	\$ 16,563	\$ 12,043	\$ 14,295	\$ 13,092
40-60	\$ 4,651	\$ 5,015	\$ 4,684	\$ 2,847	\$ 3,057	\$ 2,872	\$ 4,235	\$ 4,558	\$ 4,274	\$ 3,513	\$ 3,787	\$ 3,543
Over 60	\$ 2,132	\$ 3,923	\$ 2,175	\$ 1,421	\$ 2,457	\$ 1,460	\$ 1,948	\$ 3,542	\$ 1,992	\$ 1,790	\$ 3,140	\$ 1,828
Totals	\$ 148,158	\$ 154,064	\$ 149,814	\$ 98,134	\$ 101,549	\$ 101,228	\$ 138,084	\$ 143,329	\$ 140,418	\$ 116,207	\$ 120,656	\$ 118,369

Model 3 - AIRWG “Efficacies” - \$2 Flagfall – 20% for A,B1,B2,C1 and 4.6 minutes thereafter

Change in volume of services

Time structure	Male			Female			Urban			Rural		
	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access
		data	Economics		data	Economics		data	Economics		data	Economics
0-6	448	548	475	206	264	214	360	449	380	348	423	370
6-12	2327	2327	2327	1112	1112	1113	1966	1965	1966	1631	1631	1631
12-18	1341	1546	1561	907	1026	1070	1262	1444	1479	1053	1207	1233
18-28	749	849	807	604	662	647	745	835	805	646	722	696
28-40	228	325	254	222	278	254	251	337	283	199	272	223
40-60	60	74	62	37	45	38	55	67	56	45	56	47
Over 60	18	42	19	12	26	13	17	38	17	15	33	16
Totals	5171	5711	5504	3101	3413	3348	4655	5135	4985	3938	4345	4216

Change in MBS rebate remuneration

Time structure	Male			Female			Urban			Rural		
	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access	Current	BEACH	Access
		data	Economics		data	Economics		data	Economics		data	Economics
0-6	\$ 5,939	\$ 7,264	\$ 6,289	\$ 2,726	\$ 3,492	\$ 2,841	\$ 4,776	\$ 5,955	\$ 5,033	\$ 4,610	\$ 5,608	\$ 4,906
6-12	\$ 56,886	\$ 56,886	\$ 56,884	\$ 27,200	\$ 27,200	\$ 27,202	\$ 48,059	\$ 48,056	\$ 48,059	\$ 39,883	\$ 39,883	\$ 39,884
12-18	\$ 50,101	\$ 57,749	\$ 58,317	\$ 33,880	\$ 38,303	\$ 39,976	\$ 47,127	\$ 53,928	\$ 55,239	\$ 39,334	\$ 45,096	\$ 46,036
18-28	\$ 42,030	\$ 47,669	\$ 45,328	\$ 33,932	\$ 37,193	\$ 36,327	\$ 41,847	\$ 46,860	\$ 45,181	\$ 36,274	\$ 40,521	\$ 39,081
28-40	\$ 16,886	\$ 24,078	\$ 18,833	\$ 16,489	\$ 20,648	\$ 18,812	\$ 18,584	\$ 24,980	\$ 20,973	\$ 14,748	\$ 20,166	\$ 16,550
40-60	\$ 5,702	\$ 7,022	\$ 5,829	\$ 3,490	\$ 4,253	\$ 3,586	\$ 5,192	\$ 6,366	\$ 5,322	\$ 4,307	\$ 5,301	\$ 4,410
Over 60	\$ 2,618	\$ 6,028	\$ 2,694	\$ 1,745	\$ 3,717	\$ 1,807	\$ 2,392	\$ 5,425	\$ 2,468	\$ 2,199	\$ 4,767	\$ 2,265
Totals	\$ 180,162	\$ 206,696	\$ 194,175	\$ 119,461	\$ 134,806	\$ 130,551	\$ 167,978	\$ 191,571	\$ 182,276	\$ 141,355	\$ 161,344	\$ 153,131

GP GROUPS PAPER

Indexation

The aim of the review of GP attendance items has been to find the optimal structure of items and fee relativities *to improve incentives for provision of quality care*⁶. For this work to have enduring value in the wider context of GP financing, it is the view of the GP organisations represented on the working group that indexation issues must be addressed. Inappropriate indexation arrangements have the potential to quickly undermine the integrity of any fee structure.

