Australian Government
Department of Health

Consultation Paper

REDESIGNING THE PRACTICE INCENTIVES PROGRAM

SUBMISSIONS CLOSE
WEDNESDAY
30 NOVEMBER
2016

Consultation Paper: Redesigning the Practice Incentives Program
Publications approval number: 11670

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EXECUTIVE SUMMARY

The Practice Incentives Program (PIP) is a key driver of quality care in the general practice sector. In the 2016-17 Federal Budget, the Australian Government announced it would work towards changing the PIP through the measure entitled "*Quality Improvement in General Practice – Simplification of the PIP*". The redesign of the PIP will introduce a new Quality Improvement Incentive which will give general practices increased flexibility to improve their detection and management of a range of chronic conditions, and to focus on issues specific to their practice population.

Recent independent reports suggest the PIP could be strengthened in regard to its effectiveness by considering the appropriateness of the existing PIP incentives, increasing the focus on quality health outcomes, and maximising the use of data.

The long term goal of redesigning the PIP would be to harness innovation in health care practices as well as technology. The redesigned PIP would reduce the administrative burden associated with multiple PIP payments and move towards a system that supports practices to identify ways to work with their practice population that:

- is flexible,
- supports quality improvement,
- aligns to the evolving context of Australian primary health care, and
- is consistent with Australian Government policy priorities.

Practices would be participating in quality improvement processes that use data to drive continual improvements in the care provided. Practices would measure themselves against their own performance and it is anticipated that practices would be paid for quality care, continuous improvement and data driven quality.

It is proposed that a refreshed PIP will provide a new Quality Improvement Incentive payment, using improved data systems to strengthen the focus on quality improvement and improve health outcomes for patients. With time, it is anticipated that data will be collated from practices across regions to support the efforts of each Primary Health Network's own quality improvement efforts and for population health and planning purposes. It is anticipated that data used for regional planning will be aggregated to a national level to inform ongoing evaluation of the PIP program and inform health policy.

The Department is seeking stakeholder views on how the PIP might foster quality improvement and drive innovation. To support discussion, two initial options to redesign the PIP have been developed for consideration.

Stakeholders are invited to comment on redesign of the PIP, engage with the opportunity to reduce the complexity of the current PIP, and contribute to the discussion of how the PIP can adapt in parallel with changes to other elements of the primary health care system.

Opportunities to contribute to how the PIP is redesigned are detailed on page 19 of this Consultation Paper.

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1. INTRODUCTION

The Australian health system has many strengths and produces excellent health outcomes for most of the population at a public cost that is comparable to other similar countries.[1] However, the nature of health care is highly complex and demand for health services is expected to rise as the Australian population ages and the incidence of chronic conditions increases.[2] As demand for services increases, the ability of the health system to deliver high quality health outcomes is expected to come under increasing pressure.

The Practice Incentives Program (PIP) is a key driver of quality care in the general practice sector. Reforms underway to adapt primary health care to the changing Australian health care landscape provide an opportunity to also redesign the PIP. In the 2016-17 Federal Budget, the Australian Government announced it would work towards changing the PIP through the measure entitled "*Quality Improvement in General Practice – Simplification of the PIP*". The redesign of the PIP will introduce a new Quality Improvement Incentive which will give general practices increased flexibility to improve their detection and management of a range of chronic conditions, and to focus on issues specific to their practice population. This aim, in part, is driven by the enormous diversity of general practices that participate in the PIP.

This Consultation Paper will support discussions with stakeholders by providing an overview of how the PIP could be redesigned. The following pages outline preliminary redesign options to simplify the PIP and ensure that quality improvement and improved patient outcomes continue to be the core of the program.

Stakeholders are invited to comment on PIP redesign to support quality innovation and improvement. A number of questions posed throughout the paper will help to generate ideas and stimulate discussion.

Details on how stakeholders can participate can be found at item 10. Invitation to Collaborate.

2. DOES THE CURRENT PIP PROMOTE QUALITY IMPROVEMENT?

PIP payments are intended to support practices to undertake activities that improve the quality of care provided to their patients.

Since its creation in 1998, the PIP has evolved with various incentives offered, reworked and, in some cases, withdrawn. Over the same period there have been major changes to both the way health care is provided and the technology that supports care.

At the current time, the majority of payments made through the PIP are made to general practices, rather than to individual clinicians, and focus on aspects of care that have contributed to the quality of care over the past two decades. These include payments for eHealth, diabetes, cervical screening, asthma, quality prescribing, teaching, Indigenous health, rural health and procedural activities. A summary of PIP payments can be found at Appendix 2.

Since 1999, all practices participating in the PIP have been required to obtain accreditation. The RACGP *Standards for general practices* (the Standards) are currently the standards against which general practices are assessed to achieve accreditation.[3] Accreditation will continue to be an integral element of the PIP into the future. A recent review of Australian health care quality by the Organisation for Economic Co-operation and Development (OECD) commended Australia's efforts in increasing general practice accreditation, noting that Australia was a leader among OECD countries.[4]

2.1. Why redesign the PIP?

Given the changing landscape of primary health care, there is also a need to revise and re-invigorate the PIP.

There is scope to harness innovation in health care practices as well as technology to simplify the PIP, reduce red tape and build on the excellent quality improvement work already underway in the sector. Focussing PIP on quality of care could provide better support to the primary health care system to address patients' needs more effectively and efficiently.

A number of recent independent reports have highlighted the potential to improve the PIP's impact on health care and health outcomes.

The Grattan Institute Report *Chronic Failure in Primary Care* concluded that the PIP program imposed a burden of administration on general practice, while omitting important health issues – chronic diseases such as chronic obstructive pulmonary disease, heart disease, mental illness, and musculoskeletal and neurological conditions. The report also found that participation in PIP programs for asthma and diabetes was low compared to the disease burden, suggesting the recommended care was not being provided.[5]

The report recommended that PIP funding be systematically tied to performance and outcomes for chronic disease in practices' catchment populations.

In 2015 the OECD undertook a review of health care quality in Australia. The review compared the effectiveness of the PIP with quality improvement programs in both the Australian acute system and in primary care in OECD countries. The OECD noted that the PIP opt-in model had been successful to date, with a high take-up rate.

However, it also recommended changes to reduce the regulatory burden of the program and to promote a greater focus on quality health care.

The OECD review suggested that after two decades, the PIP might be losing its effectiveness and might also inadvertently encourage practices to participate in incentives that were easier to achieve.[6]

Another assessment of the PIP was conducted by the Australian National Audit Office (ANAO) in 2010-11. The ANAO assessed the effectiveness of the Department of Health (the Department) in undertaking PIP planning, monitoring and reviewing.[7] It found issues of concern, including:

- insufficient data to adequately assess the effectiveness of the PIP;
- a number of features that make management of PIP challenging, in particular, a diverse range of incentives with varying aims and payment arrangements; and
- the requirement for accreditation was a significant barrier to a small number of general practices receiving PIP incentives.

The ANAO recommended that the Department:

- develop the capability to understand the effect of PIP design on the likely uptake and success of proposed incentive payments;
- evaluate the PIP and develop an evaluation strategy that supported annual performance reporting of the PIP to the public; and
- develop the means to inform itself of the quality of general practice accreditation.

