Redesigning the Practice Incentives Program

Department of Health Consultation Paper

November 2016

Table of Contents

1 Overview 1
2 Does the Current PIP Promote Quality Improvement? 2
2.1 Why redesign the PIP? (Section 2.1) 2
3 Broader Government and Public Sector Reform 3
3.1 Broader government and public sector reform (Section 4) 3
4 Conclusion 5

1 Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Department of Health consultation paper on *Redesigning the Practice Incentives Program*.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

The AHHA in general supports moves towards redesigning the Practice Incentives Program (PIP), towards a more simplified system with greater emphasis on quality improvement. It is vital that the health system is organised and incentivised to ensure that primary healthcare achieves quality health outcomes for patients and operates as efficiently as possible. Improving the PIP through the use of improved data and data systems, and continuous quality improvement will strengthen the focus on quality health outcomes for patients. A flexible and adaptable PIP should also recognise regional variability and enhance quality improvement activities focussed on issues specific to practice populations.

While well-designed pay-for-performance programs may have the potential to narrow socio-economic disparities in healthcare and improve patient outcomes, poorly designed or implemented pay-for-performance programs risk perverse outcomes resulting from gaming, non-compliance, misreporting, poorly chosen performance targets and poor participation particularly by those practices with the greatest need for improvement.[1,2,3] It is essential that redesign of the PIP is approached cautiously taking note of lessons from previous experiences and from those documented in the literature to minimise unintended consequences.

While AHHA welcomes investment in the redesign of the PIP as a means of attempting to improve service delivery, quality of care and patient outcomes, it is imperative that ongoing monitoring and evaluation arrangements are in place, the program is transparent and responsive to actual achievements, and modifications are made where necessary, including eliminating those incentives that have become ineffective.

Primary Health Networks (PHN) should retain a key role in supporting practices. PNHs have an existing relationship with the practices in their area and are aware of their capacity and capability to drive change. PHNs have a whole of region view and offer additional resources to support these practices as they adopt new funding models and models of care.

The Commonwealth must ensure that short-term rational decisions aimed at improving the PIP should not be at the expense of long-term sustainable health outcomes or broader whole-of-system technical efficiency.

[1] Partel K 2014, 'Can we improve the health system with pay-for-performance?', *Deeble Institute Issues Brief No 6*, Deeble Institute for Health Policy Research, Canberra.

[2] Sutherland JM 2012, 'The long-term effect of premier pay for performance on patient outcomes', *The New England Journal of Medicine*, vol. 366, no. 17, pp. 1606-1615.

[3] Wright M 2012, 'Pay-for-performance programs: do they improve the quality of primary care?', *Australian Family Physicians*, vol. 41, no. 12, pp. 989-991.

2 Does the Current PIP Promote Quality Improvement?

2.1 Why redesign the PIP? (Section 2.1)

Consultation question:
- What elements of the current PIP should be kept and which should change?

AHHA advocates for health reforms that maintain and improve health outcomes, and support equity, accessibility and sustainability of the broader Australian health system to the benefit of the whole community. Despite a large financial investment in the PIP since its inception in 1998, evaluation of the Program has shown some modest, short-term impacts, with an absence of long-term improvements in patient outcomes and quality of care[4,5].

Redesign of the PIP should support Australian health system objectives and maintain elements of previous PIP approaches that have shown promising effects, including:

- Focussing on national health priority areas (for example, diabetes mellitus, asthma, cardiovascular health, obesity, and Aboriginal and Torres Strait Islander health).
- Utilising clearly defined, standardised outcomes, targets or care quality markers for particular diseases that align with program objectives to allow data collection and comparison across practices/regions, particularly for national health priority areas.
- Utilising sufficient, equitable and transparent incentives that are adequate to promote change, but not too large such that they result in inappropriate claiming and perverse outcomes.
- Continued access to the PIP by Aboriginal Community Controlled Health Organisations, Aboriginal Health Services and those organisations providing primary healthcare to Aboriginal and Torres Strait Islanders.

