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Supported by the NSW Ministry of Health

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Effectiveness Review of General Practice Incentive Program

The AH&MRC Acknowledges the Traditional Owners of the lands on which the AH&MRC stands, the lands of the Bidjigal and Gadigal people of the Eora Nation. The AH&MRC pays respect to Elders past, present and emerging.

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About the AH&MRC

The AH&MRC is a membership-based organisation and the Peak Body for Aboriginal Health in New South Wales. We represent 48 Aboriginal Community Controlled Health Organisations (ACCHOs) across the state.

The AH&MRC assists ACCHOs to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities. The AH&MRC is committed to the delivery of four key priorities:

- Aboriginal Community Control and Innovation
- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC welcomes the opportunity to make a submission to this inquiry on behalf of its members.

AH&MRC Response

As part of the Strengthening Medicare Taskforce report, the Commonwealth government has committed to reforming primary care funding arrangements. The AH&MRC welcomes the effectiveness review of the General Practice Incentives with the view of improving access to primary health services.

The Practice Incentive Program (PIP) is aimed at supporting general practice activities by encouraging continual improvements, quality care, and chronic care services. Outside of core funding, ACCHOs access blended funding arrangements which includes

generating Medicare income through billing MBS item numbers and accessing individual incentives payments.

The Practice and Workforce Incentive Programs provide crucial funding for NSW ACCHOs that should be retained and strengthened. While the PIP has incentivised the provision of follow up care to patients with complex or chronic conditions, there are ongoing barriers that inhibit ACCHOs from fully utilising this arrangement.

Administrative burden

There is a high administrative burden associated with the uptake of incentive program funding mechanisms.[1] The administrative requirements, such as the annual registration for the PIP Indigenous Health Incentive (PIP IHI), is widely considered overly complex and onerous.[2] Individual incentive payments tend to favour larger services that are well resourced and have adequate staff capacity. As a result, the administrative burden of these payments can offset the benefit of the incentive itself. This is particularly evident in smaller services with fewer resources and staff capacity.

Administrative processes need to be streamlined to support the longevity of accessing individual incentive payments. Clinical information systems need to be enabled to effectively record required information with further investment to improve the interoperability of the PIP and WIP across different patient information systems. While the benefits of the PIP-IHI and other incentives are crucial for ACCHOs, the administrative burden is preventing greater uptake of Tier 1 and Tier 2 payments. Patient recall and follow up requirements can be quite onerous and compound on resourcing shortages, where a streamlined approach is required. The PIP has not been sufficiently set up for

[1] The use of financial incentives in Australian general practice - Kecmanovic - 2015 - Medical Journal of Australia - Wiley Online Library
[2] RACGP A4 documents - with cover

ACCHOs to maximise its utility as a funding arrangement. It is crucial the Department of Health adequately assess the ability of health providers to navigate an already complex system with the view of improving overall utilisation.

The intent of the PIP is to improve chronic disease management for patients and should build in flexibility based on patient needs. This is particularly relevant where patients are registered for the PIP IHI at a mainstream service but access an ACCHO for follow up and team-based care. Strengthening the link between the provision of care and the payment would reduce the risk that providers claim payments without providing a follow up service.[3] Better linkages would support patients who attend multiple services for chronic disease management to receive higher quality care.

Funding arrangements should not aim to prioritise volume-based health care over a comprehensive and quality approach. Fragmented funding arrangements with high administrative burden, including the practice incentive program, are contributing to increased pressure onto the health workforce. This needs to be systematically addressed to support an already overburdened workforce and improve access to care for Aboriginal communities.

The Practice and Workforce Incentive Program, particularly the PIP IHI, is a central funding stream for ACCHOs that enables best practice management of chronic disease within Aboriginal communities. It is essential that this is retained and strengthened with further investment toward developing better systems and capacity building within services that accounts for an increase in administrative burden.

SWPE Calculations – funding for a preventative approach

[3] qaihc-submission-pip-ihi.pdf

Some PIP payments are based on the Standardised Whole Patient Equivalent (SWPE) value. This calculation is based on the practice size and aims to calculate the fraction of care given to each patient. Payments are weighted by the age and gender of each patient to account for varying needs at different life stages.[4] As a result, older patients have a higher cost associated with their care. There are limitations with this approach as it does not incentive a preventative approach to service delivery and chronic disease management. The variations of cost across categories do not align with a person-centred approach and the unique needs of individuals across the life course.

There are variations in the profile of clients that attend services regularly as "frequent flyers" and is not necessarily based on age structures. Payments should aim to incentivise care from birth across the life course and is reflective of patient needs.

Using the SWPE value as a calculation of PIP payments is in direct conflict with the Quality Improvement (QI) payments. As SWPE is based on practice size, data cleansing of information systems and upkeep of quality improvement can decrease income streams. As a result, this disincentivises services from maintaining good quality improvement measures.

Incentive payments need to promote a preventative approach and adequate healthcare planning. This includes developing quality improvements in partnership with ACCHOs. Governments should not dictate what is considered quality improvements as individual services may have varying priorities based on patient demographics.

Introduction of MyMedicare – Complex funding systems

[4] Calculating Practice Incentives Program payments - Practice Incentives Program - Services Australia

The funding environment for ACCHOs is overly complex and fragmented. In addition to capped grants, ACCHOs generate income through MBS and incentive payments with varying reporting requirements and administrative labour.[5] It is well established that the Medicare system to fund health services does not provide adequate coverage for ACCHOs. This system is prone to ongoing changes that are not always adequately reported to service providers. The incentive program is currently undergoing changes due to the introduction of MyMedicare. This adds to an already complex system where concerns have been raised regarding the impact of MyMedicare on ACCHOs.
There has been a lack of consultation with the sector, in the design and implementation of MyMedicare. It is unclear how these changes will affect the PIP and the compounding administrative burden, with concerns of a possible reduction in Chronic Disease Management care items.[6]

It is critical that ACCHOs are provided with the appropriate information and support to adopt to required changes, including patient registration. This needs to occur with additional workforce and financial resourcing to support uptake within ACCHOs. The review of Practice and Workforce incentives payments needs to consider how system changes impact the ability of service providers from fully utilising this program.

The strengthening Medicare taskforce report has set out to reform primary care funding arrangements for the benefit of improving health outcomes and access. Funding models must align to the provision of high quality, holistic and comprehensive health care that incentivises continuity across a patient's journey. Culturally competency requirements need to be at the forefront of individual incentive programs to ensure that Aboriginal patients are directly centred in funding arrangements.

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[5] Microsoft Word - Congress response to redesigning the PIP.doc (caac.org.au)

[6] In focus: QAIHC MyMedicare Discussion Paper | QAIHC Sector Leader

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Recommendations

The AH&MRC recommends:

1. Retaining and strengthening the PIP with additional investment to towards developing better systems and capacity building within services.
    - Recognition of the increased administrative burden on ACCHOs with addition resourcing to address the increase in administrative labour and recall requirements.
2. Funding mechanism should incentive a preventative approach across all life stages and be developed in genuine partnerships with the ACCHO sector.
3. Sufficient support is provided to ACCHOs in the rollout and implementation of MyMedicare through workforce and financial subsidies, as needed.
    - Additional information on how services providers and patients are directly impacted need to be targeted and developed in partnership with the sector.



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For further information please contact:

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