RACGP

Royal Australian College *of* General Practitioners

RACGP submission: Redesign of the Practice Incentives Program

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We recognise the traditional custodians of the land and sea on which we work and live.

Summary

The Royal Australian College of General Practitioners (RACGP) is Australia's largest professional general practice organisation, representing more than 33,000 members working in or towards a career in general practice in urban and rural areas.

The RACGP is broadly supportive of a quality improvement incentive payment; however, the models proposed in the Department of Health's Redesign of the Practice Incentives Program (PIP) consultation paper require further consideration. This submission outlines the necessary considerations regarding the redesign of the PIP and proposes alternative options for measuring and rewarding quality improvement.

The RACGP supports:

- the broad concept of a quality improvement incentive
- voluntary and remunerated reporting of practice data
- a quality improvement incentive that rewards practices for demonstrating a robust method of measuring quality improvement and participating in quality improvement activities.

The RACGP does not support:

- the removal of funding that supports the healthcare of disadvantaged patient groups
- the removal of all practitioner-level incentive payments from PIP
- automated data extraction from practice system software.

Submission

1. Consultation process

The RACGP welcomes the opportunity to provide written comment regarding the redesign of the PIP. However, the redesign of the PIP consultation paper (the consultation paper) indicates significant change for general practitioners (GPs) and practices and, as such, will require wide and ongoing consultation with the profession – far beyond the initially allocated timelines for consultation.

The consultation paper, released on 21 October 2016, does not provide adequate detail to analyse and inform the response required for such significant reform. In light of this, the RACGP has structured this submission around the key design concepts identified in the consultation paper, as opposed to responding to the questions raised.

The Department of Health (the Department) hosted a webcast on 16 November 2016, where it introduced diagrams illustrating proposed design models for the redesign of the PIP. The diagrams provided necessary context to the consultation paper and would have been more valuable if published at the beginning of the consultation process.

2. Rationale for quality improvement

The consultation paper states that current primary healthcare reforms provide opportunity to redesign the PIP. The RACGP acknowledges that there is undisputable benefit in considering the PIP redesign as part of wider primary healthcare reform; however, the concept of quality improvement has been on the primary healthcare agenda for many years prior to these reforms.

The Department's proposal to merge seven of the 11 incentives into a single quality improvement incentive is contrary to recommendations from external reviewers. The ANAO Audit Report stated that the PIP incentives are diverse, with varying aims and payment arrangements, implying that streamlining incentives would be beneficial.[1] However, it did not recommend the merging or removal of current incentives. The recent Organisation for Economic Co-operation and Development (OECD) review of healthcare quality in Australia recommended the expansion of the PIP to include more quality indicators. It did not recommend that incentives be removed.[2]

The Australian National Audit Office (ANAO) Audit Report recommended that the Department, 'develop the capability to model the effect of PIP design features on the likely uptake and success of proposed incentive payments'.[1] The outcome of this recommendation is unknown, and it is unclear whether the Department has analysed the proposed quality improvement incentive to determine its likely uptake and success.

3. Funding

3.1 Funding for quality improvement

The 2016–17 Federal Budget Paper No. 2 states that the Government will achieve savings of $21.2 million as a result of redesigning the PIP.[3] It also states that the savings generated will be redirected towards Health Care Homes. The RACGP does not support the removal of funds from PIP and believes these funds should be reinstated as a matter of priority. The RACGP is concerned that the redirection of PIP funding could disadvantage GPs and general practices, as the funding is not being reinvested directly back into practices. Instead, the funds will be used to support the administration of a program that will only be available for up to 200 practices.

In contrast to the statement in the 2016–17 Federal Budget papers, the consultation paper notes that the quantum of funding available to support the redesigned PIP is expected to remain at current levels. However, it has recently been confirmed that the $21.2 million has been redirected to support Health Care Homes.[4] The RACGP seeks clarification and transparency regarding the funding available to support the PIP.

3.2 PIP contributing towards a blended payment system

The redesign of the PIP should not be a cost-cutting exercise for the Government.

PIP funding was originally split from the indexed Medical Benefits Schedule (MBS) in an effort to introduce a blended payment system for general practices. PIP payments have not been indexed and, as a result, the pool of funds to support GPs and practices has eroded over time. The redesign of the PIP allows the opportunity for the Government to re-base PIP payments to their original value and introduce ongoing indexation. This would ensure the incentive payments maintain their value over time and support practices to continue to provide their patients with high-quality care.

The Government must invest in PIP to demonstrate a genuine commitment to continual quality improvement in primary healthcare. Payments for quality improvement should thus represent a greater proportion of overall GP and practice income.[2] Internationally, payments to practices for quality improvement activities are much more significant than in Australia. In the United Kingdom, for example, payments administered through the country's Quality and Outcomes Framework can represent as much as one-third of a practice's overall income.[5] In Australia, PIP represents less than 4% of total general practice expenditure.

However, increases in PIP funding should not be at the expense of patient rebates.