Overall, evidence suggests that the PIP could be strengthened in regard to its effectiveness by considering the appropriateness of the existing PIP incentives, increasing the focus on quality health outcomes, and maximising the use of data.

Redesigning the PIP would enable it to move away from process-focussed funding towards a simpler system that encourages quality improvement and innovation and allows practices to see improvements in measures that are important to them. A better design would also allow the Department to gain a national perspective on quality improvement in general practice.

The way in which the PIP might foster quality improvement and drive innovation in the future is the subject of this consultation. Stakeholders are encouraged to contribute to the discussion of how the PIP can adapt in parallel with changes to other elements of the primary health care system. The next section provides an overview of how the PIP relates to other primary health care reforms.

- What are the strengths of the current PIP?
- How has the PIP influenced your quality improvement work to date?
- What elements of the current PIP should be kept and which should change?

3. THE PIP IN THE CONTEXT OF HEALTH SYSTEM REFORM

The Australian Government believes Australians deserve a world class health system with affordable access to services provided by highly skilled doctors, nurses and allied health professionals. To achieve this goal now and into the future, the Government is undertaking a broad suite of reforms which will directly impact on and influence the general practice sector in the near future. These reforms include Stage One of Health Care Homes, the Medicare Benefits Schedule review, and the Primary Health Networks.

3.1. Health Care Homes (HCH)

On 31 March 2016, the Australian Government announced that it would provide funding for Stage One of the establishment of Health Care Homes (HCH). Under this model, eligible patients will voluntarily enrol with a participating general practice known as their HCH. This practice will provide a patient with a 'home base' for the ongoing coordination, management and support of their conditions.

More than $100 million will be directed to Stage One implementation of the HCH model. This includes $21.3 million committed through the 2016-17 Budget to fund enabling infrastructure and governance arrangements. Approximately $93 million will be drawn from funding under the Medicare Benefits Schedule (MBS) that would otherwise have supported the general practice care of patients enrolled in a HCH in this first stage.

The redesign of the PIP aims to provide a flexible and supportive structure to the HCH implementation. The Department is working internally to ensure these two policies align.

3.2. Review of the Medicare Benefits Schedule (MBS)

The Medicare Benefits Schedule (MBS) Review Taskforce, led by Professor Bruce Robinson, commenced on 3 July 2015. The Taskforce is reviewing the entire MBS to ensure it is contemporary, reflects up-to-date clinical practice and allows for the provision of health services that improve health outcomes. Currently, the MBS has more than 5,700 services listed, not all of which reflect contemporary clinical best practice.

Clinical Committees and their Working Groups report to the MBS Review Taskforce and include members with a broad range of expertise, knowledge and experience including: clinicians (general practitioners and specialists), consumer representatives, academics, nurses, health economists, allied health professionals and state representation.

Public consultation includes the release of reports by the Taskforce's Clinical Committees with recommendations that are followed by a questionnaire to gather feedback on the proposed changes. Using this format, the recent round of consultation was open for four weeks and closed on 7 October 2016. Another round of public consultation for the second tranche of Clinical Committee reports is likely to commence late 2016.

Redesigning the PIP and undertaking the MBS Review at the same time will take the health system towards services that are aligned with contemporary practice to improve health outcomes for patients.

3.3. Primary Health Networks (PHNs)

Primary Health Networks (PHNs) have been established by the Australian Government to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and improve coordination of care to ensure patients receive the right care in the right place at the right time. Supporting general practices within their regions is a core role of PHNs and embraces quality, safety and continuous quality improvement.

Emerging evidence suggests that regionally-based change management is needed in order to embed a quality improvement culture in general practice. It is also recognised that quality improvement in general practice is linked to team-based care. PHNs will have a key role in providing general practice quality improvement support into the future. The consultation process will explore the relationship between PHNs and practices, in the context of a redesigned PIP.

4. BROADER GOVERNMENT AND PUBLIC SECTOR REFORM

Redesign of the PIP is occurring in the context of broader reform to public governance, performance and accountability. The Public Management Reform Agenda seeks to support high quality resource management and performance within the Australian Government and includes an objective to streamline and reduce red tape in administering government activities.[8] This principle is reflected in the 2015-16 Budget Measure: Rationalising and streamlining Health programmes.[9]

As a public resource, the PIP must align to this agenda and to the principle that use or management of public resources must be "efficient, effective, economical and ethical".[10]

At present, while the PIP has had some positive impacts on quality of care and outcomes such as increases in screening for chronic conditions, given the need for program and funding accountability, it is essential that objectives of the program can be demonstrated.

Redesign will harness technology and make it easier for health services to participate in the PIP.

To access the PIP, general practices are currently required to complete separate applications for each of the 11 incentive payments, and monitor the guidelines for each incentive they access. This has been identified by general practices as an area of high and unnecessary regulatory burden. Redesigning the PIP will simplify this process, support quality improvement in general practice, and build on work already underway, while reducing red tape.

Stakeholder feedback is sought on ways to achieve a balance between redesigning the PIP to meet the demands of our population and supporting the critical work of the primary health care sector while also managing the PIP as a public resource in an efficient, effective, economical and ethical way.

- What aspects of the current PIP can be improved through better use of technology?
- What is the best way to ensure the PIP funds meet the principle for efficient, effective, economical and ethical use of public money?

5. HOW CAN WE REDESIGN THE PIP TO FOCUS ON QUALITY IMPROVEMENT?

The PIP has a number of strengths which could underpin a more flexible system with greater capacity to measure patient health outcomes and program effectiveness. There is increasing commentary that the PIP could be improved by drawing on lessons from quality improvement programs in the Australian acute health care system and from primary health care systems internationally. The available evidence indicates that a lack of data on outcomes of care from the PIP places Australia in a position that is below other comparable countries.[11]

The OECD recently commended the PIP as a payment infrastructure for general practice and its role in supporting accreditation. However, it also noted short comings in terms of evaluating program effectiveness.[12] There is also mounting concern that, as demand for services increases, the ability of the PIP to support delivery of high quality health care will come under increasing pressure. A redesigned PIP that is focused on quality of care has the potential to more adequately support the primary health care system to address demands in a more effective and efficient manner.

Broad support for the principle of redesigning the PIP with a focus on quality improvement in general practice has been expressed by both the Practice Incentives Program Advisory Group and the Primary Health Care Advisory Group.

5.1. Which incentives are affected?

At the present time there are 11 incentive payments in the PIP. A summary of the current payments can be found at Appendix 2.

Four existing incentive payments, some of which have recently been reformed, will continue unchanged:

- rural loading, which recognises the difficulties of providing care in rural and remote areas;
- after hours incentive, introduced on 1 July 2015;
- teaching payment, which was doubled on 1 January 2015 and encourages general practices to provide teaching sessions for the future general practice workforce; and
- the eHealth incentive, which was recently reformed.

Streamlining current incentives could have unintended effects on other Government initiatives, such as the Closing the Gap strategy. A key matter for consideration and consultation is how the PBS co-payment measure that is linked to the current Indigenous Health Incentive will be managed so that Aboriginal and Torres Strait Islander people will not be disadvantaged.

> How would we ensure that the needs of Aboriginal and Torres Strait Islander people are considered and continue to be met under a redesigned PIP?

