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Audit Report No.5 2010–11
Performance Audit

Practice Incentives Program

Department of Health and Ageing

Medicare Australia

Australian National Audit Office

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Canberra ACT
15 September 2010


Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and Ageing and Medicare Australia in accordance with the authority contained in the *Auditor-General Act 1997*.

Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled *Practice Incentives Program*.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—<http://www.anao.gov.au>.

Yours sincerely


Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

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Abbreviations and Glossary

Australian Commission on Safety and Quality in Health Care	The Commission was established by the Australian, state and territory governments to develop a national strategic framework and associated work program that will guide its efforts in improving safety and quality across the health care system in Australia
AGPAL	Australian General Practice Accreditation Limited (AGPAL) is the general practice accrediting body owned by health professional organisations.
Australian General Practice Network	Australian General Practice Network (AGPN) is the peak body representing a network of eight state-based entities and 110 local organisations that draw members from health professionals working in primary health care (commonly know as divisions of general practice).
BPA	A Business Practice Agreement (BPA) was finalised between the Department of Health and Ageing (DoHA) and Medicare Australia in May 2009 on Practice Incentive Payment (PIP) service delivery. It forms part of a broader Memorandum of Understanding (MOU) between DoHA, the Department of Human Services, and Medicare Australia.
Divisions of general practice	Divisions of general practice are local organisations drawing their membership from professional primary health care workers, primarily general practitioners and practices nurses working in general practice settings. DoHA funds the divisions primarily through the Divisions of General Practice Program.
Enhanced primary care MBS items	Enhanced primary care Medicare Benefits Schedule (MBS) items are those associated with extended care planning and management of chronic and complex medical conditions, aimed at encouraging general practitioners (GPs) to enhance their patient care.

GP	For the purposes of this report, GPs include general practitioners and/or non-specialist medical practitioners known as 'other medical practitioners', who provide non-referred services.
ISQua	International Society for Quality in Health Care (ISQua) is a non-profit, independent organisation which aims to improve safety and quality in health care. Its work includes accreditation of health standards and of health service certifying/accrediting bodies.
JAS-ANZ	Joint Accreditation System of Australia and New Zealand (JAS-ANZ) is the government-appointed body for Australia and New Zealand responsible for providing accreditation of accrediting/certifying bodies. Accreditation by JAS-ANZ is intended to demonstrate the competence and independence of these bodies.
NASH	National Authentication Scheme for Health (NASH) Program through NASH-accredited bodies will deliver smartcards with Public Key Infrastructure certificates to 500 000 health care providers (individual and organisations).
NEHTA	National eHealth Transition Authority (NEHTA) is a not-for-profit company established by the Australian, state and territory governments in 2005, to develop national e-health standards and infrastructure requirements for the electronic collection and secure exchange of health information.
QPA	Quality Practice Accreditation (QPA) Pty Ltd is the private sector general practice accrediting body.
RACF	Residential aged care facility (RACF) in this report refers to those facilities which are Commonwealth-funded.
RACGP	Royal Australian College of General Practitioners (RACGP).

RRMA	Rural, Remote, Metropolitan Area (RRMA) locality classification is used to determine the 'rurality' of each general practice, consistent with <i>Rural, Remote and Metropolitan Areas Classification (RRMA), 1991 Census Edition</i> (Departments of Primary Industries & Energy and Human Services & Health, November 1994).
Standards	RACGP's Standards for General Practice
SWPE	Standardised Whole Patient Equivalent (SWPE) is the basis for determining most PIP payment amounts. It is the sum of the fractions of care a practice provides to each of its patients, based on MBS billings, weighted for the age and sex of each patient.

Summary and Recommendations

Summary

Introduction

1. The Practice Incentives Program (PIP) aims to provide a flexible, cost-effective mechanism for the Government to encourage both short and long-term changes to general practice, to support quality care, and to improve access and health outcomes with a minimum of red tape.
2. In establishing the program objective, an inter-departmental committee (IDC)¹ report to government noted that any overlaps between PIP and other measures were mutually reinforcing rather than duplicative. The Government agreed to the objective in February 2006.
3. PIP offers 13 incentives with diverse aims to general practices and their general practitioners (GPs) to complement fee-for-service arrangements available through the Medicare Benefits Schedule (MBS) that reward high-volume, brief consultations. Examples of incentives include ones that encourage practices to: provide after-hours care for patients; equip their practices for secure, electronic transfer of patient information; and deliver recognised better practice care to patients with diabetes.²
4. PIP started on 1 July 1998. In 2009–10, approximately 4900 practices participated in PIP, making it the largest Australian Government program aimed primarily at general practices rather than general practitioners. Some \$282 million was paid to general practices and GPs under PIP in 2009–10, with an average payment to a practice of \$57 800. Eighty-two per cent of general practice care in Australia is delivered through PIP practices.³

Key characteristics of PIP payments

5. To participate in PIP, practices need to be accredited against the Royal Australian College of General Practitioners' (RACGP's) *Standards for General*

¹ The IDC comprising Departments of (then) Finance and Administration, Prime Minister and Cabinet, Health and Ageing, and Treasury, was established to advise government on the future directions for PIP.

² Table 1.1 outlines the PIP incentives and their individual aims.

³ Department of Health and Ageing, *2008–09 Annual Report*, p. 115.
<[http://www.health.gov.au/internet/main/publishing.nsf/Content/DD09CE2B6CC37536CA25765500144F4D/\\$File/Full%20Report%20of%20the%202008_09%20Annual%20Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/DD09CE2B6CC37536CA25765500144F4D/$File/Full%20Report%20of%20the%202008_09%20Annual%20Report.pdf)> [accessed 17 December 2009].

Practices (the Standards).⁴ Access to PIP payments is the primary reason for most practices attaining accreditation; approximately 67 per cent of all general practices⁵ are accredited.

6. Accreditation is undertaken by one of two entities approved by the Government for this purpose. One of these entities, Australian General Practice Accreditation Limited (AGPAL), was established with government assistance and is an industry-organised body governed by members of the health profession within a not-for-profit framework. The other, Quality Practice Australia Pty Ltd (QPA), is a for-profit agency formed to accredit general practices.

7. The level of PIP payments a general practice will receive is determined by the particular incentive adjusted, in the main, by the following factors:

- the Standardised Whole Patient Equivalent (SWPE), which is intended to be a measure of a practice's patient load being independent of the number of services provided to patients. It is based on the proportion of care a practice provides to each patient using the value of the patient's MBS fees, and then weighted using an age-sex factor. Over 75 per cent of PIP payments to practices use the practice's SWPE as a determinant; and
- the location of the general practice as determined by the rural, remote, metropolitan area (RRMA) classification, based on the population distribution from the 1991 Australian Bureau of Statistics Census of Population and Housing.⁶ General practices located in rural and remote RRMA classes have a loading of between 15 to 50 per cent added to other PIP payments.

Program administrative arrangements

8. The Department of Health and Ageing (DoHA) has overall policy responsibility for PIP and manages program planning (including eligibility

⁴ To promote access to high quality health care services, the Government supports general practice accreditation. General practice accreditation is voluntary, and does not affect eligibility for MBS payments relating to patient services.