4. Scope of redesign

The purpose of the PIP is to support general practice activities that demonstrate continuing improvement and high-quality care, enhance capacity and improve access and health outcomes for patients.[6] The current incentives have been developed according to this vision.

The consultation paper does not explicitly state whether the incentives in scope for redesign will remain as part of the new quality improvement incentive or be removed from the PIP entirely. The Government must carefully consider the implications of removing or merging any PIP incentive. Particular attention should be given to the effects of removing following:

- **Indigenous Health Incentive** – The absorption of the Indigenous Health Incentive will disadvantage Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Medical Services (AMSs) and practices with a significant Aboriginal and Torres Strait Islander patient population. Payments from the Indigenous Health Incentive make up a significant proportion of income for these practices.
- **Procedural General Practitioner Incentive** – Support for GPs providing advanced care in rural and remote practices will be significantly reduced if the Procedural General Practitioner Incentive is removed. GPs in these areas must continue to be supported in order to provide important procedural services. The health of rural patients will be at risk if access to procedural services offered by GPs is reduced.
- **General Practitioner Aged Care Access Incentive** – This incentive is paid directly to eligible GPs and supports them to provide services to aged care patients. Removal of this incentive will disadvantage aged care patients at a time when access to such services is already under strain. With the removal of this incentive, the aged care rebate should be reviewed and increased separately from the quality improvement incentive to offset the loss of the General Practitioner Aged Care Access incentive.

Indigenous, rural and aged care patients have a higher prevalence of complex and chronic disease[7]. A pooled quality improvement incentive may disadvantage these patient groups. The proposed design indicates the removal of funding supporting disadvantaged patients in favour of an incentive for general quality improvement.

Practices with a disproportionately disadvantaged patient population may find it difficult to achieve quality improvement in clinical outcomes at the same rate as other practices. The difficulty in demonstrating improvement in health outcomes, combined with the removal of the incentives that support a disadvantaged patient population, will be detrimental to GPs and practices working in areas of need.

4.1 Closing the Gap

The Indigenous Health Incentive is linked to the Pharmaceutical Benefits Scheme (PBS) Closing the Gap co-payment. Practices must continue to be supported to register patients to the PBS Closing the Gap co-payment, independent of the Indigenous Health Incentive. This requires the development of a separate process of registering patients for the PBS Closing the Gap co-payment.

4.2 Service Incentive Payments

The Department has stated that the redesigned PIP will include practice-level payments only. This indicates the removal of all Service Incentive Payments (SIPs) from the PIP. Practice-level payments provide the flexibility for practices to collectively decide where to direct quality-related funding. This payment system can support a whole-of-practice approach to quality care and allow practices to recognise not only GPs, but also the efforts of practice nurses, allied health professionals, and others who provide services within the practice.

The Government must consider the implications of removing all practitioner-level payments. Many key areas of primary healthcare, such as diagnosis, referral, prescribing, health promotion and managing long-term health conditions, rely on the behaviours and performance of the individual clinician.

Failure to target interventions at a practitioner level may result in an unfair distribution of income between the individual GP and other areas within the practice. This may be particularly challenging for GPs working in larger and corporate practices. Practice-level payments may not drive quality improvement alone and the removal of SIPs could unintentionally render the PIP irrelevant to individual GPs. There must be a system in place to reward individual GPs for their efforts in quality improvement.

5. Secondary use of practice data

5.1 Remuneration for data reporting

The RACGP opposes the automated extraction of data from practice systems. The information held by practices is an essential component for health system analysis. Agencies or departments tasked with undertaking this work should be prepared to purchase the necessary data from practices through a ‘pay for reporting’ process.

There are a several issues associated with the automated extraction of data from practice systems, including that practice systems:

- do not easily allow for the extraction of individual patient data, which becomes an issue if patients dissent to secondary use of their health information
- are not standardised, and the variability of the data recorded in different practice systems will cause issues in analysis
- can be compromised by third-party data extraction tools, significantly reducing performance for non-related tasks.

Rather than seeking to implement automated data extraction processes, a payment should be established for practices that provide data reports. Practice data is extremely rich and practices should be directly rewarded for their investment in collection, storage, and reporting when sharing data from their systems for the purposes of health system planning.

The automated extraction of practice data must not be required for practices to participate in quality improvement.

5.2 Time investment required from practices

The consultation paper states that a key driver for the redesign of the PIP is the regulatory and administrative burden PIP places on GPs and practices. The solution offered in the consultation paper

would require general practices to frequently provide de-identified data from their practice software systems. The redesign of PIP must consider any time commitment required by practices associated with the provision of data and ensure that, in the effort to reduce burden of the current PIP, it does not become a more time-intensive process.

As noted above, the automatic extraction of data is not an appropriate solution to reduce the administrative burden. Paying practices providing data reports would be a more worthwhile initiative.