5.2. Will funding amounts change?

PIP payments are drawn from the PIP Fund which is allocated specified funding by the Australian Government. It is anticipated that the quantum of funds available through the PIP will be unchanged and will take account of different payment schedules for the streamlined incentives (i.e. some incentives are paid quarterly and others annually). At this stage the impact that redesigning the PIP will have on payment mechanisms or scheduling is yet to be determined.

6. WHAT DO WE MEAN BY QUALITY IMPROVEMENT IN GENERAL PRACTICE?

Quality in health care and health systems for the purposes of this paper reflect six dimensions:

- **Effective:** delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- **Efficient:** delivering health care in a manner which optimises resource use and avoids waste;
- **Accessible:** delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- **Acceptable and patient centred:** delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- **Equitable:** delivering health care which does not vary in quality because of personal characteristics such as gender, race ethnicity, geographical location, or socioeconomic status; and
- **Safe:** delivering health care which minimizes risks and harm to service users.[13]

Continuous quality improvement (CQI) in its broadest sense is a managed approach to organisational change and process improvement.[14] In this Paper, CQI is defined as a forward looking, ongoing, systematic approach to improve patient care by improving organisational systems and service delivery (or clinical practice).[15] It includes developing ideas or tools for improvements, and developing and embedding new practices into service systems and routines.[16]

The CQI process involves collecting and reviewing data or information to identify problems and areas for improvement, developing solutions to those problems, implementing the solutions, evaluating the effect of the planned activities, and going back to assess the need for more improvements.

Many Australian general practices currently participate in a quality improvement activity that is supported by a third party and a range of established CQI programs are available.

Quality improvement activities in general practice currently take the form of participation in one of several formal continuous quality improvement processes, contracting one of numerous organisations to assist in quality improvement activities or using in-house expertise to analyse patient data and implement improvements.[17,18]

The PIP has been commended for its role in driving health care quality through the accreditation process.

- Would you participate in a patient focused quality improvement PIP Incentive?
- What are key aspects of quality improvement that should be captured in a redesign of the PIP?
- Would you like to provide an example of a quality improvement project you have undertaken in your practice?

7. HOW CAN WE USE DATA TO MEASURE AND DRIVE IMPROVEMENT?

A robust measurement system is a critical element of successful large scale quality improvement strategies.[19, 20] Systematic feedback drives changes in behaviour.

In its 2010 review of the PIP, the ANAO recommended that the PIP identify key performance indicators (KPIs) to regularly measure and report on PIP achievements, including its effectiveness. This was reiterated by the OECD Review and also by the Primary Health Care Advisory Group (which recommended Health Care Homes), reinforcing the need for stronger data collection in general practice.

There are synergies between the data requirements for Health Care Homes and the PIP into the future. Sharing data for quality improvement will be a key component of the redesigned PIP. It is proposed there will be a shift from using MBS items to identify quality of care to using data from clinical information systems. A redesigned PIP is likely to require general practices to frequently provide de-identified data (to a yet to be determined entity) from their practice software systems. A feedback mechanism would enable general practices to track improvement and adjust the health care provided to best suit their population.

This data would also allow the effectiveness of PIP to be evaluated (for the public, the general practice and the Australian Government).

It should be noted that any requirements for practices to provide data will take into consideration the variability of internet access across the country.

Data provision by general practices is not new. Over the last 10 years, thousands of Australian practices have participated in data driven improvement activities. These practices have demonstrated successful clinical system redesign, delivering safer and more reliable care for their patients. They have also developed the capacity to use data from practice software systems to deliver more proactive and systematic chronic disease management by adopting a practice population approach.

Redesigning the PIP will support all practices to build on these experiences, and allow all practices to sustain the improvements that have already been made.

7.1. Measures for improvement

The long term aim of redesigning the PIP will be to assist practices to participate in quality improvement processes, to measure the health care they provide and identify ways to work with their population in a flexible way that supports innovation and quality improvement. In this way, practices would be measuring themselves against their own performance in a continuous, quality improvement process.

Data used for performance reporting generally has a long term view with data analysis being undertaken on a yearly to five yearly basis. Long term data analysis has a place in monitoring improvements in health outcomes; however, quality improvement requires data analysis to be undertaken more frequently, perhaps monthly or quarterly, in order to inform the continual feedback loop of the continuous quality improvement process.[21]

Data management in a redesigned PIP will need to reflect this need. It is anticipated that practices would be paid for quality care, continuous improvement and data driven quality.

7.2. Development of measures for improvement

Experience of developing measures for improvement for general practice and Aboriginal Medical Services both in Australia and internationally suggest that the best option is to commence with a small number of basic measures, expanding to more over time in consultation with the sector. Such a process is reported to have led to accepted, achievable, and relevant measures of quality of care.[22]

Any work towards measures for improvement, assessment of improvement or reporting would be done in negotiation with relevant professional bodies and primary health care stakeholders.

Going forward, redesign of the PIP will provide an opportunity to collect nationally-consistent data. It will seek to avoid duplication in reporting, build upon existing successful outcomes and use existing national datasets where possible.

There is potential for measures of improvement for general practice to align to some existing KPIs for Aboriginal Medical Services which are endorsed by the Australian Health Ministers Advisory Council. Into the future, measures for improvement would need to align with those for PHNs, Local Hospital Networks and Health Care Homes as well as inform a robust future evaluation of the PIP.

8. HOW CAN WE STRENGTHEN QUALITY IMPROVEMENT IN GENERAL PRACTICE?

Stakeholder views are sought on how the Government can achieve its commitment to redesign the PIP to address concerns raised in the reviews of the program cited previously. It is proposed that a refreshed PIP will provide a new Quality Improvement Incentive payment, using improved data systems to strengthen the focus on quality improvement and improve health outcomes for patients.

8.1. What are the objectives for a quality focused PIP Incentive?

The PIP Quality Improvement Incentive payment will provide practices with funding to support ongoing participation in quality improvement activities with the aim of better health outcomes, better experience of care for patients and clinicians, and improved practice sustainability. The proposed Quality Improvement Incentive payment will:

- continue to drive improved outcomes for Aboriginal and Torres Strait Islander people;
- improve access to and equity of care for patients;
- improve the detection and management of chronic conditions;
- improve general practice quality, safety, effectiveness, efficiency and accountability; and
- improve data and information systems.

It would be based on the following broad principles:

- allow practices the flexibility to focus on issues specific to their practice population;
- provide flexibility to enable focus on Government health priorities;
- motivate relative improvement within individual practices;
- continue to drive digital health reform;
- continue to drive safety and quality through general practice accreditation;
- be administratively simple with minimal red tape for practices;
- require submission of data and, within 12 months of registering for the incentive, be able to measure outcomes and provide evidence of improvement;
- automated incentive payments based on submission of data; and
- alignment with other Government health policies.

8.2. Design options

The long term aim reflects the ethos of quality improvement and would seek to measure a practice's improvement against its own baseline, resulting in fair and attainable payments for all participating practices. The redesigned PIP will not be a "pay for performance" system.

The diversity of the Australian primary health care landscape means there is significant variation in the characteristics of the general practices which currently participate in the PIP. The diversity encompasses location and size of the practice, characteristics of the patient population, the business model used in the practice, and clinician characteristics as well as the diversity in the health care neighbourhoods in which these practices operate. Additionally, quality improvement activities may take the form of participation in a formal continuous quality improvement process, contracting an organisation to assist in quality improvement activities or using in-house expertise to analyse patient data and implement improvements.[23, 24]

The redesigned PIP will need flexibility and support health services to meet the demands of their population.

