AHHA Submission to the Effectiveness Review of General Practice Incentives

21 December 2023

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to contribute to the Department of Health and Aged Care's Effectiveness Review of the General Practice Incentives.

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, aged care and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

OUR RESPONSE

As stated in the Strengthening Medicare Taskforce report, the Commonwealth government must rethink how general practices and other primary care providers are funded. The report further states that funding models should specifically incentivise continuity of care across a patient's healthcare journey, address inequity of access and outcomes for priority population groups, and reorient care around what matters to people and communities.

Due to its siloed nature, being general practice only, the Practice and Workforce Incentives Programs is an inappropriate and inadequate mechanism to enact the proposed funding changes outlined in the Strengthening Medicare Taskforce report; excluding care providers beyond general practice who are required to improve care across a person's whole care pathway. In addition, not all practices in Australia participate in the program, which is designed to incentivise only a limited array of improvement activities. This does little to effectively shift primary care funding from paying for activity/outputs towards paying for outcomes and impact.

In this regard, value-based payment models must be considered in the context of this Incentives review, as these models are designed to incentivise person-centred, collaborative care among a wide range of multidisciplinary healthcare professionals to achieve outcomes that matter.

Value-based health care (VBHC) is a framework for restructuring health care to focus on facilitating the best possible improvements in the outcomes that matter to people and communities for the cost of achieving those improvements, across a full pathway of care. It has begun to be adopted across Australia, in States and Territories, Primary Health Networks (PHNs) and health services. The quadruple aim, which includes aims to improve health outcomes that matter to patients, experiences of receiving care, experiences of providing care and the effectiveness and efficiency of care, aligns with VBHC. Further, the 2020-25 Addendum to National Health Reform Agreement provides opportunities to progress VBHC approaches, including joint planning and funding at a local level, enhanced health data, and paying for value and outcomes.

Funding for outcomes over outputs is the direction towards which health reform in Australia is heading. However, Australia is not yet ready to enact funding for outcomes reform. Several policy changes need to occur first to increase the health sectors capacity for outcome measurement.

FUNDING FOR VALUE AND OUTCOMES

The Deeble Institute Health Policy Issues Brief, 'A roadmap towards scalable value-based payments in Australian health care', authored by Professor Henry Cutler, Inaugural Deeble Institute Fellow and Inaugural Director, Macquarie University Centre for Health Economics (MUCHE), Macquarie University, explores the barriers and enablers of moving towards a value-based payment model in Australia, and provides a series of recommendations as to how these reforms can occur[1].

In this regard, the Brief notes, 'Value-based payments are a necessary step towards securing Australia's healthcare system sustainability', but to prevent policy failure there are important policy steps that need to be taken before funding reforms are designed and introduced.

Among others, recommendations include:

- Develop a national 10-year plan for value-based payment integration into the Australian healthcare system.
- Improve cost and outcome data collection, analysis and access among government and providers, aiming for seamless, low cost collection and effective flow of information.
- Support provider education, training and innovation by identifying and promoting best practice care, developing provider assistance tools and training packages, and promoting peer-to-peer learning.

AHHA supports the exploration and adoption of VBHC payment models within the Australian system where the evidence supports their implementation. Future policy considerations, including those put to the Commonwealth government at the conclusion of this review, must emphasise the need to first enable the data measurement required to build a robust evidence base. This would facilitate the implementation of the most suitable models and justify appropriate, equitable and meaningful investment and funding decisions.

EVALUATING THE INCENTIVE PROGRAMS

Evaluation of the effectiveness of the Incentive Programs is impeded by the scarcity and incompleteness of available primary care data[2]. For example, there is a gap in the PIP statistical data published by Services Australia until 2016[3] and the data published since 2021 by AIHW, which is only on the 10 Improvement Measures of the Quality Improvement (PIP) program[2].

Traditional volume over value measurement approaches adopted to monitor and evaluate the Incentive Programs further exacerbates the knowledge issues created by data shortages. While inexpensive and simple to collect, process and output metrics do not capture the impact and effectiveness of service improvements or activities on patient health and wellbeing outcomes.

In practice, the evaluation and measurement design has had the unintended consequence of incentivising increases to the quantity rather than quality of services provided, similar to the fee-for-service model the Incentive Programs were introduced to counter[4]. For example, the GP Aged Care Access Incentive provides payments quarterly based solely on the number of eligible services provided to Residential Aged Care Facilities, rather than indicators of the 'quality of services provided'[5].

In addition, the Department of Health and Aged Care also relies on participation rates of practices in the Incentive Programs as a substitute measure for the quality and accessibility of care provided. Participation rates are not the best measure of quality or accessibility of care and should only be relied upon as measures of effectiveness if there is strong evidence to link the activities required in the Incentive Programs to improved health outcomes for consumers. Consequently, better indicators are needed to accurately monitor and evaluate the effectiveness of the Incentive Programs and meet strategic objectives to provide quality care, enhance capacity, and improve access and health outcomes.

OUTCOME MEASUREMENT

Without the critical insight provided by accessible and centralised outcomes data, the evaluation of the impact, effectiveness, efficiency and outcomes of the GP Incentive Programs will not yield the lessons needed to base the reforms called for in the Strengthening Medicare Taskforce report.

To incentivise investment in innovation that promotes equitable outcome improvements and to maximise the success of future value-based funding models in Australia, we must first invest in strengthening outcome measurement.

International evidence demonstrates that the first step to transforming a health system for value is to embed effective outcome measurement processes. In NHS Wales, for example, outcome measures such as PROMs have been demonstrated to support the delivery of value at the micro (relationship between patient and professional), meso (processes of care, pathways), and macro (population health) levels.