⁵ The total number of general practices is based on self reporting through the 2007–08, Annual Survey of Divisions. <<http://www.phcris.org.au/fastfacts/fact.php?id=6752>> [accessed 14 October 2009].

⁶ Departments of Primary Industries & Energy and Human Services & Health, (1994), *Rural, Remote and Metropolitan Areas Classification* (RRMA), 1991 Census Edition.

criteria), monitoring and review. Medicare Australia processes all applications from general practices and undertakes the day-to-day administration of PIP, including ensuring compliance with program and payment eligibility.

9. PIP is not covered by specific legislation but rather is an executive scheme supported by appropriations. To support program service delivery, a memorandum of understanding (MOU) between DoHA and Medicare Australia was signed in May 2009. A Business Practice Agreement (BPA)⁷ that forms part of the MOU, addresses the service delivery of PIP by Medicare Australia and the administrative roles and responsibilities with respect to PIP.

Audit objective

10. The objective of the audit was to assess DoHA's effectiveness:

- in undertaking PIP program planning, program monitoring and review; and
- with Medicare Australia, in ensuring PIP program delivery to general practices and their medical practitioners.

11. In undertaking the audit, the ANAO considered the 12 incentives that comprised the PIP up to August 2009.⁸ The three most recently introduced incentives at the time of audit fieldwork, namely, Domestic Violence, GP Aged Care Access and eHealth incentives, were examined in greater detail and formed case studies to support audit analysis. The ANAO also sought views on the program administration from industry, including from general practices directly through an online survey.

12. With regard to accreditation of general practice, the audit scope did not include an assessment of the Standards nor the work of the bodies that undertake accreditation of general practices. The ANAO's focus on general practice accreditation related to DoHA's management of program entry criteria.

⁷ The BPA relating to PIP is made under section 7A of the *Medicare Australia Act 1973*.

⁸ The Indigenous Health Incentive was introduced in May 2010. This incentive is referred to throughout the report, but not included in the audit scope.

Overall conclusion

13. Since 1998, \$2.7 billion has been paid to general practices and general practitioners under the Practice Incentives Program (PIP). The program has been a means of funding general practices and GPs for a diverse range of activities, outside the fee for service arrangements through the Medicare Benefits Schedule (MBS).

14. The Department of Health and Ageing (DoHA) has been broadly effective in undertaking its responsibilities for PIP planning, monitoring and review and, with Medicare Australia, has ensured delivery of a complex program to general practices and their medical practitioners. As a result of the program, general practice accreditation has increased to 67 per cent of general practices that provide most of Australia's primary health care—these practices have taken up one or more PIP incentives contributing to improved services for patients and practice management.

15. PIP has a number of features that make its management challenging; in particular it comprises a diverse range of incentives with varying aims and payment arrangements. These features and the large number of changes that have applied to PIP since its inception, particularly the addition of new incentives, highlight the importance of a systematic approach to assessing whether a new incentive payment to be delivered through PIP will appropriately target the identified needs and intended recipients. A particular consideration for PIP is that although it has facilitated the accreditation of 67 per cent of all general practices, it is often used as an umbrella program to deliver individual initiatives, such as the eHealth Incentive, that align with government policy more widely and are applicable to all general practices, not just those that are accredited.

16. Accreditation, the entry requirement to receive PIP incentives, can be a significant barrier to certain general practices including Aboriginal Medical Services (AMSs) and smaller practices. Therefore, in some cases PIP alone may not always be the most suitable means for delivering an incentive that is applicable to the entire general practice community. To illustrate, while noting that initiatives have recently been announced or progressed with the potential to offset the costs of accreditation, AMSs, and small practices servicing remote locations and non-English speaking communities, have been underrepresented in PIP.

17. In addition, the factors that determine the amount of PIP payments to individual practices—the standardised whole patient equivalent (SWPE)

measure of patient load; and the rural, remote, metropolitan area (RRMA) classification of location—can have unintended consequences for particular practices, potentially distorting uptake of an incentive and, thereby, not achieving the intended impact.

18. These characteristics of PIP underpin the importance of DoHA undertaking an assessment, to inform Government decision-making, of whether a new incentive, if placed in PIP, will best target intended recipients and deliver expected outcomes. An assessment at the design consideration stage modeled on a range of general practices with varying characteristics would assist DoHA to better understand which sectors of the general practice population are most likely to benefit, or be influenced by, an incentive placed within PIP and using parameters such as SWPE and RRMA.

19. PIP has a range of objectives and sub-objectives relating to: improved access and health outcomes; improved services to general practices and their patients; while, at the same time, minimising ‘red tape’. Each incentive is aimed at contributing to one or more of PIP’s sub-objectives. However, the KPIs that DoHA relies upon for monitoring, reporting and review at the overall program and individual incentive payment level, focus on take-up statistics rather than effectiveness measures. While DoHA has drawn on both broad and incentive-specific evaluations to inform program development, the lack of effectiveness KPIs has meant that these evaluations have been limited in their ability to inform government on the ongoing success, or otherwise, of particular incentives in meeting their objectives and sub-objectives. The use of effectiveness KPIs that are identified through a program evaluation strategy, and regularly measured and reported, would assist the assessment of PIP achievements.

20. Medicare Australia has responsibility for PIP service delivery. The arrangements between DoHA and Medicare Australia are supported by a business practice agreement that provides a sound framework for managing PIP service delivery. In practice, the assurance that DoHA obtains from Medicare Australia that correct payments are made to general practices could be improved. In particular, while PIP payments to practices are accurate according to information currently held by Medicare Australia, general practices have not confirmed the ongoing currency of a significant amount of this information for five years or more—increasing the risk of inaccuracies in payments. Furthermore, until recently, Medicare Australia’s PIP compliance audits have been based on factors such as the type of incentive payment and geographic considerations, rather than practices with higher risk of non-

compliance. Medicare Australia has advised that it is currently progressing initiatives which should improve the currency of practice information to determine their continuing eligibility for PIP incentives and consequently should provide greater assurance to DoHA on the accuracy of payments.

21. PIP has been evolving for 12 years and, as such, it is timely for DoHA to review how it manages PIP, particularly the implementation of new incentive payments. More specifically, the ANAO has made three recommendations to improve DoHA's ability to inform program development decision-making, to assess the outcomes from PIP, and to manage program entry requirements, including accreditation.

Key findings

Informing program development decision-making

22. DoHA has criteria against which to assess whether PIP is the most appropriate instrument for progressing individual incentive payments related to, for example, whether a change in the behaviour of GPs is required, that is, to support quality care, improve access and health outcomes. Based on the ANAO's assessment of three case studies: Domestic Violence; GP Aged Care Access; and eHealth, DoHA appraised each incentive against the criteria, albeit informally and without documenting. An explicit, documented assessment would provide DoHA with a more robust basis on which to advise government as to the placement of an incentive in the PIP.

23. There are also PIP design features which affect the ability of initiatives placed in the program to influence general practitioners and their practices. These relate to PIP being unavailable to general practices that are not accredited and the use of the SWPE and RRMA as the main bases for paying practices. While such features and the placement of initiatives in PIP are a matter for decision by government, DoHA has a role in assessing the impact of placing an initiative in PIP, and identifying whether any design modification may be beneficial in the light of experience.