It will also be important to include a robust evaluation strategy in the redesign of the PIP. The evaluation strategy will inform the data requirements for the PIP.

The design options presented below are intended to support discussions during consultation. The options are presented as high level concepts, with minimal detail in anticipation of drawing upon the expertise of stakeholders during the consultation, and should be considered as a guide only.

The final policy will be developed with other reform activities described in earlier sections of this paper. The aim is for the redesigned PIP to be a simpler system that can be implemented as seamlessly as possible.

8.2.1. Option 1 – Practice Incentives Program - Redesign for Quality

In this option, payments to all general practices that participate in the new PIP Quality Improvement Incentive will continue to be administered by the Department of Human Services (DHS). This will be an extension of the current PIP payment arrangements through the existing DHS infrastructure. Payments may be merged into a single incentive payment and the frequency of the payments are yet to be decided. Payments for the PIP Quality Improvement Incentive may be structured as follows:

1. sign-on payment once practices meet eligibility requirements;
2. quarterly participation payments when a practice provides data from their practice information system and continues to undertake quality improvement activities including improving data quality; and
3. quality improvement payments when a practice provides general practice data which enables a practice to measure themselves against their own previous data, continues to undertake quality improvement activities; and demonstrates quality improvement or, with time, maintenance of yet-to-be-determined defined measures for improvement.

This option would build upon existing quality improvement and data sharing activities already underway. The PIP Quality Improvement Incentive would simplify the PIP and support practices to undertake quality improvement activities whilst concurrently providing data. Additionally, work to examine the relationship between the two would be considered through an evaluation of the PIP. Initially this would be a pay for participation model but would, in time, incorporate a pay for quality with quality measures to be designed in consultation with the sector.

At the practice level, practices would choose their improvement activities and submit de-identified data regularly via an automated data extraction tool. This data would then be aggregated to provide a national picture of Australian primary health care and inform policy at a national level.

8.2.2. Option 2 – Practice Incentives Program - Third Party Provider

This option would also simplify the PIP and would extend the way many health services work with quality improvement providers. In this option, a third party quality improvement provider(s) would be engaged by the practice. Instead of the Department funding practices directly, the funds could be utilised to pay quality improvement activity providers to support general practices in their own quality improvement endeavours. A third party provider could be an independent organisation or a PHN which would pay a general practice for participation in quality improvement activities and the submission of data.

This option could build upon models used by quality improvement providers active in Australia. There are a number of organisations that support practices to undertake quality improvement activities such as plan-do-study-act cycles, clinical audit and analysis, chronic disease management tools and care coordination processes. These providers may be government, for-profit or not-for-profit organisations. [25] For example:

- the Centre for Research Excellence in Primary Health Care Microsystems, has developed the Primary Care Practice Improvement Tool (PC-PIT) - an online form which takes a 'whole of practice' approach to identifying, planning, implementing and sustaining quality improvement in practice; and
- the Improvement Foundation provides the Australian Primary Care Collaboratives Program (APCCP) which assists primary health care services undertake systematic and sustainable improvements in the care they provide to patients.

This option would need careful consideration of the role of the quality improvement providers who are currently supporting general practices as well as quality of the providers, scale and cost effective implementation arrangements.

8.3. Summary - What your practice needs to know

The redesigned PIP will streamline a number of existing PIP incentives and their associated payments[26]. Pending the outcome of the consultation, your practices may receive one incentive payment, which could be paid quarterly, and you will be able to choose to focus your improvement efforts on issues most relevant to you and your patient population.

8.3.1. The Support Organisation

In option one, you participate by providing data and participating in quality improvement activities. In option two, you participate by enrolling in a recognised quality improvement program or work with a quality improvement organisation to undertake quality improvement activities. It is envisaged that these may be auspiced by your PHN, which will have responsibility for supporting your practice.
Under either option, participating practices will have two activities to undertake each month:

1. submission of their data from their practice information systems; and
2. a commitment to undertake quality improvement activities during the upcoming month.

8.3.2. Measures for Improvement

With time, a set of nationally consistent measures of quality would likely be used to guide your quality improvement activities.

The redesigned PIP will recognise that the baseline results of these measures will vary largely from practice to practice depending on the population it serves and the resources available to it. For example, a remote practice will have different results from an inner city practice. Hence the focus is on deliberative effort and relative improvement rather than absolute outcome. The new PIP Quality Improvement Incentive is therefore NOT a pay for performance scheme.

8.3.3. Improvement Ideas and Actions

Your practice will choose the areas in which you want to develop improvement ideas. Innovation and collaboration are encouraged, and a support organisation may be able to assist by sharing the best improvement ideas from other practices. Ideas will be implemented by your practice team using incremental changes and informed by quality improvement processes used throughout Australia, including, for example the notion of 'planned actions'.

8.3.4. Data

Data will assist in supporting your quality improvement activities. A key aspect of quality improvement is using practice data to understand both your own improvements and, with time, your practice in the context of other similar sized practices, or practices with similar patient populations.

With time, it is anticipated that data will be collated from practices across regions to support the PHN's own quality improvement efforts and for population health and planning purposes. While yet to be developed, it is anticipated that data used for regional planning will be aggregated to a national level to inform ongoing evaluation of the PIP program and inform health policy.

Stakeholders are invited to become involved in the consultation process and provide views on:

- Do you support the concept of a Quality Practice Improvement Incentive payment as outlined?
- Do you support the use of collated regional data for population health and planning purposes?
- Do you have any suggestions to improve the proposed Quality Improvement Incentive payment?

9. NEXT STEPS

Excellent quality improvement work is already underway throughout Australia. This consultation is being held to ensure that the changes to the PIP enable it to continue to have a key role in supporting quality health care. PIP will also be subject to compliance and audit to ensure that it provides an effective system, serving the Australian public and health care providers well in the future.

10. INVITATION TO COLLABORATE

Stakeholders are invited to comment on redesign of the PIP and engage with the opportunity to reduce the complexity of the current PIP, and embark on innovative and collaborative policy design by providing views on the questions posed in the box to the right.

There are a number of ways that stakeholders can provide input:

1. Participate in the consultation process through a forum or webcast. Details can be found on the on-line consultation hub which will provide details when they are available at **consultations.health.gov.au**

2. Provide a written submission that comments on specific elements or all elements of this Consultation Paper including quality improvement in general practice; the role of data and measuring improvement; the development of KPIs; the policy parameters for strengthening quality improvement; and/or the design options.

Submissions must clearly indicate whether the Department may publicly release the submitter's details and/or the submission.

