



AMA

**AMA Submission on the
PIP Indigenous Health Incentive
Review**

June 2019

INTRODUCTION

The Practice Incentives Program Indigenous Health Incentive (PIP IHI) was introduced in 2010 as a key part of the Closing the Gap measure, to support health services provide improved and more targeted care to Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease. The introduction of the PIP IHI, has led to an increase in the number of health checks provided for Aboriginal and Torres Strait Islander patients with chronic disease and better access to prescription medicines.¹ However, it is unclear as to whether this incentive has led to better health outcomes.

There have been generally high levels of registration of health services and of patients for the PIP IHI², with around 3,700 general practices and Indigenous health services signed on to the incentive and around 64,700 patients registered in 2014-15.³ However, there is little evidence that funding provided through the PIP IHI has been used by practices to enhance the provision of high-quality chronic disease care.

The AMA is aware that two independent evaluations of the Indigenous Chronic Disease Package, including the PIP IHI, were undertaken in 2013² and 2014⁴ which identified some areas for future consideration, particularly in relation to the administrative burden of the PIP IHI and cultural awareness training requirements. The AMA has also received feedback from stakeholders on these issues.

ADMINISTRATION

Feedback from stakeholders indicates that the paperwork associated with registering for the PIP IHI is considered onerous in both the mainstream general practice and Aboriginal Community Controlled Health Organisation (ACCHO) settings. In the ACCHO setting, a very large proportion of all patients will need to be registered, either because they have a chronic disease or because they are eligible for the Closing the Gap Pharmaceuticals Benefits Scheme (CTG PBS) co-payment. ACCHO's therefore potentially have thousands of people they need to register or re-register prior to the end of each calendar year. The administrative burden this adds to ACCHOs is very large and disproportionate to mainstream general practice. Additionally, it has been raised that the registration process itself is of little benefit to patients, and that it is unclear how this income stream is being used to improve services.² However, the AMA would expect that health services with large registered patient cohorts, who would be receiving significant funding from the incentive payment should be able to demonstrate how that funding is being utilised to improve the care of indigenous patients. The AMA considers that the PIP Advisory Group may need to explore what service indicators might be appropriate, particularly for practices or ACCHO's with a significant proportion of patients registered to reflect how the incentive payments are contributing to improved services.

The registration and annual re-registration process currently requires a GP signature. Given, the declaration the GP is signing is really a declaration of the practice, the AMA believes that this

¹ The Close the Gap Campaign Steering Committee. Close the Gap Progress and Priorities Report 2016.

² Bailie R, Griffin J, Kelaher M, McNear T, Percival N, Laycock A, Schierhout G. 2013, *Sentinel Sites Evaluation: Summary Report*, Menzies School of Health Research, [http://www.health.gov.au/internet/main/publishing.nsf/Content/F91E3427B3480DBCCA257E1A0079EDBB/\\$File/sentinel-sites-summary-report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F91E3427B3480DBCCA257E1A0079EDBB/$File/sentinel-sites-summary-report.pdf)

³ Aboriginal and Torres Strait Islander Health Performance Framework 2017

⁴ KPMG. 2014, *National Monitoring and Evaluation of the Indigenous Chronic Disease Package: Final Report* Australian Government Department of Health, Canberra. [http://www.health.gov.au/internet/main/publishing.nsf/Content/A6E7808688131113CA257E1A0079FC30/\\$File/icdp_evaluation_main%20report_vol1%20\(2\).pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A6E7808688131113CA257E1A0079FC30/$File/icdp_evaluation_main%20report_vol1%20(2).pdf)

requirement could be removed and the form signed or completed by the practices authorised contact (presumably the practice manager). This would free GPs time to be utilised for direct patient care.

Should voluntary patient enrolment as recommended by the General Practice and Primary Care Committee as part of the MBS Review be implemented across all patient cohorts the AMA would expect that patient registration process for the PIP IHI could be made redundant. The AMA would also expect that this could significantly streamline and automate the payment process for practices participating in the incentive. Additionally, it would ensure that a greater proportion of funding could be utilised for providing services that that would enhance patient care.

One benefit of the annual patient re-registration requirement is that it provides an impetus for care providers to follow-up with their patients. Thus, providing an important opportunity for the GP to review the patient's ongoing health and well-being and provide preventive, treatment or chronic disease management interventions as clinically required. However, data has shown that re-registrations in the year following initial registration have been limited, noting that this could potentially be the result of factors outside of the control of health services, such as patient mobility.²

CULTURAL AWARENESS TRAINING

Access and uptake of cultural awareness training by general practice staff has increased since the implementation of the PIP IHI, with evidence suggesting that general practices are becoming more oriented to Aboriginal and Torres Strait Islander patient needs⁵. However, there are concerns that the cultural awareness training requirements for the PIP IHI are inadequate, both in terms of not all providers undertaking the training, and that the minimum training requirement itself is not sufficient.