24. General practice accreditation was designed to promote access to high quality primary health services, with most accredited general practices considering that accreditation has a positive impact on the quality of patient care that they provide. Nevertheless, general practice accreditation can be an entry barrier for participating in PIP for some types of practices. The cost and work effort needed for accreditation are regarded by over 80 per cent of ANAO survey respondents as 'high' or 'very high'. As a result, small practices

servicing remote locations and non-English speaking communities, as well as AMSs, have been underrepresented in the program.⁹ Overall, there has been limited assessment by DoHA of the impact of restricting incentive access to accredited general practices. This is particularly important for incentives such as eHealth, which is part of a broader initiative that the Government aims to progress across the whole health sector.

25. While the SWPE was designed to reward practices that spent more time with individual patients, it actually provides greater payments to practices that have higher numbers of patient visits as opposed to fewer, longer consultations. The SWPE also results in solo practices and those treating Indigenous patients receiving disproportionately less in PIP payments. The SWPE formula has not been subject to review since its implementation along with the PIP in 1998–99.

26. The other central factor in determining PIP payments, RRMA, is based on outdated 1991 Australian Bureau of Statistics census data and is not used consistently by DoHA; a district can be assigned different RRMA categories under different programs. The timing to implement the planned replacement of the RRMA classification for PIP is subject to government consideration.¹⁰

27. An assessment at the design stage, modelled on a range of practices with varying characteristics, would assist DoHA to understand how the proposed incentive will translate into the target population if placed in PIP and the impact of using parameters, such as SWPE and RRMA. More broadly, an analysis of the PIP design features, the SWPE and program entry requirements, on the effectiveness of incentives, would assist DoHA in advising government on the benefits, or otherwise, of program design modifications.

⁹ The ANAO notes that progress has been made to increase Aboriginal Medical Service (AMS) accreditation rates, and that a one-off grant for general practices to attain accreditation was announced as part of the 2010–11 Budget measure, the Practice Nurse Incentive Program.

¹⁰ Based on a further review of RRMA in 2008 sought by the Minister for Health and Ageing, the Government announced as part of the 2009–10 Budget, that RRMA will be replaced by the Australian Standard Geographical Classification—Remoteness Areas system, in a phased approach from July 2009. While most RRMA-based programs will be changed over to the Australian Standard Geographical Classification—Remoteness Areas in 2009–10, the Government is yet to determine the timing to apply this change to PIP.

Assessing the outcomes from PIP

28. Since its inception in 1998, PIP has had a range of objectives and aims relating to, for example, a 'blended' payment approach,¹¹ and improving services to general practice patients, while minimising 'red tape' for practices. PIP also comprises a significant number of incentives, each with their own aims. These complexities highlight a need for DoHA to implement a strategic approach to program management activities to measure, assess and report the effectiveness of PIP.

29. To examine the extent to which DoHA determines and reports on PIP outcomes, the ANAO assessed: PIP achievements against its objectives; DoHA's setting of and reporting against KPIs and associated targets; and DoHA's evaluations of PIP at the broad program and individual incentive level.

30. The ANAO's analysis indicated that PIP has positively contributed to increased accreditation rates and aspects of its objective, such as improved services to patients and improvements in general practices. In the view of stakeholders, however, PIP's administrative burden on general practices has not decreased, with 80 per cent of ANAO survey respondents considering that there had been at least a slight increase over the last five years in the cost and work effort to receive PIP incentives. This contrasts with aim of the program to achieve results with a 'minimum of red tape', and suggests that initiatives implemented to address administrative burden have not been fully effective. PIP Online, a key measure identified to reduce 'red tape', is planned to be introduced in October 2010.

31. Over the same period, while there has been an increase of 86 per cent in MBS expenditure on GP-related services, PIP expenditure has risen 25 per cent, with savings measures for PIP, and changes to the MBS and GP workforce contributing to these trends. This highlights that the balance in financial incentives provided through PIP and benefits through the MBS has shifted towards practices providing higher volume services. The ANAO's analysis suggests that PIP, with an aim of encouraging general practices to spend more time with their patients in individual visits, has not made a notable difference in limiting MBS fee-for-service expenditure that rewards brief consultations.

¹¹ A 'blended' payment approach provides general practices and GPs with income from a range of sources, such as PIP, and payments for individual services from MBS rebates and patients.

32. The broader program evaluations and incentive-specific evaluations of PIP undertaken by DoHA, while informing program changes, have been limited by a lack of effectiveness key performance indicators (KPIs) identified ‘up-front’ and used as the basis for quantitative assessment of PIP achievements against its objectives and sub-objectives. DoHA’s performance monitoring and reporting, at both the broader program and individual incentive level, focuses on take-up statistics rather than effectiveness measures and does not allow for trend analysis over time. An evaluation strategy would provide DoHA with a more considered and planned approach to the assessment of PIP incentives that have been operating over an extended period, and assist in reducing gaps and delays in evaluation activity.

DoHA’s assurance on the quality of accreditation processes

33. The Australian Government has a commitment to the accreditation of general practices and has previously contributed funds to assist in establishing the Standards for General Practices. These Standards are administered by the Royal Australian College of General Practitioners (RACGP).

34. The ANAO assessed whether DoHA gains assurance over the quality of accreditation processes, especially the consistency of assessments and compliance with the Standards. Without such assurance there are risks that general practices could be assessed inconsistently, and that general practices do not maintain their compliance with the Standards across an accreditation cycle. As accreditation is the key eligibility requirement for PIP, a poor compliance regime could allow some general practices to continue to receive PIP payments while not adhering to the Standards. More broadly, a lack of adherence to the Standards could limit the achievement of high quality primary health care that government expects from accreditation.

35. The following features for the accreditation of general practices limited DoHA’s assurance on the quality and rigor of the accreditation processes:

- when conducting accreditation assessments, the two accrediting—Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Australia Pty Ltd (QPA)—each used their own accreditation framework that general practices were required to follow;
- while both accrediting bodies seek assertions from general practices on adherence to the Standards across the accreditation cycle, there are no checks on these claims through risk-based interim assessments; and

- there is a lack of clarity as to the auditability of the current Standards and their applicability to all general practice settings, such as those that operate outside office settings.¹²

36. DoHA has worked previously with the health profession to develop an improved governance framework with the potential to address many of the issues affecting accreditation arrangements, including the possible use of a single accreditation framework. The resulting proposals were not progressed for consideration by government.

DoHA's assurance on the accuracy of PIP payments to practices

37. DoHA receives reports from Medicare Australia for the release of funds to make quarterly payments to practices and on the payment amounts sent to practices, as well as those payments withheld. Such reports, together with regular liaison meetings and PIP compliance audit reports, provide DoHA with a degree of assurance against its responsibilities for public money under the *Financial Management and Accountability Act (1997)*.