Submissions should be no more than 10 – 15 pages and be received by the Department by **30 November 2016**

at: PIPRedesign@health.gov.au
Primary Healthcare Branch
Health Services Division
Department of Health
MDP 24, GPO Box 9848
Canberra City ACT 2601

or

3. Respond to the anonymous questionnaire on the Department of Health web site **consultations.health.gov.au**

- What are the strengths of the current PIP?
- How has the PIP influenced your quality improvement work to date?
- What elements of the current PIP should be kept and which should change?
- What aspects of the current PIP can be improved through better use of technology?
- What is the best way to ensure the PIP funds meet the principle for efficient, effective, economical and ethical use of public money?
- How would we ensure that the needs of Aboriginal and Torres Strait Islander people are considered and continue to be met under a redesigned PIP?
- Would you participate in a patient focused quality improvement PIP Incentive?
- What are key aspects of quality improvement that should be captured in a redesign of the PIP?
- Would you like to provide an example of a quality improvement project you have undertaken in your practice?
- Do you support the concept of a Quality Practice Improvement Incentive payment as outlined?
- Do you support the use of collated regional data for population health and planning purposes?
- Do you have any suggestions to improve the proposed Quality Improvement Incentive payment?

APPENDIX 1 OVERVIEW OF THE PRACTICE INCENTIVES PROGRAM (PIP)

This section provides a brief overview of the PIP since its commencement and summarises recent assessments of the effectiveness of the PIP.

History of the PIP

The development of the PIP can be traced back to the introduction of the General Practice Reform Strategy in 1992 which aimed to address specific issues facing general practice in Australia.[27, 28, 29] The Australian Government also committed funding in the 1992-93 Budget for the establishment of the Divisions of General Practice[30] to support general practitioners to work with each other and with other health professionals to improve the quality of service delivery at a local level. Strengthening of primary care continued to be a focus of the Commonwealth through the 1990s. The PIP commenced in 1998 with the aim of encouraging continuing improvements in general practice through financial incentives to support quality care, and improve access and health outcomes for patients. Over the past 18 years, the PIP has evolved, as a range of incentives have been offered, reworked and, in some cases, withdrawn.

Accreditation and general practice standards

All practices participating in the PIP have been required to obtain accreditation since 1999.

Practice branches providing less than 3,000 services per annum do not need to be accredited to be eligible for the PIP. Practice branches providing 3,000 or more services per annum must maintain full accreditation, or be registered for accreditation to be included in the calculation of the practices PIP payments. Practices registered for accreditation must achieve full accreditation within 12 months of joining the program.

A recent review of Australian health care quality by the OECD commended Australia's efforts in increasing general practice accreditation, noting that Australia is a leader among OECD countries.[31]

While the OECD commended Australia's efforts, there has been some debate about barriers that prevent or deter some general practices from attaining accreditation, including cost and administrative burden. The Department has been working with the Commission and the RACGP to better understand this issue.

The RACGP *Standards for general practices* (the Standards) are currently the standards against which general practices are assessed to achieve accreditation.[32] The RACGP is reviewing the Standards and a new version is expected to be released in late 2017.

APPENDIX 2 THE PIP IN 2016: A SUMMARY OF THE 11 INCENTIVES

The PIP is funded through the Practice Incentives for General Practices Fund (the Fund) which provides a flexible funding pool predominantly for incentive payments to general practices. Over 5,400 general practices received PIP payments during the 2014-15 financial year.

The PIP currently consists of 11 incentives:

- Asthma Incentive
- After Hours Incentive
- Cervical Screening Incentive
- Diabetes Incentive
- eHealth Incentive
- General Practitioner Aged Care Access Incentive
- Indigenous Health Incentive
- Procedural General Practitioner Payment
- Quality Prescribing Incentive
- Rural Loading
- Teaching Payment

A summary of each incentive is provided in the pages that follow.

By moving to combine and reduce the total number of PIP incentives, a reduction in administrative imposts on general practice and general practitioners is anticipated.

Eligibility

Practices must first register for the PIP and can then choose to apply for all or some of the incentives. Practices must meet the eligibility requirements of each incentive they apply for.

To be eligible to participate in the PIP, a practice must:

- meet the PIP definition of an 'open practice' (when one or more registered medical practitioner(s) provide face to face medical or health services to patients at the practice location registered for the PIP)
- be accredited or registered for accreditation against the Royal Australian College of General Practitioners (RACGP) Standards for general practices
- if the practice is registered for accreditation, full accreditation must be obtained within 12 months of joining the PIP & ensure their accreditation is up-to-date at all times
- maintain current public liability insurance
- make sure all general practitioners and nurse practitioners maintain current professional indemnity cover

Types of Payments

Practice Payments - intended to support the practice to purchase new equipment, upgrade facilities or increase remuneration for GPs working at the practice.

Service Incentive Payments (SIP) - made to individual GPs to recognise and encourage the provision of specified services to individual patients.

Rural Loading Payments - practices participating in the PIP, with a main practice location situated outside capital cities and other major metropolitan centres, are automatically paid a rural loading.

Calculation of Payments

PIP practice payments are based on a measure of the practice size known as the Standard Whole Patient Equivalent (SWPE) value. The SWPE value is calculated using MBS claims by patients attending the practice during an historical 12 month period and includes MBS services provided by both GPs and nurse practitioners.

The PIP guidelines provide more detail on how SWPE values are calculated.

When Payments are made

To qualify for payments, practices must be participating in the PIP and meet the eligibility requirements of the incentives for the entire quarter including the 'point in time' date. The 'point in time' date corresponds to the last day of the month before the next PIP quarterly payment.

Quarterly payment month	Quarterly payment period	'Point in time' assessment of eligibility	SWPE value reference period
February	November to 31 January	January	October to 30 September
May	February to 30 April	April	January to 31 December
August	May to 31 July	July	April to 31 March
November	August to 31 October	October	July to 30 June

Asthma Incentive

The PIP Asthma Incentive aims to encourage GPs to better manage the clinical care of people with ***moderate to severe asthma***. Generally, patients must meet the following criteria to be assessed as having moderate to severe asthma:

- Symptoms on most days; or
- Use of preventative medication; or
- Bronchodilator[1] use at least three times per week; or
- Hospital attendance of admission following an acute exacerbation of asthma.

Payments and Requirements for Practices to receive the incentive

The PIP Asthma incentive has two components:

1. Sign-On Payment - **$0.25 per SWPE** - A one-off payment to practices that:
   - maintain a patient register, and a recall and reminder system; and
   - implement an asthma cycle of care.
2. Service Incentive Payment (SIP) - $100 per completed cycle of care per year
   - A SIP is paid to GPs for each cycle of care completed for a patient. GPs must be working at the PIP practice that is signed on for the PIP Asthma Incentive; and
   - The asthma cycle of care must be delivered within a 12 month period and include the three steps of Assessment, Planning and Review.

Obligations of Practice to receive the incentive

The practice must:

- be able to substantiate its claims for payments, which may include evidence of its patient register, and recall and reminder system, and the completion of cycles of care for patients with moderate to severe asthma;
- provide information as part of the ongoing audit program to verify the practice meets the PIP eligibility requirements;
- make sure information given is correct; and
- advise of any changes to practice arrangements.

After Hours Incentive

The new After Hours Incentive commenced in May 2015 with the first payment to practices in August 2015.

The After Hours Incentive aims to support general practices to provide their patients with appropriate access to after hours care.

The complete after hours period is:

- outside 8 am to 6 pm weekdays
- outside 8 am to 12 noon on Saturdays, and
- all day on Sundays and public holidays

The complete after hours period is broken into:

- sociable after hours period – 6 pm to 11 pm weeknights
- unsociable after hours period – 11 pm to 8 am weekdays, hours outside of 8 am and 12 noon Saturdays, and all day Sundays and public holidays.