5.3 Ensuring quality data

The consultation paper states that the data collected would enable general practices to track improvement and adjust the healthcare provided to best suit their patient population. As such, quality improvement is dependent on the value of the underlying data. In order to facilitate its access to high-quality data for health system analysis and quality incentive purposes, the Government would need to:

- develop clear and high-quality data collection and reporting processes for practices
- analyse the costs associated with cleansing, recording and reporting on clinical data, and ensure that GPs and practices are adequately remunerated to cover these costs
- provide education and training in health information technology (IT) and data governance
- ensure that the appropriate security, policies and legislation are developed to protect patients' sensitive health information.

6. Suggested models of quality improvement

The RACGP does not support the Option Two payment model outlined in the consultation paper. Funding for practice quality improvement should be paid directly to practices and GPs rather than third-party providers. Practices must have the opportunity to develop and implement their own quality improvement mechanisms or decide to contract a third-party provider of their choosing.

Funding should not be used to support Primary Health Networks (PHNs) as third-party providers, as PHNs are already funded to assist general practices to undertake quality improvement.

6.1 Rewarding quality improvement processes

Practices should be rewarded for demonstrating a robust method of measuring quality improvement and participating in quality improvement activities.

The redesign of the PIP should avoid duplication by rewarding practices and GPs for participating in quality improvement programs and processes already used in general practice. An incentive payment should be paid to practices and GPs that demonstrate that they are involved in quality improvement and that their activities have led to improvement. Practices and GPs can demonstrate their involvement in quality improvement through various programs that already exist in primary healthcare, such as:

- **National Key Performance Indicators for Aboriginal and Torres Strait Islander primary healthcare (nKPIs) –** nKPIs are designed to improve the delivery of primary healthcare services by supporting continuous quality improvement activity among service providers.[8]
- **Quality Improvement and Continuing Professional Development (QI&CPD) –** The Medical Board of Australia requires all medical practitioners to demonstrate participation in ongoing continuing professional development. The RACGP QI&CPD Program requires GPs to participate in quality improvement activities, such as clinical audit, research or 'plan, do, study, act' cycles.[9]
- **Quality improvement module within the RACGP *Standards for general practices* (the Standards) (4th edition)** – Practices must be accredited against the Standards to participate in

PIP. The Standards include a number of indicators that require completion of quality improvement activities.[10]

6.2 Quality improvement indicators

In addition to recognising practices for implementing robust quality improvement methods, the Government could implement indicators in areas where specific quality improvement is required. The consultation paper does not specify quality improvement indicators. It is expected that further consultation will occur with the sector once quality improvement indicators have been developed.

Quality improvement indicators should focus on evidence-based areas known to improve patient health outcomes, and support practices to focus in areas that are important to their patient population, including the areas in scope for redesign (eg aged care, chronic disease cycles of care, Aboriginal and Torres Strait Islander health). Indicators could also be developed to encourage improvement in areas that have not previously been targeted. These indicators should align with strategic priority areas.

The RACGP suggests that the quality and safety of care could be universally improved through various incentives for evidence-based activities, as indicated in the RACGP's *Vision for general practice and a sustainable healthcare system*[11]:

- **Comprehensiveness of care** – A comprehensiveness payment would recognise the GPs and practices that provide a broad range of services to the community. The payment should be based on an agreed range of measures for comprehensive service provision. This could include undertaking work such as:
    - providing 'same-day care for sick children' – This would reduce the pressure on hospital emergency departments by redirecting parents with children presenting with minor ailments to their GP[12]
    - providing palliative care services – The demand for palliative care services will increase with Australia's aging population and general practice should be better supported to provide end-of-life care as part of a needs-based service delivery model.
- **Quality, safety and research activities** – Payments could recognise GP leadership in areas such as clinical governance, research in general practice and primary healthcare and quality use of medicines.
- **Complexity** – Dedicated funding is required to support practices to provide high-quality care to patients with complex clinical needs and those who are hardest to reach. A complexity loading could be applied to GP and practice payments based on the practice population characteristics such as:
    - socioeconomic status of the community in which the practice operates
    - rurality of the practice
    - patients who identify as an Aboriginal and/or Torres Strait Islander person
    - age of individual patients.

- **Team-based care –** Payments for providing coordination of care and working to bridge the gap between hospitals and the primary healthcare sector will support specific activities with proven patient benefit. This could include:
    - post-hospital discharge follow-up consultation – A follow-up visit with a GP within seven days of hospital discharge is associated with a lower risk of hospital readmission[13]
    - supporting hospital-in-the-home programs
    - patient handover between sectors.

7. Future consultation

The 2016–17 Federal Budget Paper No. 2 states that the quality improvement incentive will be introduced from May 2017.[3] The Department has since stated a more realistic timeframe of at least 18 months to implement the redesigned PIP, which would indicate a June 2018 introduction. The RACGP supports a revision of the current published timeline to ensure the final design is informed by further consultation with the profession.

Further consultation with the profession on the detailed aspects of the redesigned PIP is required. The profession should be consulted on the proposed indicators for quality improvement, as well as payment details.

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