38. ANAO sampling indicated that Medicare Australia has information to support all payments being made to practices. Medicare Australia relies on practices to provide the information necessary to receive a PIP payment and assumes this information remains current unless advised. A large amount of information held on practices by Medicare Australia used to make these payments, however, has not been updated for significant periods. Based on a sample of 70 practices, over 40 per cent of After-hours and Practice Nurse Incentives payments made in May 2009 (representing 15 per cent of total payments) were determined on information that was received by Medicare Australia between five and 10 years previously.

39. Most details on practices are currently manually entered by Medicare Australia staff. A review of the PIP database found that some information, such as accreditation expiry dates that are required to test for ongoing eligibility, had not always been recorded. Developments underway at the moment, such as annual confirmation statements and the ability for practices

¹² In July 2010, the RACGP advised that it was developing a preferred approach to ensure that practices maintain their compliance with the Standards for the duration of the accreditation cycle. Furthermore, the RACGP accepted that there may be, in very rare circumstances, some practices that might not be able to achieve all Standards in the current edition. It noted that the Standards were developed with robust stakeholder consultation, including field testing to ensure both applicability and feasibility within general practice settings.

to apply for PIP incentives and update details electronically through PIP Online, should assist in addressing this issue, and any risks concerning the currency of information.

40. Until 2009–10, the compliance audit program for PIP generally did not target high-risk practices. However, there was recognition by both agencies that the After-hours and Practice Nurse Incentives had the highest degree of potential non-compliance and a substantial proportion of the audits concentrated on these payments.¹³

41. To receive Tier 3 of the After-hours Incentive, practices are required to ensure patients have access to after-hours care by a practice doctor 24 hours a day, seven days a week. After-hours telephone calls made by the ANAO to 34 practices with low after-hours MBS item billings that were receiving After-hours Incentive payments of almost \$500 000 in 2008–09, demonstrated the importance of using secondary sources of information to identify practices with higher risk of non-compliance. While patients may have various means of accessing 24-hour care from practice doctors, none of the practices contacted answered the calls in person. Answering machines provided callers with an after-hours number for a practice doctor in only half the cases, with two practices indicating that no practice doctors were available after-hours.

42. During the course of the ANAO audit, Medicare Australia developed its 2009–10 PIP compliance audit program. In this, Medicare Australia identified audits on the After-hours, Practice Nurse and Domestic Violence Incentives, proposing to target practices whose MBS after-hours and practice nurse item billings do not appear to be commensurate with their PIP requirements.

Agencies' responses

Department of Health and Ageing

Individual incentives available through the Practice Incentives Program cover a broad range of activities in general practice, and aim to support quality care as well as improve access and health outcomes for patients. The Department, in consultation with Medicare Australia, has been

¹³ With the development of the Practice Nurse Incentive Program and Medicare Locals, announced in the 2010–11 Budget, the PIP Practice Nurse Incentive will be abolished at the end of 2011. Tier 1 of the After-hours Incentive will cease by July 2011, with Tiers 2 and 3 finishing by July 2013.

undertaking a number of activities to improve the administrative arrangements for the program. The recommendations included in the audit report will further guide and enhance this ongoing work.

Medicare Australia

Medicare Australia welcomes the ANAO performance audit findings that the Business Practice Agreement between Medicare Australia and the Department of Health and Ageing provides an appropriate framework for delivery of Practice Incentive Program payments.

Medicare Australia supports the recommendations in the report.

43. Extracts of the proposed report were also provided to the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the National eHealth Transition Authority (NEHTA), the RACGP, AGPAL, QPA, and the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). The comments subsequently provided are included in Appendix 1 of the report.

Recommendations

Recommendation No. 1

Paragraph 2.86

To better inform its advice to government on the development and use of the Practice Incentives Program (PIP), the ANAO recommends that DoHA develop the capability to model the affect of PIP design features on the likely uptake and success of proposed incentive payments.

DoHA response: Agreed

Recommendation No. 2

Paragraph 3.65

To improve the ability to assess the effectiveness of the PIP, the ANAO recommends that DoHA:

- (a) develop an evaluation strategy for the overall program and its individual incentives that includes the identification and monitoring of key performance indicators; and
- (b) publicly report against relevant high-level indicators on an annual basis.

DoHA response: Agreed

Recommendation No. 3

Paragraph 4.29

To support DoHA's management of PIP entry criteria and the Government's expectations of general practice accreditation, the ANAO recommends that DoHA develop the means to inform itself of the quality of general practice accreditation.

DoHA response: Agreed

Audit Findings and Conclusions

1. Introduction

This chapter provides background information on the Practice Incentive Program. It also outlines the audit objective, scope and methodology, and the report structure.

Background

1.1 The Practice Incentives Program (PIP) started on 1 July 1998, in response to a series of recommendations made by the General Practice Strategy Review Group, a group of DoHA officials and general practice interests, appointed by the then Minister for Health and Family Services. The Group recommended a program that included discrete elements to provide funding to general practices that was not related to the volume of fee-for-service payments to practices.

1.2 The Group also recommended that the program transition to allow access to payments only by general practices accredited against the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practice*.

1.3 PIP replaced the Better Practice Program and resulted in a significant increase in general practice participation; 4480 practices were participating in PIP by 30 June 1999,¹⁴ compared with 2 461 practices participating in the Better Practice Program 12 months previously,¹⁵ an increase of 82 per cent.

1.4 Currently, PIP is the largest Australian Government program aimed primarily at general practices rather than general practitioners. In 2009–10, general practices were paid \$261 million through the program with 4881 practices participating in the program as for the May 2010 payment.¹⁶

PIP objectives

1.5 The current objective for PIP was agreed by government in February 2006. The program aims to provide a flexible, cost-effective mechanism for the Government to encourage both short and long-term changes to general

¹⁴ Health Insurance Commission (1999), *Annual Report 1998–99*, p. 101.

¹⁵ Dept of Health and Ageing (2005), *General Practice in Australia:2004*, p. 80.

¹⁶ This payment excludes payments under PIP to general practitioners (\$19.3m in 2008–09), as well as payments withheld to practices. It includes payments withheld from previous years and released in 2008–09.

practice, to support quality care, and to improve access and health outcomes with a minimum of red tape.

Background leading to the current PIP objective

1.6 The original PIP objective was based on the policy foundations set by recommendations from the General Practice Strategic Review Group, as follows:

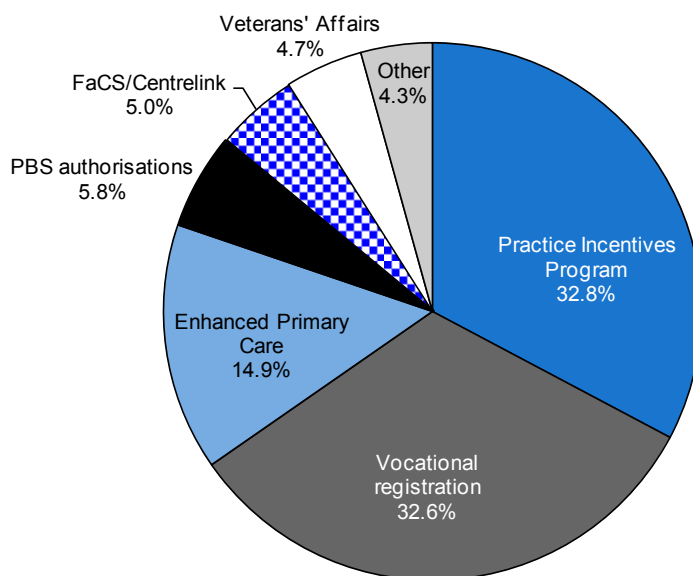
The Practice Incentives Program (PIP) aims to recognise general practices that provide comprehensive, quality care and are accredited or working towards accreditation against the Royal Australian College of General Practitioners' Standards for General Practice. PIP is part of a blended payment approach for general practice that aims to compensate for the limitations of fee-for-service arrangements, which provide greater rewards to practices with high volume, brief consultations.

