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Review of General Practice Incentives

Introduction

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) is the peak body for Aboriginal Community Controlled Health Services (ACCHSs) in the Northern Territory. ACCHSs are valued for the provision of culturally appropriate, holistic primary health care and are well positioned to address barriers to accessing health care.

This submission outlines the feedback and recommendations of the ACCHS sector in the NT with regards to the Workforce Incentive Program (WIP) and Practice Incentive Program (PIP). This includes discussion points from consultations with KPMG on 04 December 2023 and 07 December 2023. AMSANT notes, however, that the feedback process occurring over a short time period late in the year when many organisations are on reduced staffing limits the capacity to obtain meaningful feedback from a wide range of services.

Domain 1: Impact (on policy objectives)

Considerations for the Review noted in the consultation document "include fostering a more person-centred approach and encouraging collaborative care among a wide range of multidisciplinary healthcare professionals". The ACCHS model of care provides complex and comprehensive care to Aboriginal and Torres Strait Islander patients by multidisciplinary teams in a culturally responsive manner. When considering how to achieve these goals in the Australian health system, the ACCHS sector should be viewed as existing experts and leaders in collaborative care.

Recommendations:

1. The ACCHS sector should be viewed as existing experts and leaders in collaborative care.

Domain 2: Effectiveness (in influencing system reform)

The PIP rural loading is designed to recognise the difficulties of providing care in rural and remote areas; however, the current system disadvantages remote and very remote communities. Using the Rural, Remote and Metropolitan Areas (RRMA) model to classify remoteness rather than the Modified Monash system, RRMA Code 6 (remote centres) are given a 25% loading whereas RRMA Code 5 areas are given a 40% loading (Services Australia, 2023). This means that remote centres such as Alice Springs, where there is a severe workforce crisis, receive less in loading than rural areas such as Byron Bay that are much less remote. This should be amended so that the needs of remote areas are better addressed. The Modified Monash Model (MMM) was developed and updated more recently than RRMA (Department of Health, 2019). It would be a more useful measure of remoteness for applying rural

loading and would achieve consistency with WIP, which is more streamlined for health services to maintain awareness of their classification across one system. The rural loading should be graded so that MM7 receives a 100% loading and MM6 receives a 50% loading. This is because there is a big jump in cost of service delivery from MM6 to MM7 (including higher salaries, cost of accommodation and transport, additional leave requirements for very remote staff and other expenses) that needs to be recognised.

The PIP Indigenous Health Incentive is intended to support the overburden of chronic disease; combining the Patient Registration payment and Outcomes Payment Tiers 1 and 2, this can add up to $500 per patient per calendar year. Removing the Indigenous Health Incentive as part of a review of the PIP would widen the disparity in burden of disease. It is essential that the targeted Indigenous Health Incentive remains.

Aboriginal Health Practitioners (AHPs) working in ACCHSs have a scope that is equivalent to registered nurses and now are required nationally to be registered through AHPRA, but they currently receive the same WIP Practice Stream incentive rate as Aboriginal Health Workers (AHWs) ($16,250 per year per SWPE value of 1,000). This should be amended so that AHPs receive the equivalent incentive rate to nurses ($32,500 per year per SWPE value of 1,000).

Standardised Whole Patient Equivalent (SWPE) is weighted by gender and age, which overlooks the burden of chronic disease at a younger age in Aboriginal and Torres Strait Islander people compared to the general population. Weighting should be calculated by gender and age according to Indigenous status.. The weighting for Aboriginal status should be at least 50%, given the much earlier onset of chronic disease and high rate of complex multimorbidity combined with higher rates of poverty and social disadvantage in Aboriginal people (AIHW, 2015; AIHW & NIAA, 2023).

Recommendations:

2. Change to using the Modified Monash Model system of classifying remoteness for PIP rural loading.
3. Appropriately increase the PIP rural loading for remoteness with a doubling between MM6 and MM7. .
4. Retain the PIP Indigenous Health Incentive.
5. Increase the WIP Practice Stream incentive payment for Aboriginal Health Practitioners (AHPs) to be equivalent to nurses' incentive rate.
6. Standardised Whole Patient Equivalent (SWPE) should include weighting by Indigenous status by at least 50%.

Domain 3: Efficiency (admin processes, eligibility, payment streams)

ACCHSs, particularly in remote areas, have different processes and needs from mainstream GP services, which should be reflected in the implementation of the PIP.