While AHHA supports the redesign of the PIP, a number of concerns need to be addressed in future designs of this program, including:

- Development and collection of a national primary healthcare minimum dataset, to enable the effective evaluation and monitoring of the PIP[6].
- Use of targets that measure patient outcomes and care quality rather than practice infrastructure and service quantity.
- Utilisation of rigorous, verifiable and auditable data collection methods and analysis, to improve accuracy of results and to minimise non-compliance and gaming[7].
- Continuous transparent evaluation of PIP outcomes and cost-effectiveness to enable adaptation or removal of ineffective incentives.
- Definitions of performance using absolute and relative thresholds, with progression over time in recognition of continued improvements in quality of care.
- Ensuring risk-adjustment methodologies are integrated into the program.
- Reduction in the administrative burden for practices or practitioners claiming the PIP.

---

[4] Greene J 2013, 'An examination of pay-for-performance in general practice in Australia', *Health Services Research*, vol. 48, pp. 1415-1432.

[5] Wright M 2012, 'Pay-for-performance programs: do they improve the quality of primary care?', *Australian Family Physicians*, vol. 41, no. 12, pp. 989-991.

[6] Primary Health Care Advisory Group 2015, *Better Outcomes for People with Chronic and Complex Health Conditions*, Commonwealth Department of Health, Canberra.

[7] Nell AL, Nelson MR, Richardson T, Mann-Leonard M and Palmer AJ 2015, 'General practice after-hours incentive funding: a rationale for change', *Medical Journal of Australia*, vol. 203, no. 2, pp. 82-86.

- Structures and processes to support quality improvement should tap into intrinsic motivation rather than solely rely upon extrinsic motivation (financial incentives), this could potentially involve providing feedback at the practice/practitioner level compared with peers on clinically relevant measures of patient outcomes[8].
- Increased whole of practice team approach to health care provision, with recognition of changing roles in the primary health workforce.
- Methodology that complements the Health Care Homes model, supporting innovative care practices around chronic disease management.
- PHN should retain a key role in supporting practices due to their existing relationship with the practices in their area and awareness of their capacity and capability to drive change. PHNs have a whole of region view and offer additional resources to support these practices as they adopt new funding models and models of care.
- Strengthening of consumer engagement and participation.
- Facilitating collaboration between practices to share quality improvement project methodology and outcomes, allowing effective changes to be propagated.
- Encouraging multi-layered approaches to improving quality of care and in designing quality improvement projects. This should encourage integration, collaboration and multidisciplinary care and should allow for local, regional and national collaborations.
- Providing support around quality improvement and methods/structures to reduce perceived difficulties, including clear and simple examples of quality improvement projects that can be replicated to encourage participation.

3 Broader Government and Public Sector Reform

3.1 Broader government and public sector reform (Section 4)

Consultation question:

- What is the best way to ensure the PIP funds meet the principle for efficient, effective, economical and ethical use of public money?

AHHA strongly agrees that public funds should be used in an efficient, economical and ethical manner to ensure value and to warrant continued investment in the PIP.

AHHA accepts that pay-for-performance programs such as the PIP aim to improve patient outcomes by driving evidenced-based practice, continuous quality improvement, incremental change and reforms. However, current research provides very limited evidence connecting these goals with pay-for-performance programs[9,10,11]. Hence, careful consideration is needed to maximise any potential positive impacts in PIP reforms.

Program redesign must ensure that new incentives such as the Quality Improvement in General Practice PIP are closely monitored and evaluated against delivery of clearly defined objectives, targets and outcomes. This will require careful consideration during program development and

[8] Greene J 2013, 'An examination of pay-for-performance in general practice in Australia', *Health Services Research*, vol. 48, pp. 1415-1432.

[9] Sutherland JM 2012, 'The long-term effect of premier pay for performance on patient outcomes', *The New England Journal of Medicine*, vol. 366, no. 17, pp. 1606-1615.

[10] Greene J 2013, 'An examination of pay-for-performance in general practice in Australia', *Health Services Research*, vol. 48, pp. 1415-1432.