1.7 In 2002, the Productivity Commission undertook a research study on the administrative and compliance costs associated with Australian Government programs that impact on general practice.¹⁷ The study found that in 2001–02, participation in PIP accounted for 32.8 per cent (\$74.6 million) of general practice costs associated with administering government programs. Figure 1.1 shows the relative costs associated with general practices administering government programs.

¹⁷ Productivity Commission, *General Practice Administrative and Compliance Costs*, Research Report, Canberra, 2003.

Figure 1.1**Estimated GP administrative costs, 2001–02**

Total = \$228m



Source: Productivity Commission. *General Practice Administrative and Compliance Costs*, Research Report, Canberra, 2003. p.xxi.

1.8 The Government established the General Practice Red Tape Taskforce¹⁸ in May 2003 to address the issues raised by the Productivity Commission. Based on the Taskforce's recommendations, in December 2003, the Government decided that DoHA, in consultation with the general practice profession and other stakeholders, should undertake a second-stage review of PIP, with a view to short- and long-term changes to reduce unnecessary red tape.

1.9 A progress report to government on this review highlighted the lack of clarity of PIP objectives, particularly given that the aims of some of the PIP incentive payments may have been addressed through extension of the

¹⁸ The Taskforce was a cross-agency group comprising Departments of Prime Minister and Cabinet, Health and Ageing, Veterans' Affairs, (then) Family and Community Services, Centrelink and (then) Health Insurance Commission. It had formal consultative mechanisms through a General Practice Reference Group comprising the Australian Medical Association, the RACGP, Australian Divisions of General Practice (now Australian General Practice Network), and the Rural Doctors Association of Australia.

Medicare Benefits Schedule (MBS).¹⁹ Consequently, the Government established an inter-departmental committee (IDC)²⁰ to advise it on the future directions for PIP. The IDC report to government noted that any overlaps between PIP and other measures were ‘mutually reinforcing rather than duplicative’, and recommended a revised PIP overall objective, agreed by the Government in February 2006 as indicated at paragraph 1.5.

Key features of PIP

PIP payment types

1.10 PIP comprises a series of elements or incentives. Table 1.1 outlines the current payment types and their aims.

Eligibility Criteria

1.11 In order to join the PIP, general practices must:

- be accredited or registered for accreditation as a ‘general practice’ against the RACGP *Standards for General Practices* (the Standards), and maintain practice accreditation through reaccreditation, currently set by the RACGP, every three years;²¹
- have public liability insurance; and
- ensure that all medical practitioners at the practice have professional indemnity cover.²²

1.12 Once entry requirements are met, there are eligibility requirements for practices to receive incentives under PIP; eligibility varies with each particular incentive, some of which differ further with components or tiers within incentive type. These are outlined at Appendix 2.

¹⁹ The MBS had been extended to include after-hours items and chronic disease management items—relevant to PIP after hours and chronic disease incentives.

²⁰ The IDC comprised Departments of (then) Finance and Administration, Prime Minister and Cabinet, Health and Ageing, and Treasury.

²¹ The Royal Australian College of General Practitioners, *Standards for General Practices 3rd edition*, 2006, available from <<http://www.racgp.org.au/standards>> [accessed 8 July 2009].

²² PIP Eligibility Requirements <<http://www.medicare.gov.au/provider/incentives/pip/files/2709-8-pip-guidelines.pdf>> [accessed 22 January 2010].

Table 1.1**PIP incentives and aims**

	Aim of incentive
eHealth Incentive	To encourage practices to keep up to date with the latest developments in eHealth.
After-hours Incentive	To encourage general practices to provide patients with access to quality after-hours care.
Teaching Incentive	To encourage general practices to provide teaching sessions to undergraduate medical students, to ensure practitioners of tomorrow are appropriately trained and have actual experience of general practice.
Quality Prescribing Incentive	To encourage practices to keep up to date with information on the quality use of medicines.
Practice Nurse Incentive	To encourage general practices in rural and remote areas to employ practice nurses and/or Aboriginal health workers, and in urban areas of workforce shortage, to employ practice nurses and/or Aboriginal health workers and/or other allied health workers.
Cervical Screening Incentive	To encourage general practitioners (GPs) to screen under-screened women, and to increase overall screening rates.
Diabetes Incentive	To encourage GPs to provide earlier diagnosis and effective management of people with established diabetes mellitus.
Asthma Incentive	To encourage GPs to better manage the clinical care of people with moderate to severe asthma.
Procedural GP Incentive	To encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services.
Domestic Violence Incentive	To encourage general practices in rural and remote areas to act as a referral point for women experiencing domestic violence.
GP Aged Care Access Incentive	To improve access to primary care for residents of Commonwealth-funded aged care facilities.
Rural loading	To recognise the difficulties of providing care, often with little professional support, in rural and remote areas.
Indigenous Health Incentive	To support general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic diseases.

Source: DoHA guidelines.

Incentive features

1.13 The recipient (whether the general practice or GPs working in PIP practices), bases for payment amounts and payment determination (prospective or retrospective), and frequency vary across incentives, and can further vary for components or tiers within incentives, as outlined in Table 1.2.

Table 1.2**PIP incentive payment features**

Incentive	Recipient	Payment basis	Determined	Frequency
eHealth	General practices	\$6.50/SWPE ²³ up to \$50 000 per annum	Retrospectively	Quarterly
After-hours	General practices	Tier 1: \$2/SWPE per annum Tiers 2: \$2/SWPE per annum Tiers 3: \$2/SWPE per annum ²⁴	Prospectively	Quarterly
Teaching	General practices	\$100 per session	Retrospectively	Quarterly
Quality Prescribing	General practices	\$1/SWPE	Retrospectively	Annually
Practice Nurse	General practices	\$8.50/SWPE/annum urban practices \$7.00/SWPE/annum rural and remote practices	Prospectively	Quarterly
Diabetes Sign-on	General practices	\$1/SWPE one-off.	Retrospectively	One-off
Diabetes Outcomes	General practices	\$20/diabetic SWPE per annum	Retrospectively	Quarterly
SIP	GPs	\$40 per patient completing a cycle of care per annum	Retrospectively	Quarterly
Cervical Screening Sign-on	General practices	\$0.25/SWPE one-off	Retrospectively	One-off
Cervical Screening Outcomes	General practices	\$3/weighted female whole patient equivalent (aged 20-69 years)/annum	Retrospectively	Quarterly
Cervical Screening SIP	GPs	\$35/cervical smear from target group ²⁵	Retrospectively	Quarterly
Asthma Sign on	General practices	\$0.25/SWPE one-off	Retrospectively	One-off
Asthma SIP	GPs	\$100 per patient completing a cycle of care per annum	Retrospectively	Quarterly
Procedural GP	General practices	Tier 1: \$2000/annum Tier 2: \$4000/annum Tier 3: \$10 000/annum Tier 4: \$17 000/annum	Prospectively ²⁶	Quarterly
Domestic Violence	General practices	\$1/SWPE up to \$4000 per annum	Prospectively	Quarterly
GP Aged Care Access	GPs	Tier 1: \$1000 when QSL1 reached. Tier 2: \$1500 when the QSL2 reached. ²⁷	Retrospectively	Quarterly (max. two payments per annum)
Rural loading	General practices	RRMA 3: 15 per cent RRMA 4: 20 per cent RRMA 5: 40 per cent RRMA 6: 25 per cent RRMA 7: 50 per cent	Applied to total practice payments	Quarterly