Designation of a 'home' practice can be difficult for clients in remote areas with high mobility between communities who may therefore receive equal amounts of care at multiple health services. Similarly, clients may spend time between remote and urban areas (including for healthcare needs such as being required to relocate for treatments such as dialysis or chemotherapy) and may therefore receive care at both remote and urban health services. These circumstances may result in shared care between two ACCHSs, or between an ACCHS and a government health service – or in rarer cases, private general practice. Such mobility of clients blurs the definition of 'resident' and 'visitor' to a clinic, and therefore how they should be enrolled. ACCHSs that share care of clients with another service are therefore disadvantaged by rules that restrict incentive payments to 'home' clinics. A balance may be for Chronic Disease Management items to only be completed by home clinics, but other services such as the 715 health check should count towards incentives even if completed outside the home clinic.

The shortage of general practitioners is impacting on the capacity to complete MBS items that require on site doctor review – particularly care plans and reviews of care plans. This is going to severely impact on PIP Payments in very remote ACCHSs - but more importantly, it also impacts on chronic disease care. A Telehealth care plan should be introduced. Initially this could only be in MM6/MM7 areas and in all ACCHSs and could require an on-site clinician (such as a nurse or AHP) to review the patient, before completing the consultation with the GP by Telehealth. The justification for all ACCHSs being able to access this is the ongoing significant shortage of general practitioners within the sector and the high burden of chronic disease in Aboriginal people. There should be no loss of quality with this arrangement given the extended scope of practice of nurses and AHPs and the well developed multidisciplinary model operating in the community controlled health sector.

The introduction of MyMedicare registration will result in Indigenous clients having to register for both MyMedicare and the Indigenous PIP system – these processes should be streamlined to reduce the administrative burden on both patients and ACCHSs. NACCHO and affiliates should be supported to lead the process of identifying issues that affect the sector and advising on solutions- this should not be the role of PHNs given ACCHS affiliates' deep knowledge of the sector. Further, as these issues are likely to also affect patients outside the ACCHS sector (including Indigenous people who use non-ACCHS primary care services), it is likely that rules that improve the efficiency of incentive programs in the ACCHS sector would also benefit mainstream services. It has been proposed that enrolment in the Indigenous PIP would automatically enrol Aboriginal people in My Medicare but this change is not going to commence for another 12 months at the time of writing (January 2024). This is a welcome development but will mean that services will need to enrol people in both schemes for twelve months. Given the high administrative burden of PIP incentives, the streamlining of Indigenous PIP and MyMedicare should be brought forward to March 2024.

Member services' feedback indicates that the WIP Practice Stream payment is not always sufficient to justify the administrative burden of reporting and is therefore not an efficient use of the incentive. ACCHSs are generally not resourced to carry out the administrative tasks of incentive programs. Very

remote services often have very limited administrative staff particularly at the clinic level, so clinicians often need to undertake administrative work at a time of severe clinical workforce constraints. The amount of funding received by services is not commensurate with the administrative burden across many of the PIP incentives. The incentive should be increased to account for this and administrative processes should be streamlined.

Recommendations:

7. While Chronic Disease Management items should only be completed by home clinics, other services such as the 715 health check may be completed by other services.
8. A telehealth item for care plans and care plan reviews should be introduced for all services in MM6 and MM7 locations and for all community controlled health services. There should be a requirement that an on site clinician is involved in the care planning process.
9. NACCHO and affiliates should be supported to lead the process of identifying issues with MyMedicare implementation that affect the ACCHS sector and advising on solutions.
10. Bring the new PIP permanent enrolment system forward to March 2024, linked to MyMedicare so that patients only have to be enrolled in one scheme from March.
11. Increase the WIP Practice Stream payments and review/streamline administrative processes for all PIP Payments.

Domain 4: Sustainability

Long-term effectiveness of incentive programs will require effective communication processes; however, member services have encountered a number of communication issues that generated administrative and financial burden. An ACCHS reported reclassification of MMM level without notification or warning, and the same ACCHS's funding was changed from quarterly to annually also without notification. This meant the ACCHS was not able to plan financially for the reduction in the Rural Loading and change in funding schedule. Finally, member services reported that COVID-19 payments were stopped without notification. Effective communication also requires the ability for services to respond to changes or other issues relating to WIP and PIP funding through a clear appeals process – services report that they are not aware of any current feedback or appeal mechanisms.

The WIP is capped at 4,000 SWPE value per quarter (DoHAC, 2023). Some larger ACCHSs may provide services for up to 17,000 clients; a cap on incentive payments disadvantages these services. The incentive payment cap should be removed to facilitate equitable payment to larger ACCHSs.