Cultural awareness training can currently be undertaken online or in a face-to-face setting, and there are concerns among stakeholders about the adequacy of online training. Some stakeholders consider that cultural awareness training should be delivered face-to-face and tailored to local community contexts. Furthermore, some general practices that have participated in face-to-face cultural awareness training appeared to have gained some benefit, with some suggesting that more practical strategies focussing on how to engage well with Aboriginal and Torres Strait Islander patients, rather than a focus on history, would be more useful.⁴

When it comes to monitoring the cultural competence of a general practice or ACHHO the AMA suggests that Patient Reported Experience Measures (PREMs) might be a mechanism that could be utilised by practices to demonstrate their cultural competence. Under *Criterion Q1.2 – Patient feedback* in the Royal Australian College of General Practitioners *Standards for General Practice – 5th edition* are required to collect and respond to patient's feedback about their experience with the practice. Thus, accredited practices should have a mechanism in place that could be utilised to obtain feedback and a measure from Indigenous patients as to the practice's cultural competence.

BEST PRACTICE MANAGEMENT OF CHRONIC DISEASE

Data shows that payments made to health services for the delivery of care to patients who were registered for the PIP IHI showed little evidence that it was resulting in any improvement in chronic illness care. Almost one-third of patients registered for the PIP IHI either did not attend any specific 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 services were not billing for providing care in a way that triggers payments.² This has raised questions about the specification and application of the eligibility criteria

⁵ Baillie R, et al. op.cit.

for the incentive's funding tiers and the ability of the current payment system to appropriately reward services for delivery of high-quality care.²

Furthermore, research has shown that incentive payments to general practices are unlikely to be sufficient to improve the quality of care to patients unless they are carefully designed.⁴ Stakeholders have argued that incentives 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 that these services should have flexibility in how PIP IHI revenue is reinvested back into enhancing their primary care services.

When it comes to the outcomes payments of the incentive the AMA notes that the volume of services provided is not necessarily a reflection of the quality of care provided. The AMA recognises the potential for the medical home model of primary care to support and reward quality general practice, and especially to enable well-coordinated multi-disciplinary care for patients with chronic and complex diseases. Within a medical home model of care patients with chronic and complex care needs need access to a broad range of allied health services. The GP is best placed to understand the patient need for these services and the medical home allows the Care Team to ensure care is appropriately coordinated and provided in accordance with the agreed care plan. Having a care plan then is fundamental to improving the management of chronic disease. It is therefore reasonable that a practice participating in the IHI would have developed or reviewed a GP Management Plan (GPMP) for the patient.

The GPPCCC has recommended combining the GPMP and the TCA, making the GPMP the access point for MBS funded allied health items. The AMA is supportive of this recommendation as it aligns with the AMA's Chronic Disease Plan. If this GPPCCC recommendation is implemented the AMA would envisage that access to and utilisation of GP referred allied health items could be considered in terms of assessing the quality and comprehensiveness of chronic disease care made available and/or provided. However, it must be remembered that patient engagement and activation is vital if there is to be an improvement in the patient's outcomes.

Rather than the outcomes payments as they are currently, the AMA would be open to consideration of a quarterly payment per patient to the participating practice. This payment to support the practice in providing or facilitating coordinated access to the comprehensive range of services available in, or outside of the practice, that an Indigenous patient with chronic disease, particularly if they have multiple morbidities, would need. This payment would also need to support the collection of relevant data.

Data is a key driver of quality. It helps a practice to reflect on the benefit of its activities, and what gaps there might be in the care/services they provide. The AMA believes it would be reasonable for practices participating in the IHI to collect relevant data to help inform them as to the status of their patient outcomes so they could look at how patients might be better supported, and their outcomes improved. For example, Patient Reported Outcome Measures (PROMs) and aggregated clinical indicators for any Indigenous cohort of patients might be more reflective of the quality of care received as perceived by patient. In addition, data on key clinical indicators could also be collected and aggregated to assess the proportion of the patient cohort whose condition/s had been stabilised or improved.

RESPONDING TO PATIENT MOBILITY

The AMA would expect that eHealth technology and appropriate and effective transfer of care mechanisms to play an important role in enabling practices to maintain continuity and consistency of care for those members of their patient cohort who are geographically mobile.

The AMA expects that information shared to the patient's My Health Record, with the patient's permission, would help inform the activities of and care provided by any practitioner who picks up their care while they are away from their usual practice. The AMA would also expect that where a practitioner is aware that a patient will be mobile that they provide them with a health summary or an effective temporary transfer of clinical care document to facilitate seamless care.

The introduction of telehealth consultation and case conferencing items for GPs, Nurse Practitioners in a collaborative agreement with a medical practitioner, and Allied Health Providers as per a number of recommendations made under the MBS Review, would enable the usual care providers to provide or facilitate patient care while they are away from their usual practice. Thus, helping to ensure continuity and consistency of care.

Into the future, the AMA would expect that innovative eHealth apps aimed at monitoring patient health indicators, that support the management of their condition/s and that facilitate access to care will be increasingly utilised to support patient care.

CONCLUSION

The AMA believes there are some opportunities to improve the PIP IHI, including streamlining the PIP IHI registration, modifying the payment model to better support access to and delivery of high-quality chronic disease care, and using data to drive quality. A further opportunity is to enhance efforts to build the cultural competency of health service staff through training that is tailored to local community contexts.

Overall, any changes to the PIP IHI must ensure that the specific health needs of Aboriginal and Torres Strait Islander people are met, and that health providers are supported to provide high quality patient care.