²³ SWPE refers to the standardised whole patient equivalent. See paragraph 1.14 for an explanation.

²⁴ Practices may participate in up to three of the tiers. Payments are cumulative.

²⁵ Target group is under-screened women aged 20 to 69 years.

²⁶ The last prospective payment was made in November 2009, as it is moving to retrospective payments.

²⁷ QSL1 (Qualifying Service Level 1): 60 relevant Medicare Benefits Schedule (MBS) services claimed in year. Relevant MBS services relate to those delivered to residents of residential aged care facilities.
QSL2: 140 relevant MBS services claimed in year.

Incentive	Recipient	Payment basis	Determined	Frequency
Indigenous Health Incentive Sign-on	General practices	\$1000 one-off	Retrospectively	One-off
Patient registration		\$250/eligible patient/annum		Quarterly
Outcome Tier 1		\$100/eligible patient/annum		
Outcome Tier 2		\$150/eligible patient/annum		

Source: ANAO analysis from DoHA Guidelines as at May 2010.

Basis for determining payment size

1.14 The level of PIP payment a general practice will receive is determined by the particular incentive, adjusted in the main, in response to the following factors:

- the Standardised Whole Patient Equivalent (SWPE), which is intended to be a measure of a practice's patient load being independent of the number of services provided to patients. It is based on the proportion of care a practice provides to each patient using the value of the patient's MBS fees, and then weighted using an age-sex factor. Over 75 per cent of PIP payments to practices use the practice's SWPE as a determinant; and
- the location of the general practice as determined by the rural, remote, metropolitan area (RRMA) classification, based on the population distribution from the 1991 Australian Bureau of Statistics Census of Population and Housing.²⁸ General practices located in rural and remote RRMA classes have a loading of between 15 to 50 per cent added to their PIP payments.

1.15 These factors are explored more fully in Chapter 2.

Participation in PIP

1.16 The participation rate in May 2010 of 4881 is estimated by the ANAO to represent approximately 67 per cent of all practices.²⁹ Almost 82 per cent of

²⁸ Departments of Primary Industries & Energy and Human Services & Health, (1994), *Rural, Remote and Metropolitan Areas Classification (RRMA), 1991 Census Edition*.

²⁹ The total number of general practices is based on self reporting through the 2007–08, Annual Survey of Divisions. <<http://www.phcris.org.au/fastfacts/fact.php?id=6752>> [accessed 14 October 2009]. The survey has limitations as an estimate of total practices, as it is not clear as to the reporting patterns by, for example: a) practices with a number of branches; and b) general practitioners who operate from a single location, but share practice management arrangements. Currently, there are no more reliable statistics on the total number of general practices in Australia, as Medicare Australia does not have practice information on those practices not receiving PIP payments. It plans to have better information on

Footnote continued on the next page...

general practice patient care was being delivered by PIP practices at that time, by over 21 000 full-time equivalent (FTE) GPs.

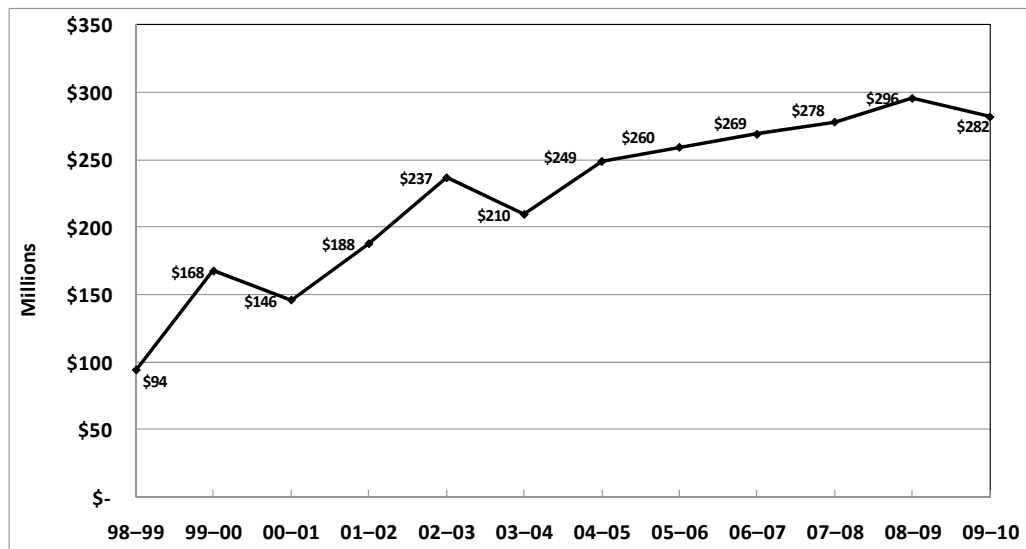
PIP payment expenditure

1.17 PIP payment expenditure has varied since its inception because of a range of factors. These include: the addition, cessation and replacement of incentives, changes to incentives themselves, including rates of payment and eligibility criteria, participation of practices and the size of practice participating by type of incentive.

1.18 The resulting payments to general practices and general practitioners are shown in Figure 1.2.

Figure 1.2

Total PIP payments to general practices and general practitioners (\$ millions)



Source: ANAO analysis of Medicare Australia data (except for 1998–99, which is based on HIC Annual Report).

Notes: GST excluded. Payments vary marginally from expenditures, as Medicare Australia may withhold and release payments at a later time to practices (or practitioners) for a range of reasons, for example, failure to provide evidence of current accreditation status.

practices in the future in determining unique health identifiers by organisations at locations, a key component of the National e-Health Strategy. See [http://www.health.gov.au/internet/main/publishing.nsf/Content/604CF066BE48789DCA25751D000C15C7/\\$File/Summary%20of%20National%20E-Health%20Strategy-final051208.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/604CF066BE48789DCA25751D000C15C7/$File/Summary%20of%20National%20E-Health%20Strategy-final051208.pdf) [accessed 7 September 2009].