At the micro level they have enabled the delivery of more individualised care targeted at the outcomes that matter to the individual. At the meso level, co-ordinated PROMs collection has enabled services to identify areas of relative good and poor outcomes through benchmarking, enabling targeted programs and improved clinical performance. At the macro level, PROMs collection has facilitated the development of collated datasets to support decision makers and funders to make decisions based on need and to assess the effectiveness and cost effectiveness of care[6].

Australia cannot expect to develop effective funding models that are focused on improving outcomes when we do not have appropriate outcomes data to inform the development of such models or to subsequently assess their effectiveness. Investment must first focus on enhancing the maturity of outcome measurement in Australia and strengthening the capacity of healthcare professionals and decision makers to understand and use these measures before moving to the development of new funding models. If this does not occur, we risk:

- undermining equity though making investment decisions based on advocacy rather than evidence,
- developing funding models that fail because we have insufficient information to develop appropriate incentives that effectively balance provider and funder risk,
- introducing funding models that exacerbate the low value in current care processes.

INFRASTRUCTURE AND INTEROPERABILITY

With general practice electronic health records currently unregulated, there is inconsistency in the use of clinical terminologies and classifications and insufficient infrastructure to support outcome measurement. This impedes the interoperability and data linkages required to ensure outcomes data is in the right format, timely and of sufficient quality to support decisions within care relationships and inform improvements in performance through all levels of the health system[6].

To inform the appropriate design of Incentive Programs, data infrastructure and digital interoperability must be in place to enable linked data that is able to form a holistic understanding of health care needs. Alignment and coordination with the implementation of the *National Healthcare Interoperability Plan 2023-2028* can support this.

WORKFORCE

Ineffectiveness and inefficiencies of the current health system have placed significant pressure on the health workforce. The fragmented nature and high administrative burden of current funding arrangements, including the Incentive Programs funding, must be systematically addressed to ensure the workforce is supported to deliver quality care and improve care access for priority populations and in priority locations.

However, changing the way healthcare is funded will inevitably create substantial upfront costs for providers. This includes those costs associated with 'investing in new relationships, better information technology and data analysis skills, new models of care and new governance and risk management practices.'[1]. These costs cannot be ignored, and practices must be adequately supported during any transition process.

Supporting the workforce to shift to new funding structures must occur as part of a long-term reform vision that includes adequate resourcing support and transparent timeframes. In particular, consideration must be made to address the burdens in rural and remote practices to ensure that the provision of quality care is accessible to all Australians regardless of their regionality and determinants of accessibility.

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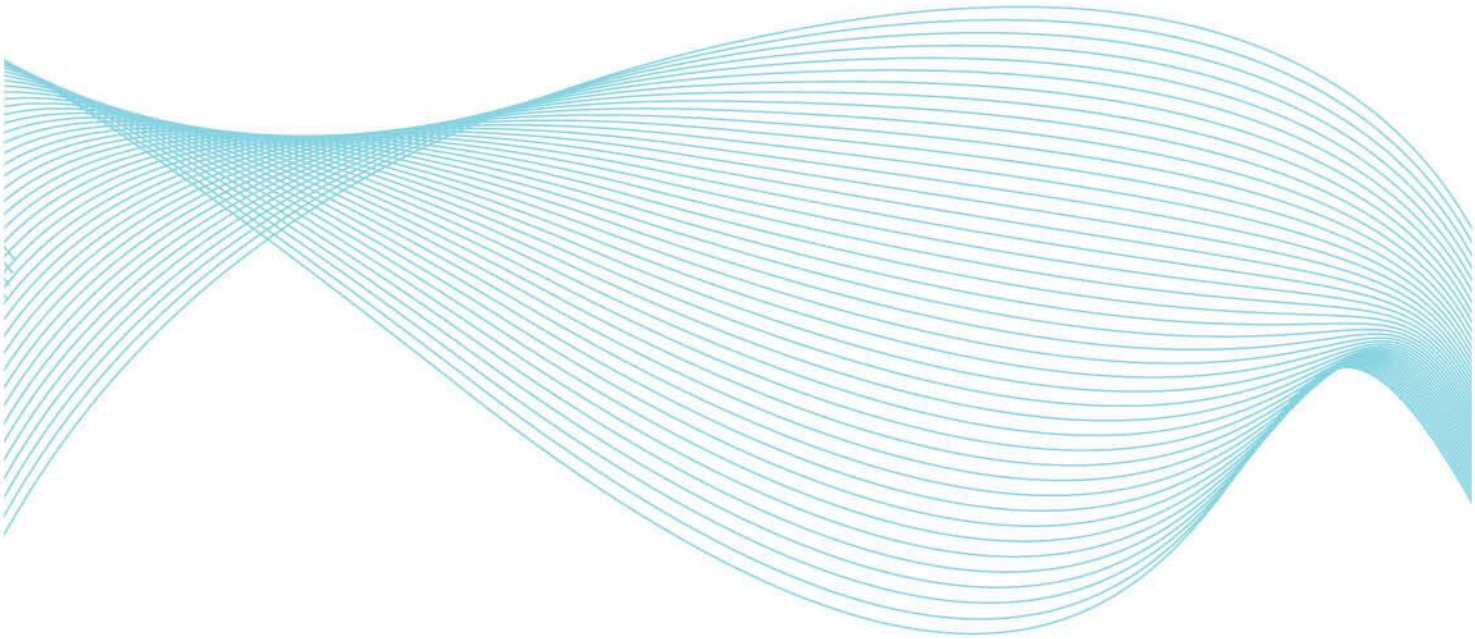

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