QAIHC

Queensland Aboriginal and
Islander Health Council

QAIHC SUBMISSION TO THE
DEPARTMENT OF HEALTH

CONSULTATION PAPER

Redesigning the Practice Incentives Program (PIP)

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QAIHC

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QAIHC receives funding support from the Australian and Queensland Governments.

Recommendations

1. The Department of Health ensures that in undertaking any redesign of PIP that Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHO) are in no way financially disadvantaged as compared to the current PIP arrangements.
2. In an environment of broad primary health sector reform that there is consideration for how the Health Care Homes, the Medicare Benefit Schedule Item Review and National Disability Insurance Scheme will integrate and impact the redesigned PIP and resulting income for ACCHO.
3. The Queensland Aboriginal and Islander Health Council (QAIHC) supports a redesign of the PIP and the Indigenous PIP on the provision ‘1’ above is upheld and that the administrative burden is reduced.
4. Any redesign and associated payments will support better patient centred care.
5. QAIHC recommends further close consultation by the Department regarding development of the detail underpinning the Quality Improvement (QI) PIP.
6. Reforms to PIP must ensure that ACCHO dealing with Aboriginal and Torres Strait Islander clients have an additional loading reflecting the documented complexity of physical, social and emotional issues of this population and to meet the widely recognised comprehensive definition of Indigenous health.
7. Complementary systems such as the Close the Gap prescribing program be retained and strengthened should the Indigenous PIP be disestablished.
8. Consultation be undertaken as to which indicators will be used in a future redesign and that these be developed by Primary Health Experts with an articulation of their purpose provided.
9. Indicators should not purely be biomedical but encompass the patient experience and community controlled co-design and partnership.
10. The custodian of the Aboriginal and Torres Strait Islander data sets should not be a third party that sits outside of the ACCHO sector.
11. The data that is reported should not be any more than is already reported (National KPI and to Ochre Streams) and further consultation be undertaken regarding the data sets.
12. Issues relating to security, governance and the sharing of Aboriginal and Torres Strait Islander data, for example with PHN, be addressed in consultation with the ACCHO sector.
13. Ongoing evaluation of the redesigned QI PIP is essential to ensure improved care and better health outcomes for Aboriginal and Torres Strait Islander people.

Introduction

QAIHC welcomes a redesign of the PIP and the PIP Indigenous Health Incentive. This is based on independent evaluation findings of the Indigenous Chronic Disease Program (ICDP) regarding the PIP Indigenous Health Incentive, other independent evaluations of the PIP *and* that the redesign does not financially disadvantage not-for-profit Aboriginal Community Controlled Health Organisations (ACCHO) and the Aboriginal and Torres Strait Islander communities they serve.

This submission includes recommendations from QAIHC in response to the *Redesigning PIP Consultation paper*, Commonwealth of Australia, 2016. This submission is not formatted according to the consultation questions but rather addresses key issues relevant to Queensland ACCHO and provides corresponding recommendations (as above).

Background

In November 2008, the Council of Australian Governments (COAG) announced a new PIP to encourage better care, particularly from mainstream general practices, of Aboriginal people with chronic disease, and to help close the gap in health disparity between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. The PIP Indigenous Health Incentive commenced in May 2010. Incentive payments were paid to general practices and Aboriginal & Islander Community Controlled Health Organisations (ACCHO) caring for registered patients with chronic disease who identified as Aboriginal and/or Torres Strait Islander.[1]

The intent of the PIP Indigenous Health Incentive is for health services to provide improved and more targeted care to Aboriginal and Torres Strait Islander patients. The PIP Indigenous Health Incentive substantially increased the number of GP Management Plans for Aboriginal and Torres Strait Islander people over the period 2008-2012. However, the most significant outcome was related to the PBS CTG-payment measure (or Close the Gap scripts) for patients registered with the PIP Indigenous Health Incentive. Eligibility for subsidised PBS medicines is linked with the PIP Indigenous Health Incentive.[2]

Two independent reviews of the PIP Indigenous Health Incentive found that initial registration for the PIP Indigenous Health Incentive was largely driven by interest in accessing the benefits of the PBS co-payment measure, and to some extent by financial gain.[3] Delivery of adult health assessments and registration payments for the PIP Indigenous Health Incentive are now considered to represent a significant income stream for some health services.

Many concerns were raised by the ACCHO sector (and in a 2010 NACCHO submission) about the introduction of the PIP Indigenous Health Incentive in 2010.[4] The main concern was related to financing general practices for the health of Aboriginal and Torres Strait Islander people and how financing for-profit services could benefit the Indigenous community. The other concern related to the potential for rorting by general practices providing little regular care to Aboriginal and Torres Strait Islander people. These concerns were confirmed in two subsequent independent evaluations that are summarised here.

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[1] Couzos A, Thiele DD. (2010) The new "Indigenous health" incentive payment: issues and challenges *Medical Journal of Australia* 192 (3) 154-157.