1.19 In 2008–09, the average PIP payment made to a general practice was \$61 600, or \$19 700 per FTE GP in participating practices. Payments to practices can vary considerably, based on location and participation in incentives, and practice size. For example, in 2008–09, one practice received over \$576 000 in payments, with five per cent of practices averaging \$426 000 in payments, seven times the overall average; these practices received \$36 000 per FTE GP, 90 per cent more than average.

1.20 Total payments to practices vary considerably between payment types. The Information Management/Information Technology (IM/IT) Incentive³⁰ represented over 32 per cent of payments in 2008–09, while the Asthma Sign-on payment accounted for only 0.02 per cent of payments. The full range of payments by type is shown at Table 1.3.

Table 1.3

PIP payments by type to general practices/practitioners, 2008–09

Incentive	Payments to practices/GPs (\$'000)	Percentage of total (%)
IM/IT (replaced by eHealth)	96 095	32.5
After-hours	56 356	19.0
Teaching	10 125	3.4
Quality Prescribing	2 399	0.8
Practice Nurse	52 559	17.8
Cervical Screening (sign-on and outcomes)	11 841	4.0
Diabetes (sign-on and outcomes)	10 017	3.4
Asthma (sign-on)	53	0.0
Procedural GP	9 333	3.2
Domestic Violence	309	0.1
GP Aged Care Access	7 928	2.7
Asthma, Diabetes and Cervical Screening SIPs	11 360	3.8
Rural loading	27 545	9.3
<i>Total</i>	<i>295 919</i>	<i>100.0</i>

Source: ANAO analysis of Medicare Australia data.

³⁰ IM/IT Incentive was replaced by the eHealth Incentive in August 2009.

PIP subject to significant number of changes

1.21 The incentives available through PIP have undergone a number of changes since the program commenced in 1998. These are summarised below and outlined in more detail at Appendix 3.

Previous and new PIP incentives

1.22 Incentives relating to mental health management, care planning and information management/information technology (IM/IT) have been previously included in the program, but are no longer available, or have been replaced. Incentives introduced in the two years to May 2010 are the Domestic Violence, GP Aged Care Access, eHealth and Indigenous Health Incentives.

1.23 As well as incentive introductions and cessations, PIP incentives have been subject to a large range of changes since their introduction; for example:

- more flexible delivery of asthma care was introduced within the Asthma Incentive in November 2006;³¹
- eligibility for the After-hours Incentive (Tiers 1 and 2) needed the medical deputising service to be registered for accreditation by 1 January 2001 and fully accredited by 1 January 2002;³² and
- changes in requirements to receive IM/IT, from three to two levels of payments, including the requirement for encryption of patient/clinical data during electronic transfer from November 2006.

1.24 Prospective payments are being progressively changed to retrospective, over a three-year period to November 2012.³³

³¹ The SIP requirement for an Asthma 3+ Visit Plan was replaced by 'asthma cycle of care' requirements.

³² With the development of the Practice Nurse Incentive Program and Medicare Locals, announced in the 2010–11 Budget, the PIP Practice Nurse Incentive will be abolished at the end of 2011. Tier 1 of the After-hours Incentive will cease by July 2011, with Tiers 2 and 3 by July 2013.

³³ The last prospective payment for the Procedural GP Incentive was made in November 2009. From this time, retrospective payments will be progressively introduced for the Procedural GP, Practice Nurse, Domestic Violence and After-hours Incentives, in turn. The first retrospective payment of the After-hours Incentive is planned for November 2012.

Program administrative arrangements

Program administration is split between DoHA and Medicare Australia

1.25 DoHA has overall policy responsibility for PIP and manages the program planning, including the eligibility criteria, program monitoring and review. Medicare Australia processes all applications from general practices and undertakes the day-to-day administration of PIP, including making PIP payments and ensuring compliance with program and payment eligibility. While implementation of program changes is largely undertaken in Medicare Australia, DoHA is responsible for the program planning including the payment guidelines.

Agency agreements covering the program roles and responsibilities

1.26 The service delivery and delegations were originally outsourced to Medicare Australia's predecessor the Health Insurance Commission (HIC), part of the Health and Ageing portfolio, under a schedule that formed part of the 1998 Strategic Partnership Agreement (SPA) between DoHA and the HIC.³⁴ In 2004, Medicare Australia was established as an agency in the Human Services portfolio, and took over the responsibilities of the HIC, including the administration of PIP. While the SPA no longer had any official status, the provisions of the SPA have broadly governed the relationship between the agencies up until recently.

1.27 A memorandum of understanding (MOU) between DoHA, Department of Human Services and Medicare Australia was signed in May 2009. A Business Practice Agreement (BPA) that forms part of the MOU addresses the service delivery of PIP by Medicare Australia.

Legislative authority

1.28 PIP is not covered by specific legislation but is an executive scheme supported by appropriations. The BPA relating to PIP is made under section 7A of the *Medicare Australia Act 1973*. The BPA is important in defining the administrative roles and responsibilities with respect to PIP, given that this

³⁴ Australian National Audit Office Audit Report No.5, Canberra, 2002–03, *The Strategic Partnership between the Department of Health and Ageing and the Health Insurance Commission*, p.11.

legislation does not identify the particular responsibilities across the two agencies.

The audit

Audit objective and criteria

1.29 The objective of the audit was to assess DoHA's effectiveness:

- in undertaking PIP program planning, program monitoring and review; and
- with Medicare Australia, in ensuring PIP program delivery to general practices and their medical practitioners.

1.30 To form its opinion in this audit, the ANAO used the following criteria:

- DoHA effectively managed program planning, including assessing the suitability of the incentive for PIP, developing the incentives for effectiveness, managing risks, and consulting with relevant stakeholders;
- DoHA maintained a program outcome focus, reporting on, and evaluating the achievements of PIP incentives and the program as a whole;
- DoHA effectively managed PIP eligibility requirements by assessing the impact of general practice accreditation against the RACGP Standards as the key entry criteria and by gaining assurance on the quality of accreditation processes; and
- the arrangements between DoHA and Medicare Australia promoted effective PIP service delivery to general practices and provided DoHA with assurance that eligible practices are paid correctly.

Scope and method

1.31 The audit focused on:

- DoHA's administrative responsibilities for PIP, including the communication and coordination with external organisations on matters related to the program planning, monitoring and review, such as those associated with accreditation of general practices and eHealth;
- the arrangements between DoHA and Medicare Australia to support PIP service delivery, including implementation of new incentives; and

- Medicare Australia's quality assurance and compliance approaches for PIP.

1.32 In undertaking the audit, the ANAO considered the 12 incentives that comprised the PIP up to August 2009. The Indigenous Health Incentive, introduced in May 2010, is referred to throughout the report, but not included in the audit scope. The three incentives most recently introduced at the time of audit fieldwork, namely, Domestic Violence, GP Aged Care Access and eHealth Incentives, were examined in greater detail and formed case studies to support audit analysis.

1.33 With regard to accreditation of general practice, the audit scope did not include an assessment of the Standards nor the work of the bodies that undertake accreditation of general practices. The ANAO's focus on general practice accreditation related to DoHA's management of program entry criteria.