A feature of the existing framework is the application of Wage Cost Index 5 (“WCI5”) to medical benefits. WCI5 is a composite index comprising 60% safety net adjustment (“SNA”) and 40% CPI. The dollar quantum of the SNA increase is expressed as a percentage of Average Weekly Earnings (“AWE”). Because the level of AWE is much higher than the level of the safety net wage, this produces typically very small increases in the SNA component of WCI5, far less than the 3 to 4% (and sometimes higher) figures seen for AWE.

The SNA increase is supposed to replicate the effect of productivity gain. Expressed another way, the theoretical underpinning of WCI5 is that labour must achieve productivity gain in return for real wage increases. And, if the productivity gain is achieved, then it ought to be possible for medical practitioners and their employees to enjoy increases in their remuneration consistent with community standards within the constraints of the relatively slow increase of MBS fees.

The representative groups consider that WCI5 is an inappropriate and inequitable mechanism for indexation of benefits for GP consultations. Productivity gains are not evenly distributed across all areas of medicine. In some areas, the gains have been dramatic due to the falling real cost and increasing power of computer-based equipment (pathology and diagnostic imaging stand out).

Furthermore, there is a real problem for the medical profession in “capturing” the benefits of productivity gain. There are many examples where the productivity gain is quite dramatic, but “downstream” (reflected in costs elsewhere in the health system, rather than in the doctor’s own practice).

GPs who provide good quality primary care resulting in timely diagnosis and intervention, and in high quality management of chronic conditions, generate large savings in hospital costs and the PBS. But there is no mechanism to measure and reward those contributions.

The essential issue with WCI5 is that it over-estimates the productivity gains that can be achieved in GP attendances, which essentially come down to health professionals spending time with patients. There is certainly scope for some productivity gains. Nobody would suggest that none can be achieved. GP informatics remains an area with potential. But it is not possible to continually reduce the time spent with patients. On the contrary, it is now

⁶ As per terms of reference, clause 1

being recognised more widely that high quality care can require an increase in consultation times and that time well spent can generate other downstream savings in more focussed use of prescription pharmaceuticals and investigations.

The representative groups do not consider that WCI5 as now constructed provides a sustainable structure for indexation of GP rebates. To the extent that WCI5 over-estimates the productivity gains than can be achieved, then it has many consequences—some perhaps not intended—including:

- Inevitable pressure on GPs to increase the proportion of services that are privately billed at or above the schedule fee;
- Associated with that, further falls in the rate of bulk-billing;
- Adverse consequences for those unable to pay “market rates” for GP co-payments;
- Reduced access to care in the areas where needs may be highest; and
- The risk of reduced overall quality in primary care due to impaired access and equity, with consequential increasing costs of hospital care.

The current formula does not appropriately recognise medical practice costs. Medical practice costs are driven by multiple factors, such as wages, accommodation, accreditation and IT which are readily quantifiable and must be fairly included as the basis for 50% of any new indexation formula’s derivation. The other 50% should be tied to increases in AWE as determined by the ABS.

It is the view of the GP Groups that indexation issues cannot be quarantined as simply a transitional issue. On the contrary, there is a structural problem with WCI5 and it needs to be addressed.

In summary, addressing indexation is intrinsic to a structure that will work as an incentive in the medium to longer term. Rather than undermining any new fee structure, indexation should actually support its direction and the implicit incentives within it. Anything less would be at odds with the proposals in this report.

The GP Groups recommend to Government that the work of the Attendance Item Restructure Working Group be extended to review and provide recommendations on the indexation methodology.