[2] (KPMG) and sentinel sites

[3] sentinel

[4] MJA papers

The Menzies School of Health Research Evaluation through the Sentinel Sites Program found that "there was little clear evidence that funding derived from the incentives payments was being used by practices to enhance systems providing high-quality chronic illness care". They recommended that the "design of the PIP Indigenous Health Incentive measure needs some revision if investment is to result in improved care delivery and value for money".[5] The evaluation also reported that:

> "To the extent that there have been improvements in recording of Aboriginal or Torres Strait Islander identity, this appears to have been driven largely by the perceived benefits of the PBS Co-payment measure, with little evidence of impact of the PIP Indigenous Health Incentive registration process."

The Sentinel Sites Evaluation reported "almost one-third of registered patients either did not attend any specific Health Service on enough occasions to generate a Tier 2 payment (more than five times in a calendar year) over the course of 2010 and 2011 or Health Services were not billing for providing care in a way that triggers payments". This raised questions for the evaluators about the eligibility criteria for the incentive and the ability of the current payment system to reward quality care.

A survey of health services showed that many were not aware of how PIP Indigenous Health Incentive funds were being used. Interviewees were generally unwilling or unable to say specifically how funding derived from the incentive payments was used. Overall, there was little evidence to suggest that funding was used to drive quality chronic illness care (a point supported by the KPMG evaluation discussed below).

The annual re-registration of patients for the PIP Indigenous Health Incentive was also a significant administrative burden for ACCHO.

Overall, the evaluation recommended that incentives <u>should be focused on health services that can demonstrate an interest and potential to provide high quality care to Aboriginal and Torres Strait Islander patients and populations</u>.

Another independent evaluation from the KPMG reported:

> "These strategies [Indigenous PIP] need to focus more on demonstrable improvements to patient outcomes. This will require stronger policy levers that encourage general practices and Indigenous health services to appropriately and effectively meet the chronic disease care needs of Aboriginal and Torres Strait Islander people." [6]

This evaluation recommended "modifying the PIP Indigenous Health incentives so that they are more explicitly linked to demonstrable quality and practice improvement outcomes". This was a key outcome based on the failure to elicit sufficient evidence of improved efforts towards quality care. The report stated that "while many organisations signed up to the base incentive, approximately 30 per cent did not then attract any of the patient-specific outcome payments".

Concerns were also raised by stakeholders that "the cultural awareness training requirements within the ICDP were inadequate, particularly for providers participating in the PIP Indigenous Health Incentive, both in terms of not all providers undertaking the training and that the minimum training requirement itself was not sufficient".

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[5] sentinel

[6] KPMG

The KPMG report recommended that consideration needs to be given to:

- whether incentives continue to be broadly available or targeted to those primary health care organisations that have demonstrated their capacity to work effectively to improve outcomes;
- linking available incentives more explicitly to quality practice requirements and demonstrable outcomes for patients such as Quality Use of Medicine requirements; and
- exploring additional policy levers that could be used to require demonstrable improvements to patient care practices that are culturally competent.

Discussion

QAIHC understands that the PIP Indigenous Health Incentive will be amalgamated into the redesigned QI PIP. QAIHC reports that many of its Members support the amalgamation providing it doesn¹t lead to reduced income. Hence the concerns pertaining to the QI PIP relate to the detail underpinning how it might work. In addition, there are other current issues that will influence chronic care for Aboriginal and Torres Strait Islander people that will add further uncertainty, such as Health Care Homes and the Medicare Benefit Scheme review outcomes.

QAIHC agrees that the PIP Indigenous Health Incentive has been a blunt instrument to influence quality care and has been a major source of wasted funds within the mainstream sector. For example, whilst all funds within ACCHO were redirected towards Aboriginal health care, this has not been the case for private general practices. It was always unclear how the extra revenue generated within mainstream would support closing the gap.

QAIHC recommends close consultation by the Department regarding development of the detail underpinning the QI PIP. If the ACCHO sector is closely consulted regarding the redesign, a solution can be found for:

How registration towards the CTG scheme can be maintained to address the program intent

It is important that the CTG measure continues to support its original intent. The original intent was to enhance medicines access to patients at high risk of forgoing their medicines. In addition, the intent was to ensure that high-risk patients could receive quality care and appropriate follow-up. CTG scripts can only be written from practices that are accredited and have participated in cultural safety training - such as those that services participating in the PIP. As such, CTG script measure has been very successful and should be protected.

Registration for the CTG could continue if a practice is a regular provider of health care to the patient, can record patient consent and the Indigenous origin of the patient, and is accredited with the PIP. There might be a need to ensure that patients registered for CTG by a practice have at least had an item 715 generated for that patient to ensure quality practice and health outcomes.