1 A bronchodilator is a substance that dilates the bronchi and bronchioles, decreasing resistance in the respiratory airway and increasing airflow to the lungs.

Payments and Requirements for Practices to receive the incentive

There are 5 levels of payments and each practice can only qualify for one payment level. Each level has its own set of eligibility requirements and obligations. The levels are:

LEVEL 1

Participation - **$1.00 per SWPE per year**

- The practice must have formal arrangements in place with other providers including Medical Deputising Services, other practices, after hours services and cooperatives, to ensure access for practice patients in the complete after hours period

LEVEL 2

Sociable after hours cooperative coverage - **$4.00 per SWPE per year**

- The practice must participate in a cooperative arrangement that provides after hours care to practice patients in the sociable after hours period and ensure formal arrangements are in place to cover the unsociable after hours period

LEVEL 3

Sociable after hours practice coverage - **$5.50 per SWPE per year**

- The practice must provide after hours care to practice patients directly through the practice in the sociable after hours period and ensure formal arrangements are in place to cover the unsociable after hours period
- Practices cannot participate in a cooperative to be eligible for this payment and patients must be able to receive care directly from a practice GP.

LEVEL 4

Complete after hours cooperative coverage - **$5.50 per SWPE per year**

- The practice must participate in a cooperative arrangement that provides after hours care to practice patients for the complete after hours period.

LEVEL 5

Complete after hours coverage - **$11.00 per SWPE per year**

- The practice must provide after hours care to practice patients in the complete after hours period
- Practices cannot participate in a cooperative to be eligible for this payment and patients must be able to receive care directly from a practice GP.

Obligations of the Practice to receive the incentive

To be eligible for the PIP After Hours Incentive, practices must:

- Be registered for the PIP and meet the requirements for the payment level claimed for the entire quarter before the payment month;
- Provide after hours care for patients in accordance with the RACGP Standards for general practices; and
- Clearly communicate after hours arrangements to patients, including information available within the practice, on the practice website or through a telephone answering machine.

Cervical Screening Incentive

The PIP Cervical Screening Incentive aims to encourage GP's to screen ***under-screened women aged between 20 and 69 years*** who have not had a cervical smear in the last four years for cervical cancer and to increase overall screening rates.

Payments and Requirements for Practices to receive the incentive

1. Sign-on payment - **$0.25 per SWPE**
   - A one off payment to practices that agree to have their practice details provided to state and territory cervical screening registers;
   - receive information from state and territory cervical screening registers and consider how they can improve the level and quality of participation in the National Cervical Screening Program; and
   - agree to state and territory cervical screening registers providing information to Human Service about the aggregate number of women screened in the practice.
2. Outcomes payment - **$3.00 per female WPE[2] per year**
   - An outcomes payment is paid to practices that have met a screening target of at least 70% of the practice's female patients aged between 20-69 years in a 30 month reference period.
3. Service incentive payment (SIP) - **$35 per screening**
   - Payment to GPs for screening women between 20-69 years who have not had a cervical smear within the last 4 years.
   - GPs must work at a PIP practice that is signed on to the PIP Cervical Screening Incentive.

Obligations of Practice to receive the incentive

The practice must:

- give information as part of the ongoing confirmation statement and audit process to verify that the practice has met the eligibility requirements;
- make sure information given is correct; and
- advise in writing of any changes to practice arrangements.

Diabetes Incentive

The PIP Diabetes Incentive aims to encourage GPs to provide earlier diagnosis and effective management of people with established diabetes mellitus.

Payments and Requirements for Practices to receive the incentive

The PIP Diabetes Incentive has three components:

1. Sign-on Payment - **$1.00 per SWPE**
   - One-off payment to practices that use a patient register and recall and reminder system for their patients with diabetes mellitus.
2. Outcomes Payment - **$20 per diabetic SWPE per year**
   - Payment to practices where at least 2% of practice patients are diagnosed with diabetes mellitus and GPs have completed a diabetes cycle of care for at least 50% of these patients (eg. If a practice has 1000 patients, a practice is eligible if 20 patients have diabetes mellitus and at least 10 of those patients have completed a diabetes cycle of care).
3. Service Incentive Payment - $40 per competed cycle of care per year
   - Payment to GPs for each annual cycle of care completed for patients with established diabetes mellitus.

2 WPE – Whole Patient Equivalent – the fraction of care provided by the practice to each patient.

Obligations of Practice to receive the incentive

The practice must:

- be able to substantiate its claims for payments, which may include evidence of its patient register, and recall and reminder system, and the completion of cycles of care;
- provide information as part of the ongoing confirmation statement and audit process to make sure the practice meets the PIP eligibility requirements;
- make sure information provided is accurate, and
- advise in writing of any changes to practice arrangements.

eHealth Incentive

The PIP eHealth Incentive aims to encourage practices to keep up to date with the latest developments in eHealth and adopt new eHealth technology as it becomes available. It aims to help practices improve administration processes and patient care.

Payments and Eligibility Requirements for Practices to receive the incentive

To be eligible to receive the eHealth Incentive practices must participate in the PIP and meet each of the 5 requirements below. Eligible practices can receive a maximum payment of **$6.50 per SWPE per year, capped at $12,500 per quarter.**

REQUIREMENT 1:
INTEGRATE HEALTHCARE IDENTIFIERS INTO ELECTRONIC PRACTICE RECORDS

- The practice must apply to Human Services to obtain a Healthcare Provider Identifier-Organisation (HPI-O) and store the HPI-O in a compliant clinical software system;
- ensure that each general practitioner within the practice has their Healthcare Provider Identifier-Individual (HP-I); and
- use a compliant clinical software system to access, retrieve and store verified Individual Healthcare Identifiers (IHI) for presenting patients.

REQUIREMENT 2:
SECURE MESSAGING CAPABILITY

- The practice must have a standards-compliant secure messaging capability to electronically transmit and receive clinical messages to and from other healthcare providers.

REQUIREMENT 3:
DATA RECORDS AND CLINICAL CODING

- work towards recording the majority of diagnoses for active patients electronically, using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system.

REQUIREMENT 4:
ELECTRONIC TRANSFER OF PRESCRIPTIONS

- ensure the majority of their prescriptions are sent electronically to a Prescription Exchange Service (PES).

REQUIREMENT 5:
MY HEALTH RECORD SYSTEM

- use compliant software for accessing the My Health Record system;
- apply to participate in the My Health Record system upon obtaining a HPI-O; and
- upload shared health summaries to the My Health Record system for a minimum of 0.5 per cent of their Standardised Whole Patient Equivalent (SWPE) or the default SWPE, whichever is greater.

This incentive has been developed in consultation with the NEHTA, and aligns with the directions set out in the Australian Government's National eHealth Strategy.

The PIP eHealth Incentive will encourage the adoption of new eHealth technology as it becomes available, to assist practices to improve administration processes and the quality of care provided to patients.

Obligations of Practice to receive the incentive

The practice must:

- provide information as part of the ongoing confirmation statement and audit process to make sure the practice has met the PIP eligibility requirements;
- make sure information provided is correct; and
- advise of any changes to practice arrangements.

General Practitioner Aged Care Access Incentive

Payments are made once per year.