A positive piece of feedback was that ACCHSs have not needed to provide CQI data (Aboriginal Health Key Performance Indicator data) to access the Quality Improvement Incentive of the PIP. ACCHSs all currently report on national key performance indicators with this data being provided to the Commonwealth and ACCHSs also share clinical data with AMSANT and NACCHO to support CQI

activities. Avoiding data over-distribution is respectful of Indigenous data sovereignty principles and should not be changed.

There is a current severe workforce crisis in the NT (particularly outside of Darwin) and other very remote areas. One third of the vacancies in the Aboriginal primary health care system are in the NT despite the NT making up less than 10% of the Australian Aboriginal population. Nationally, over half of the workforce vacancies in Aboriginal primary health care were in remote or very remote areas (AIHW, 2023). The majority of the NT Aboriginal population live in remote or very remote areas where the workforce crisis is most acute. The impact of this workforce crisis on chronic disease outcomes will be substantial given that continuity of care and development of trusting relationships is central to effective long term care, particularly in cross-cultural contexts.

Aboriginal people have very high and growing rates of chronic disease – for example, Central Australian Aboriginal people have the world's highest rate of type two diabetes, and Northern Australia also has one of the world's highest rates of diabetes in pregnancy and diabetes in children and young people (Hare et al 2022, Hare et al 2020, Titmuss et al, 2022). Additionally, rates of preventable hospital admissions for Aboriginal and Torres Strait Islander people are highest in remote and very remote areas, with rates overall increasing by 20% between 2013-2014 to 2018-2019 (AIHW, 2023b). An NT study found that rates of hospitalisation were lowest for those with medium rates of access to primary health care compared to those with low and high access (those with high access were likely to be the sickest and thus highest users of both primary healthcare and hospital services). There was substantial reduction in rates of hospitalisation for renal disease (rates reduced by approximately 80% and cardiovascular disease (rates reduced by 65%) in those with medium access to primary healthcare compared to those with low access.

Remote area nurses are the most common clinician working in Aboriginal primary healthcare. Remote area nurses and AHPs have an expanded scope of practice based on protocols in the Remote Primary Health care manuals used in the NT and other remote regions. This scope of practice is similar to that of a nurse practitioner in less remote contexts. AHPs are central to safe effective care and bear a high burden of responsibility given that they live in community and can be contactable out of hours at any time by community members. Midwives are also essential to safe childbirth and improved pregnancy outcomes and can also be endorsed for a wider scope of practice.

General practitioners already receive workforce retention payments that reward doctors for working in remote areas for longer periods. This needs to be extended to nurses, midwives and AHPs, with tiered payments for MM6 and MM7 areas, and set at a level that will reward retention similar to current GP payments given the costs of remote living are similar for any profession.

There could be consideration of a top-up payment for any clinician that works in the same organisation in MM7 regions for longer periods. Linking this incentive to an organisation rather than a community would support operational requirements of services (such as moving staff to short-staffed clinics to

maintain service delivery) whilst still incentivizing clinicians to stay in one region in order to improve cross-cultural understanding, and relationships with communities and individuals.

Urgent action needs to be taken to improve GP/population ratios in MM6/MM7 areas, particularly in those regions with high Aboriginal populations where the need is most acute. If other measures have not been introduced within 12 months, the WIP retention payments should be increased particularly in MM7 areas where the shortages are most acute.

Currently, the PIP after-hours payments are tiered to provide the highest rewards to services providing '24/7' care. However, the magnitude of the increase in payments from Level 2 (four dollars per SWPE for care up to 11pm during weeknights in a cooperative arrangement), to Level 5 (11 dollars per SWPE for 24/7 care) does not reflect the real cost of providing this level of care, particularly in very remote areas. There should be graded increases in payments for MM6 and MM7 areas (so that the payment is at least double in MM7 areas) and the SWPE cap should be removed.

Recommendations:

12. Introduce WIP payments for nurses, midwives and AHPs set at a similar level to general practitioners.
13. Increase PIP for general practitioners particularly in MM7 if other measures to improve access to GPs in remote and very remote areas are not making a difference within 12 months.
14. Review and improve communication with ACCHSs for anticipated changes to WIP and PIP programs. Program changes must be communicated in advance.
15. Establish and/or clarify a clear appeals process for program changes or other issues.
16. Remove the incentive payment cap to facilitate equitable payment to larger ACCHSs for all PIP payments.
17. ACCHSs should be allowed to continue accessing the PIP Quality Improvement Incentive without having to provide Aboriginal Health Key Performance Indicator data.
18. Increase the After-hours PIP incentive rate for MM6/MM7 areas, with the MM7 payment being at least double the base payment.

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