[11] Wright M 2012, 'Pay-for-performance programs: do they improve the quality of primary care?', *Australian Family Physicians*, vol. 41, no. 12, pp. 989-991.

implementation to minimise risks, maximise the most effective methodology and practises, and to evaluate the effectiveness of the program.

The focus of a new Quality Improvement in General Practice PIP should be around flexibility, support of innovative care models, whole practice team approaches, transparency and information sharing. Changes to the PIP should also complement phase 1 implementation of the Health Care Homes program.

Program redesign must ensure that the objectives are defined for the Quality Improvement in General Practice PIP to achieve desired outcomes including making quality improvement implicit in the culture of primary care practices, while still allowing for flexibility across practices and practice populations to initiate programs that are responsive to local community needs.

A new Quality Improvement in General Practice PIP should demonstrate and incorporate the following principles:

- Evaluation and monitoring of the PIP to measure its effectiveness and cost-effectiveness in achieving specified objectives and targets, with recognition of relative and absolute change and unintended consequences. These aggregated results should be made publicly available.
- An approach that complements current primary healthcare reforms including the Health Care Homes trial and implementation of My Health Record.
- Standardised quality or outcome indicators for particular diseases, it is important that these markers are not just selected for their ease and cost of measurement. These indicators must be validated and should be evidenced-based markers of outcome, this may involve a single outcome measure or alternatively a small panel of indicators including structural, process and outcomes based measures to identify improvement in care quality and patient outcomes. This would also involve moving away from process or infrastructure based measures.
- Encourages multi-layered approaches to improving quality of care and in designing quality improvement projects. This should enhance integration, collaboration and multi-disciplinary, team-based care and should allow for local, regional and national collaborations.
- Encourages team-based care, innovative models of care and progression towards enhanced roles in the primary healthcare workforce, enabling all healthcare professionals to work to the full extent of their scope of practice.
- Provides guidance for quality improvement processes and methods to reduce perceived difficulties. This should include clear and simple examples of quality improvement projects that can be replicated to promote participation and ongoing support, and an IT hub for practices and practitioners to share learnings and methodology, to benchmark performance and to enable the Department of Health to provide feedback to practices.
- An approach that is person-centred, strengthening consumer participation and engagement in quality improvement processes and healthcare.
- Reduced administrative and reporting burden through streamlined reporting and the automatic collection of data.
- Financial incentives that adequately encourage improvement, while not being too high as to result in increased health system costs and perverse outcomes.

4 Conclusion

While AHHA supports the government's policy intent of reforming the Practice Incentive Program to include a quality improvement incentive, a number of concerns need to be addressed.

The Commonwealth must rectify the shortage of adequate data across the Australian primary healthcare setting. The PIP reform process highlights the need for a primary healthcare minimum dataset to guarantee effective monitoring and evaluation of patient outcomes in response to the program and any reforms. This dataset should utilise meaningful and evidenced-based patient outcomes to support informed decision-making into the future and to benchmark general practice performance. Evaluation and monitoring of the PIP must focus on patient outcomes and quality of care, rather than one-off infrastructure changes or volume based metrics. This will promote healthcare achievements that align with national health priorities and that are relevant to patients and the community.

Any reforms made to the PIP must seek to complement current primary healthcare reforms, including the Health Care Homes trial and implementation of My Health Record. Primary Health Networks should also retain a key role in supporting practices. This will foster moves towards a person-centred, team-based primary healthcare system that is innovative and supports continuous quality improvement. Additionally these changes must recognise differences between practices and practice populations, allowing flexibility in the focus of quality improvement projects.

Australian Healthcare and Hospitals Association
Unit 8, 2 Phipps Close

Deakin ACT 2600
PO Box 78

Deakin West ACT 2600
P: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: ahha.asn.au
@AusHealthcare
facebook.com/AusHealthcare
linkedin.com/company/australian-healthcare-&-hospitals-association
ABN: 49 008 528 470