Submission to the Practice Incentives Program Indigenous Health Incentive Review

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This submission draws predominately on the mixed-methods Sentinel Sites Evaluation (SSE) of the Indigenous Chronic Disease Package (ICDP). The ICDP was funded over four years from 2009 – 2013. The funding support the implementation of 14 measures, including the Practice Incentives Program (PIP) Indigenous Health Incentive (PIP-IHI). In summary, the SSE was a multisite, place-based, formative evaluation spanning 24 urban, regional and remote locations in all Australian States and Territories. The evaluation was intended to inform ongoing implementation of the ICDP. Sites were selected where there was early and relatively intense ICDP investment. Data were collected, analysed and reported in six monthly intervals over five evaluation cycles between 2010 and 2013.

Specifically, we draw on:

- Administrative data on the uptake and use of the PIP-IHI from the Department of Health;
- More than 700 interviews\(^1\) with key informants from Aboriginal Health Services and the private general practice sector—including employees of Medicare Locals. Key informants were purposively sampled for their knowledge and experience with the ICDP, and included general practitioners, nursing staff, practice managers, ICDP workforce such as Outreach Workers, programme managers, management staff and pharmacists;
- A total of 670 people participated in community focus groups;
- Clinical indicators were collected from 41 Aboriginal Health Services and private general practices.

The full methods are described elsewhere, and are publicly available. (Bailie et al. 2013) **It is important to note the scope of data collection that we are drawing on for this submission and that it covers both Aboriginal Community Controlled Health Organisations, State/Territory managed Indigenous PHC services and private General Practices.**

In this submission we respond to the following questions posed by the PIP-IHI Discussion Paper:

1. **Streamlining administration**
   How does the patient registration process improve or impede chronic disease management and care? Is the current financial incentive for patient registration contributing to better management of chronic disease? Is the current registration processes burdensome and how can it be streamlined? Should the payment be linked to the provision of care rather than an administrative process?

2. **Best practice management of chronic disease**
   Should all PIP IHI registered patients receive a Health Check (MBS 715)?

3. **Provision of culturally appropriate care**
   Do the current PIP IHI guidelines facilitate culturally appropriate care for Aboriginal and Torres Strait Islander patients? Is a requirement that cultural awareness training be undertaken appropriate for health practices?

**Definitions:**

- ‘Aboriginal Health Services’ refers to Aboriginal Community Controlled Health Organisations and State/Territory managed Aboriginal Health Services. In the SSE all except one of the AHSs were Aboriginal Community Controlled Health Organisations;
- ‘General Practice’ refers to privately run and corporate General Practices;
- ‘Health Service’ refers to General Practices and Aboriginal Health Services;
- ‘Sentinel Site’ refers to a geographically defined area that was the focus of the ‘place-based’ SSE activities.

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\(^1\) Some individuals were interviewed more than once in a cycle to gain deeper understanding of the information provided. A number of interviewees were interviewed each cycle. In total there were 374 individuals who provided input across the SSE.
1. Streamlining administration

How does the patient registration process improve or impede chronic disease management and care? Is the current registration processes burdensome and how can it be streamlined?

Across all evaluation cycles, concerns were raised by interviewees about the additional demand made on administrative resources of Health Services as a result of the requirements for PIP-IHI, notably the need for annual re-registration of patients. In many Health Services there was a perception that the incentive rewarded paperwork and had no benefit to clinical outcomes – this was regarded as a disincentive for participation by some providers.