The PIP General Practitioner Aged Care Access Incentive (ACAI) aims to encourage GP's to provide increased and continuing services in Australian Government funded residential aged care facilities (RACFs).

Payments

The PIP GP ACAI payments are based on a GP providing a required number of eligible MBS services in RACFs in a financial year. The PIP GP ACAI has two payment tiers:

- **Tier 1** payment of **$1500 per year** - GPs must provide at least 60 eligible MBS services in RACFs in a financial year.
- **Tier 2** payment of **$3500 per year** - GPs must provide at least 140 eligible MBS services in RACFs in a financial year.

Eligible GPs can receive 2 payments totalling **$5,000 for the financial year**.

Requirements to receive the incentive

To be eligible for PIP GP ACAI payments, GP's must:

- work from a PIP practice;
- provide eligible Medicare Benefits Schedule (MBS) services to residents in RACFs;
- reach the Qualifying Service Level (QSL) by providing the required number of MBS services in RACFs in a financial year; and
- use a Medicare provider number that's linked to a PIP practice when claiming MBS services in RACFs.

Obligations of Practice to receive the incentive

The practice must:

- provide information as part of the ongoing audit process to verify that the practice has met eligibility requirements;
- make sure the information given is correct; and
- advise of any changes to practice arrangements.

Indigenous Health Incentive

The PIP Indigenous Health Incentive (IHI) aims to support general practices and Indigenous health services to provide better health care for Aboriginal and/or Torres Strait Islander patients, including best practice management of chronic disease.

Payments

The PIP IHI has three components:

1. Sign-on Payment - **$1000 per practice**

A one-off payment to practices that agree to undertake specified activities to improve the provision of care to their Aboriginal and/or Torres Strait Islander patients *(see Requirements and Obligations).*

2. Patient registration payment - **$250 per patient per year**

A one off annual patient registration payment is made to practices for each Aboriginal and/or Torres Strait Islander patient who:

- is a 'usual' patient of the practice;
- is aged 15 years and over;
- has a chronic disease(s);
- has had, or been offered, a health check for Aboriginal and/or Torres Strait Islanders (MBS item 715);
- has a current Medicare card; and
- has provided informed consent to be registered for the PIP IHI.

3. Outcomes payments

There are two tiers of outcomes payments available each calendar year for each registered patient and are based on MBS services provided each year the patient is registered. Practices may be eligible for either, or both, outcomes payments even if the patient is currently registered for the PIP Indigenous Health Incentive at another PIP practice.

- **Tier 1 Outcomes Payment** – Chronic Disease Management **$100 per patient per year.** Paid to practices that prepare a General Practitioner Management Plan (GPMP) (MBS 721) or co-ordinate the development of Team Care Arrangements (TCA) (MBS 723) per calendar year. The practice also needs to contribute to a review of a multidisciplinary care plan in a Residential Aged Care Facility twice a year (MBS 731).
- **Tier 2 Outcomes Payment** – total patient care **$150 per patient per year.** An annual payment is made to practices that provide the majority of care for a registered patient. For the purpose of this incentive, eligible MBS items are those commonly used in general practice and chronic disease management (refer to guidelines for the eligible MBS items).

Requirements of Practice to receive the incentive

- Identification of Aboriginal and/or Torres Strait Islander patients.
- Cultural awareness training must be undertaken by at least two staff members (one must be a GP) within 12 months of signing on to the incentive.
- The practice must be the patients 'usual care provider' ie. provide the majority of care to the patient.
- The practice must conduct Aboriginal and/or Torres Strait Islander health assessment and refer patients to eligible allied health professional for up to 5 services per calendar year and/or receive up to 10 follow up services per year from a practice nurse or registered Aboriginal Health Worker (MBS items required).
- As part of the health assessment, GPs should examine a patient's vision and ensure diabetes patients have an annual retinal examination.
- The practice must use MBS definitions of a chronic disease that has been present for at least 6 months.
- Practices must receive patient consent to register their eligible patients for the PBS Co-payment Measure and annotate PBS prescriptions.

Obligations of Practice to receive the incentive

- The practice must keep all IHI and PBS Co-payment Measure patient registration and consent forms at the practice;
- prove its claims for payment by being able to provide:
  - proof that a system is in place to make sure their Aboriginal and/or Torres Strait Islander patients, aged 15 years and over, with a chronic disease are followed up through use of a recall and reminder system, or staff actively seeking out patients to make sure they return for ongoing care;
  - proof of completing appropriate cultural awareness training; and
  - records of patient consent.
- provide information as part of the ongoing audit process to verify that the practice has met eligibility requirements;
- make sure the information given is correct; and
- advise of any changes to practice arrangements.

Procedural General Practitioner Payment Incentive

Payments are made every 6 months.

The PIP Procedural General Practitioner (GP) Payment aims to encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services.

For the purposes of this payment, a procedural GP is one who provides non-referred procedural services in a hospital theatre, maternity care setting or other appropriately equipped facility, which in urban areas would normally be a specific referral-based specialty.

Eligible procedural services are

- Obstetric delivery
- General anaesthetic, major regional blocks
- Abdominal surgery, gynaecological surgery requiring general anaesthetic, endoscopy.

Payments and Requirements for Practices to receive the incentive

There are four tiers of procedural payments, the tiers are not cumulative and each GP can only qualify for one tier per six month payment period. Payments are made in August and February.

***TIER 1:** $1,000 PER PROCEDURAL GP PER 6 MTH PERIOD*
- a GP must provide at least one eligible procedural service in the six month reference period.

***TIER 2:** $2,000 PER PROCEDURAL GP PER 6 MTH PERIOD*
- a GP must meet the Tier 1 requirements and provide after-hours procedural services on a regular or rostered basis (15 hours per week on average, either on call or on a roster) throughout the six month reference period.

***TIER 3:** $5,000 PER PROCEDURAL GP PER 6 MTH PERIOD*
- a GP must meet the Tier 2 requirements and provide 25 or more eligible surgical and/or anaesthetic and/or obstetric services in the six month reference period.

***TIER 4:** $8,500 PER PROCEDURAL GP PER 6 MTH PERIOD*
- a GP must meet the Tier 2 requirements and deliver 10 or more babies in the six month reference period. Where a sole GP in a community delivers less than 10 babies, but meets the obstetric needs of the community, the practice may qualify for a Tier 4 payment.

Obligations of Practice to receive the incentive

The practice must:

- be able to substantiate its claim for a required level of procedural activity;
- a statement or evidence of their after-hours commitment;
- give information as part of its ongoing audit program to verify that the practice has met eligibility requirements;
- make sure information given is correct; and
- advise of any changes to practice arrangements.

Quality Prescribing Incentive

Payments are made once per year.

The PIP Quality Prescribing Incentive (QPI) aims to encourage practices to keep up-to-date with information on the quality use of medicines. The PIP QPI rewards participation by practices in a range of activities recognised or provided by the National Prescribing Service (NPS).

Payments and Requirements for Practices to receive the incentive

The PIP QPI payments are calculated at **$1.00 per SWPE per year**.

Payments are made to the practice annually in the May quarter based on information supplied by the NPS.

To qualify for a payment through the PIP QPI, practices must participate in 3 activities in the reference period 1 May to 30 April for each FTE GP each year, on average, and one of the activities must be a clinical audit.