What standardised data sets should look like where they pertain to Aboriginal and Torres Strait Islander people

QAIHC and member services have decades of experience with standardised data sets and how this information can be used for both CQI and reporting on key performance indicators (nKPIs). The development of standardised data sets for program monitoring with the QI PIP need to be developed in consultation with QAIHC and need to be aligned with Health Care Home indicators and PHN indicators, and the national KPIs.

In addition, issues relating to security and governance of the data need to be addressed in consultation with the Aboriginal and Torres Strait Islander sector. QAIHC is ideally placed and is already offering a wide range of services for collecting, analysing and reporting on data collected by ACCHO on a broad range of indicators for CQI activities.

How aggregated data might be interpreted (where it pertains to Aboriginal and Torres Strait Islander people)

Aggregated data should be able to inform resource allocation and program development at the regional level (data for action), otherwise it is just a statistic. The interpretation of aggregated data is influenced by the data to be collected but also by the context. This means that appropriate mechanisms need to be established to ensure data is not misinterpreted by PHN, the Department or other agencies. This will require local and regional data agreements involving QAIHC and ACCHO within Queensland.

How quality care can be defined so that it doesn't just include biomedical indicators of quality, but also takes into account quality improvement with the patient experience and community control (co-design and partnership) as markers of quality care

This is part of the triple aim of health care reform, so that data can drive more patient-centred care and also support the transitioning of care to Aboriginal community control at regional and local levels.

Including patient experience measures also means that the redesigned PIP can start to reward practices to improve on their patient feedback systems by incentivising the collection of patient feedback. Patients are ultimately the arbiters of what is quality care.

QAIHC has attached an Appendix to this submission pertaining to the development of a Patient Feedback Guide. QAIHC recommends the Department refer to this Appendix when developing the QI PIP to support patient experience measures of quality care.

How the proposed QI PIP will improve patient-centred care

QAIHC notes that the Department’s discussion paper does not include patient-centredness as an indicator of quality. One of the key principles for the QI PIP should be to improve the patient experience. QAIHC believes this is an oversight and that it is important that it be corrected.

How State and Territory Affiliates and PHN work together as key providers of support for QI PIP within their respective member services/practices

QAIHC recommends that the Department consider how the development of QI PIP can also support PHN to partner with State and Territory Affiliates such as QAIHC.

How QI PIP mechanisms can equitably reward QI pertaining to Aboriginal and Torres Strait Islander patients

QAIHC recommends that the rural loading should be retained and factored into the formula for the redesigned PIP.

QAIHC recommends an Indigenous-specific loading for every Aboriginal Whole Patient Equivalent (WPE) to reflect the differential burden of disease, increased socioeconomic disadvantage, and to reflect the under-utilisation of health care services which leads to the inverse care law.

- The Standardised Whole Patient Equivalent (SWPE)has always underestimated patient numbers within ACCHO because of care delivered without MBS claims, care by Aboriginal Health Worker’s, patient mobility, and the focus on patients who are 'hard to reach'. In addition, the SWPE applies an age-sex standardisation to the numbers of patients seen in the practice over 12 months. This means that older patients have a weighting added, so that a 75-year-old patient is worth 4 times that of a child less than one year of age. This weighting has unfairly discriminated against the different age-sex structure within the Aboriginal and Torres Strait Islander population since the inception of the SWPE as a funding formula.

- To adjust for this, the Indigenous loading must age-adjust the WPE weightings and apply this new SWPE formula to the number/age of Aboriginal/Torres Strait Islander practice population.

QAIHC recommends that the 'Indigenous loading' should only be applied to general practices if the practice has completed cultural safety training or other criteria of quality care.

QAIHC recommends that this loading would not remove any sign-on payment. Sign-on payments for Indigenous patients should continue to be higher than non-Indigenous patients as with the PIP Indigenous Health Incentive.

QAIHC also recommends other amendments to the payment triggers. For example, to relieve the administrative burden of having to complete the PIP Indigenous Health Incentive registration form each calendar year (because chronic disease patients hopefully would stay with the usual GP) the $250 payment could be triggered when the patient has a GP Management Plan item 721, Team Care Arrangement item 723, a review of the GPMP or TCA item 732, as this will show that the patient is still with the same GP or clinic. If the patient attends elsewhere, this will cancel the registration with the initial clinic.

QAIHC recommends that a Tier 2 payment should include a chronic disease item to trigger this payment as one of the 5 services that needs to be provided to the patient in the calendar year (as currently this payment is paid typically though the Tier 1 payment.

How the redesign might be evaluated by the Department of Health

QAIHC recommends a role having explicit oversight of an evaluation of the redesigned PIP as to whether it can show that there is improved care being delivered to/with Aboriginal and Torres Strait Islander people.

Conclusion

QAIHC recommends continual support of ACCHO towards quality improvement activities. These services are leading the way in quality care delivery (both biomedical and patient experience measures) and in community participation and patient-centered care. However, more needs to be done to support these services to develop the capability to collect the information necessary for ongoing monitoring and continuous quality improvement.

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