Concerns were raised that there was no way of determining whether or not a patient was already registered prior to commencing the paper work for registration. Underlying these difficulties was a general lack of capability in use of information systems that can be used to identify eligible patients in a Health Service, and those that need initial registration or recall for re-registration. (Bailie et al. 2013)

Health Services participating in the PIP IHI in general lacked good systems to support the intent of the measure and, with a few exceptions, funding derived from the PIP IHI has not been used to develop better systems for identification of patients, follow-up and recall. This is important as the state of use of clinical information systems is constraining quality of chronic illness care, and specifically the extent to which the PIP IHI can achieve its intended outcomes. (Bailie et al. 2013)

Poor functioning clinical information systems and lack of staff capacity to use these systems effectively were identified as barriers to greater uptake of the Tier 1 and Tier 2 payments. Some interviews noted that there is no place on clinical information systems to clearly mark if patients are PIP IHI registered. Recall and reminder systems were reported to not be functional – in many cases this was compounded by staff not knowing how to use the existing clinical information system effectively. Health Services were often unable to generate disease lists for Aboriginal and Torres Strait Islander patients and other patients easily. There were many parallel systems being set up, such as Excel spreadsheets, to track care for PIP IHI registered patients, and these were generally not integrated with existing systems. There were no examples in the SSE of Health Services using money generated through the PIP IHI to improve information systems to support care for Aboriginal and Torres Strait Islander people. (Bailie et al. 2013)

The effective operation of the PIP IHI requires Health Services to have effective systems for follow-up and recall of patients. Participating Health Services in general lacked good systems to support the requirements of the incentive and the intent of the measure. This identified need for further investment in systems development and effective use of clinical information systems to improve delivery of care has been noted in other research we have undertaken in Aboriginal primary health care. (Bailie et al. 2014; Bailie et al. 2015b; Bailie et al. 2016; Bailie et al. 2017)

Is the current financial incentive for patient registration contributing to better management of chronic disease? Should the payment be linked to the provision of care rather than an administrative process?

The PIP-IHI was intended to bring about systematic changes in service delivery such as encouraging improvements in chronic illness care, enhancing capacity, access and health outcomes for patients through culturally appropriate and coordinated care. Only a small proportion of patients are being re-registered in the year following initial registration; indicating limited potential for the measure to provide long term benefit for people in the community. There is little evidence that the measure has had
an impact on quality of chronic illness care, or on the development of systems to support delivery of high-quality care.

In the SSE there was little evidence that patients participating in the PIP-IHI received additional and complementary health services. While some providers indicated that the potential access to additional services was a motivating factor for registering patients, patients did not appear to receive these services. Few patients received care in a way that generates Tier 1 payments. The PIP-IHI may have stimulated more interest and awareness, and possibly completion of GPMPs and TCAs and review processes, however the low levels of Tier 1 payments indicated that the financial incentive has not had an important influence on the type of care provided to patients.

Patients registered for the PIP-IHI were expected to have a diagnosed chronic disease; therefore, it is notable that additional payments reflecting continuity of care and planned review (tier 1 or 2 payments) were not triggered for around 30% of patients. This indicates a substantial proportion of patients registered for the PIP-IHI were not attending health services regularly, or health services were not billing for care in a way that triggered payments. There was wide variation between sites in the proportion of PIP registered patients for whom neither Tier 1 nor Tier 2 payments were made (range from less than 10% to almost 50%). There was a higher percentage of PIP-IHI registered patients for whom no payments were made in Indigenous Health Services than in the general practice sector (Figure 1). (Bailie et al. 2013; Bailie et al. 2015a)

![Figure 1: Percentage of tiers 1 and 2 payments for people registered for the PIP Indigenous Health Incentive for sentinel sites and the rest of Australia, by sector and year 2010–2011. GP, general practice; AHS, Aboriginal Health Service; PIP-IHI, Practice Incentives Program Indigenous Health Incentive.](image-url)
As noted in an earlier section, in many Health Services there was a perception that the incentive rewarded paperwork had no benefit to clinical outcomes – this was regarded as a disincentive for participation by some providers. Other providers felt they ‘could use the money’ and, therefore, would participate, but with no real expectation of improved care for patients. At the same time, there was an increasing emphasis in many Health Services on practice manager roles being responsible for maximising Medicare revenue (not necessarily with a view to improving care).

Some interviewees in the later evaluation cycles expressed the view that registration payments should be replaced by payments for care delivered and services should not be benefitting financially from simply signing up patients without delivering care. Clinicians raised concerns about using GPMPs and TCAs as indicators of quality of care.