Recognised activities include:

- a clinical audit of prescribing for specific drug groups, using materials approved or produced by the NPS (available to all practices three to four times a year);
- case studies using problem-based distance learning provided by the NPS; and
- practice visit(s) by an independent pharmaceutical detailer as approved by the NPS. These 'academic detailing' visits are a resource for GPs and promote the quality use of medicines. The availability of this option may be geographically limited.

Obligations of Practice to receive the incentive

The practice must:

- provide information as part of the ongoing audit process to verify that the practice has met eligibility requirements;
- make sure the information given is correct; and
- advise of any changes to practice arrangements.

Rural Loading Incentive

Practices participating in the PIP, with a main practice located outside capital cities and other major metropolitan centres, are automatically paid a rural loading. The rural loading recognises the difficulties of providing care, often with little professional support, in rural and remote areas.

Payments and Requirements for Practices to receive the incentive

The PIP rural loading is added to PIP practice payments. Service Incentive Payments (SIPs) don't attract a rural loading.

The rural loading is based on the classification of the practice using the *Rural, Remote and Metropolitan Areas (RRMA) Classification, 1991 Census Edition* (Department of Primary Industries and Energy and Department of Human Services and Health, November 1994).

To be eligible for the PIP rural loading the main practice location must participate in the PIP and must be located in RRMA 3-7. The rural loading ranges from 15% - 50% of total practice payments.

RRMA Classification	% of total practice payments
RRMA 1 - Capital City	0%
RRMA 2 - Metro area (pop >100,000)	0%
RRMA 3 - Large rural centre (pop 25,000-99,999)	15%
RRMA 4 - Small rural centre (pop 10,000-24,999)	20%
RRMA 5 - Other rural area (pop <10,000)	40%
RRMA 6 - Remote centre (pop >5000)	25%
RRMA 7 - Other remote area (pop <5000)	50%

Obligations of Practice to receive the incentive

The practice must:

- provide information as part of the ongoing audit process to verify that the practice has met eligibility requirements;
- make sure the information given is correct; and
- advise us of any changes to practice arrangements.

Teaching Payment Incentive

The PIP Teaching Incentive aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students who are preparing for entry into the Australian medical profession.

Payments and Requirements for Practices to receive the incentive

Payments are intended to compensate practices for the reduced number of consultations due to the presence of the student.

Practices will receive **$200 per 3 hour teaching session**. Practices can claim a maximum of two sessions per GP, per calendar day.

An eligible teaching session must be:

- provided to a student enrolled in an undergraduate or graduate medical course accredited by the Australian Medical Council;
- provided by a GP who is responsible for the teaching session, including those sessions provided outside the practice, such as home visits and consultations in hospitals or aged care facilities; and
- provided by a GP from a practice participating in the PIP.

Teaching sessions are not payable:

- for registrars and junior doctors, nursing, allied health or pharmacy students; and
- if the supervising GP is paid for teaching activities through other Australian Government funded teaching programmes, such as the John Flynn Placement Program.

Obligations of Practice to receive the incentive

- Practices must be able to substantiate claims for payment using documentary evidence of the teaching sessions provided to medical students;
- provide information as part of the ongoing audit process to verify that the practice has met eligibility requirements;
- ensure information is correct; and
- advise in writing of any changes to practice arrangements.

APPENDIX 3 FUNDING MODELS: A SNAPSHOT

In the 1990s the PIP shifted funding for general practitioners away from the fee-for-service model towards a blended payments model. This section provides a snapshot of the literature on funding models. It is not intended to be exhaustive and those with expertise in this area are encouraged to make a submission to the consultation process.

There is consensus within the literature that health reform needs to adopt funding models that better reward the value of the care provided rather than simply the volume as seen in fee-for-service models.[33] The announcement of Health Care Homes signals a renewed desire to move away from a fee-for service model in general practice and will use bundled payments, a form of capitation.

However, there is uncertainty in how to make that shift in regard to the PIP. One theory is that value will need to be measured directly through application of comprehensive quality measurements that allow for quality and costs of care to be assessed. However, there is a lack of both the required measures and the operational ability to implement them to appropriately evaluate quality and costs.[34] Another theory is that value-based payments may be more easily achieved by altering payment incentives to promote behaviours that have a demonstrated relationship to desired outcomes, whether or not real-time measurement can always confirm the desired outcomes are achieved.[35]

Pay-for-performance or outcome

This information is provided here to support a discussion as the focus of the policy is on payment for quality.

The effect of quality improvement incentives as a pay-for-performance (P4P) funding model on patient health outcomes is a topic of great interest to both the international and Australian primary health care sectors. P4P funding models are payment systems designed to improve health service performance by rewarding high value activity. P4P aims to alter the behaviour of health care workers by linking payments to achievement of certain pre-determined criteria resulting in an improvement in quality of health care and health outcomes.[36] While they provide increased transparency and evidence of activity they have been known to have unintended consequences. [37, 38, 39, 40, 41, 42, 43, 44, 45]

Capitated payments

A capitated payment model is a population-based funding approach focused on funding needs at the population level.

Payments are made as a block-funding arrangement where funds are periodically allocated to service providers in a lump sum based on population size and the perceived health care needs of the population. This means health care providers are paid a set amount to provide a defined package of care for a patient over a specified period of time. The set payment amount encourages providers to focus on effective and appropriate patient engagement to deliver that care. Capitation models can be implemented as payments to individual professionals, care teams or organisations such as general practices.

Currently capitation payments are more common in hospital funding than in the Australian primary health care sector.[46] Examples in Australia include Aboriginal Community Controlled Health Services, some Victorian community health services, and other non-government organisations that employ or contract general practitioners on a periodic basis.[47] Allocation of funding is determined by patient registrations.

As with the P4P model, there are both advantages and disadvantages to using capitation as a funding model and there is insufficient evidence to support or not support capitation to improve the quality of primary health care. [48, 49, 50]

Blended payments model

Blended funding in primary health care describes a method of payment where services, or different elements of care, are grouped together into one payment. Services must be coordinated by the patient's general practitioner in order for certain items to be claimable, though parts of the work can be delegated to allied health workers or nurses and can be coordinated through incentives such as Chronic Disease Management Items and care plans which involve the community health sector in a partnership approach.[51]

Combinations of payments, e.g. P4P and capitated payments are increasingly used in primary health care systems internationally. This approach is generally referred to as blended funding. Blended payment models could also be used to accommodate different local contexts such as rural and remote health care.

Blended payments can reduce incentives based on volume of services, lead to more effective services, greater team based care, improve data utilisation and better coordination and care integration.[52] [53] However, blended payments may encourage fragmentation by working in condition-specific pathways and may prevent access for those with greatest need. They can also be data intensive and may introduce a financial risk for the provider particularly in relation to performance.[54]

Blended funding models in primary health care are complex and challenging and require well-integrated systems.

Summary of funding models

There is insufficient evidence to support or not support the use of financial incentives of any one model to improve the quality of primary health care. To date there is little rigorous evidence of their success in improving the quality of primary health care, or of whether such an approach is cost-effective relative to other ways of improving quality of care.[55] Therefore, there is a need for a considered and careful approach to redesigning the PIP.

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All information in this publication is correct as at October 2016

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