Specific suggestions (Bailie R et al. 2013; Bailie et al. 2013):

- Removal of the registration payment for patients and an increase in the funding for Tier 1 payments;
- A blended payment of part PIP and part Service Incentive Payment (SIP) so there was some incentive to both the practice and to individual clinicians, depending on the financial model of the practice. It is possible that service organisations could themselves develop internal systems to pass on at least part of the incentive payment to clinicians;
- Doing away with the requirement for patients to re-register every year for the PIP Indigenous Health Incentive, possibly with a requirement to re-register only if they choose to change to a different service or for the re-registration to be linked automatically to the service that receives the Tier 2 payment;
- A payment that is triggered if a ‘suite of services is delivered’ such as GPMP, TCA, health assessment, follow-up care (in another section of this submission we will provide evidence that may not support the inclusion of health assessments).

Tier 1 payments currently carry the lowest financial value, but probably require the most significant reorientation of clinical practice towards high quality chronic illness care. The small number of Tier 1 payments indicates that few services have been influenced to change their systems in a way that increases delivery of the sort of planned and multi-disciplinary care that is required to trigger a Tier 1 payment. It appears that the financial value of the Tier 1 payment will need to be significantly increased to achieve the change that this incentive is designed to achieve.

‘There is currently a $250 registration payment; if there is a reduction in this it would make no different to me as a GP as I’m on a salary so no direct effect. If the patient registration was abolished I would propose loading the money into the Tier 1. I suggest directing the Medicare incentives to where they work – incentives into developing long-term relationship with patients, similar to the diabetes cycle of care payments which triggered payment once the service was provided to the patient.” (Interviewee, AHS, GP)

The major objection to removal of the patient registration payment would almost certainly be from services for which this has become a significant source of revenue. Concerns over loss of this income could be allayed by increasing the value of other incentives.
2. Best practice management of chronic disease

Should all PIP IHI registered patients receive a Health Check (MBS 715)?

The limited use of follow-up items raises questions about the effectiveness of health assessments as a catalyst for enhancing access to preventive care and chronic disease management. (Bailie et al. 2014; Bailie et al. 2019) There is clear evidence of lack of follow-up from the Indigenous-specific health assessments (MBS 715). (Bailie et al. 2013; Bailie et al. 2014; Dutton et al. 2016; Bailie et al. 2018; Bailie et al. 2019) Constraints to provision of follow-up care included practitioners' lack of awareness of item numbers, staffing, poor state of clinical information systems, billing against non-Indigenous-specific items or more general follow-up items, emphasis on health assessments with less attention to requirements for follow-up, limited capacity to arrange and facilitate follow-up, and communication and transport challenges for patients. (Bailie et al. 2014) Given the concerns raised about administrative burden for the PIP-IHI and the identified gap in effective use of clinical information systems for effective recall and reminder it does not seem appropriate to add another item of care that requires good system supports, such as preventive health assessments.

3. Provision of culturally appropriate care

Do the current PIP IHI guidelines facilitate culturally appropriate care for Aboriginal and Torres Strait Islander patients? Is a requirement that cultural awareness training be undertaken appropriate for health practices?

Following initial delays, access to and uptake of cultural awareness training was fairly well established by the end of the SSE (2013). On-line and face-to-face training was being used and valued. Changes in practices at General Practice as a result of the training included making the physical environment more welcoming to Aboriginal and Torres Strait Islander patients; increasing sensitivity to terminology; greater appreciation of cultural responsibility and impact on attendance at Health Services; and greater confidence in practices for identifying Aboriginal and Torres Strait Islander clients. Remaining gaps at the time of the SSE included lack of clarity regarding adequacy of training for meeting the needs of overseas trained doctors and meeting the needs in situations of high staff turnover – this was for all Health Services. A reported strength of the PIP IHI was the requirement for cultural awareness training for General Practices, where even relatively small inputs have resulted in changes that seem likely to improve the accessibility of General Practice to Aboriginal and Torres Strait Islander patients. (Bailie et al. 2013)
References