1.34 The assessment of the RRMA classification used as the basis for Rural loading and for access to particular payments was limited, as the classification has been examined in another audit.³⁵

1.35 The audit methodology included:

- examining and reviewing DoHA, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and Medicare Australia's files and documents relating to PIP;
- interviewing staff members from DoHA, FaHCSIA and Medicare Australia's national offices and Medicare Australia's South Australian state headquarters;
- liaising with DoHA, FaHCSIA and Medicare Australia's internal audit areas;
- interviewing and seeking the views of a range of key non-government stakeholders, such as industry and professional peak bodies;
- surveying general practitioners and practice managers on aspects of planning for policy advice, implementation of changes, accreditation, administration of PIP payments and compliance activities. The web-

³⁵ Australian National Audit Office Audit Report No. 26 2008–09, *Rural and Remote Health Workforce Capacity – the contribution made by programs administered by the Department of Health and Ageing*, pp. 123–25.

based survey was voluntary and links were sent to practices through cooperation with the Australian General Practice Network and associated divisions of general practice, the Australian Medical Association, and the Australian Association of Practice Managers. The ANAO received 629 valid responses, and responses were weighted to reflect the geographic distribution of practices;

- analysing PIP and relevant MBS data from Medicare Australia; and
- undertaking substantive compliance checking on practices, by making after-hours telephone calls to 34 PIP practices with low after-hours MBS item billings that were receiving PIP payments to provide 24-hour patient care by practice doctors.

1.36 The audit was conducted in accordance with ANAO auditing standards at a cost of \$632 000.

Report Structure

1.37 The audit findings are reported in the following chapters:

Chapter	Chapter overview
2. Program Planning	<i>Examines DoHA's assessment of the suitability of incentives for PIP, developing the incentives for effectiveness, management of risks during the program development phase, and consultation and coordination with relevant stakeholders.</i>
3. Program Achievement, Reporting and Evaluation	<i>Assesses PIP's achievements against its objectives, setting of and reporting on KPIs and associated targets, and evaluation of the program and its incentives.</i>
4. Program Eligibility—Accreditation of General Practices	<i>Examines how DoHA: assesses the ongoing impact of accreditation against the RACGP Standards as the program entry criteria; gains assurance over the quality of accreditation processes; and has managed the governance arrangements supporting accreditation.</i>
5. PIP Service Delivery	<i>Examines the extent to which the arrangements between DoHA and Medicare Australia promote effective service delivery to general practices and provide DoHA with assurance that eligible practices are paid correctly.</i>

2. Program Planning

This chapter examines DoHA's assessment of the suitability of incentives for PIP, developing the incentives for effectiveness, management of risks during the program development phase, and consultation and coordination with relevant stakeholders.

Introduction

2.1 Since its commencement PIP has been subject to a variety of changes, including the addition of 12 separate incentives and associated payments up to August 2009. These incentives are: Teaching, Quality Prescribing, Procedural GP, Practice Nurse, Asthma Management, Diabetes Management, Cervical Screening, Mental Health Incentive, Care Planning, ACAI, Domestic Violence, and eHealth. The time at which incentives were introduced, payment structures and criteria changed, and incentives ceased are at Table A 2, Appendix 3.

2.2 The resulting diversity of aims and coverage of general practice activities creates a complex environment and underscores the importance of program development. When introducing new incentives into PIP, steps should be undertaken to ensure that the incentive has the potential to address the underlying identified health problem and program integrity is maintained. In particular, the ANAO examined the extent to which DoHA:

- in developing its advice to government, assesses the suitability of an incentive for PIP; and
- develops incentives and payments that progress the PIP objective within general practices, with appropriate
 - identification and management of risks that might impact on the effectiveness of the incentive within practices, and
 - consultation and coordination process with relevant stakeholders.

2.3 To assess these aspects, the ANAO undertook case studies on the development of the three PIP incentives introduced between May 2008 and August 2009—Domestic Violence, GP Aged Care Access, and eHealth.

Assessing the suitability of an incentive for PIP

2.4 Developing program payments aimed at general practices involves consideration as to whether the payment should be included under PIP, or

separate from PIP such as the General Practice Immunisation Incentives Scheme. While placement of payment in PIP is a matter of decision by government, DoHA has a role in gaining a sound understanding of: the potential of the proposed incentive to contribute to the PIP objective; and whether the incentive, if placed in PIP, will best target identified needs and the intended recipients.

2.5 PIP has characteristics with the potential to affect the incentives' cost effectiveness and access by practices, namely:

- use of the Standardised Whole Patient Equivalent (SWPE) as the basis for determining the amount payable for payments based on 'practice size';³⁶
- use of the Rural Remote Metropolitan Areas (RRMA) classification to determine rurality, and as a result, the Rural loadings applied to payment amounts, and eligibility for some incentive types; and
- the types of practices eligible for the program.

Determining whether payments contribute to PIP objectives

Consistency with PIP objectives

2.6 While there was no formal, documented assessment by DoHA as to the contribution of the three case study incentives to the PIP objectives, the ANAO determined that the aims of each of these incentives were consistent with the objective current at the time. In particular:

- The eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in eHealth, considered by the Royal Australian College of General Practitioners (RACGP) to be pivotal to a safe and high-quality health care system.³⁷ This incentive's aim is, therefore, consistent with the current PIP objective.
- The GP Aged Care Access Incentive's (ACAI's) aim at improving access to primary care by Commonwealth-funded residential aged care

³⁶ The exceptions to the use of SWPEs as the basis for determining payment amounts are, for incentives in the audit scope: Teaching Incentive, Rural loading, Procedural GP Incentive, and Service Incentive Payments (SIPs) paid to general practitioners rather than general practices.

³⁷ RACGP (2008). *General Practice ehealth: Thinking local, acting nationally to improve health care for all*. p. 4. <http://www.racgp.org.au/policy/eHealth_Policy.pdf> [accessed 15 September 2009].

facility (RACF) residents, is consistent with the PIP program's current aim which includes 'improved access' as a key component.

- The Domestic Violence Incentive aims to encourage practices to act as referral points for women experiencing domestic violence, consistent with the PIP's original objective³⁸ current at the time that the Domestic Violence Incentive was announced, May 2005. DoHA advised that the incentive helps improve access to domestic violence services which, in turn, may improve health outcomes for victims, consistent with the current objective, which requires incentives to support improved health outcomes.

Criteria to assess new incentives for PIP

2.7 In early 2006, the Interdepartmental Committee (IDC), established by the Government to advise it on future directions on PIP,³⁹ proposed criteria to be used by DoHA to assess whether PIP is the appropriate instrument for progressing Government objectives. The criteria related to the following areas:

- a required change in the behaviour of GPs, i.e. to support quality care, improve access and health outcomes;
- applicability of the initiative to general practices rather than individual GPs;
- the cost effectiveness of the initiative to engender behavioural change, compared to fee-for-service payment models;
- the appropriateness of pursuing the initiative through general practice rather than alternative health facilities such as specialised clinics, hospitals, etc;
- the value of the initiative in the light of existing initiatives/programs;
- the inclusion of appropriate checks and balances in the initiative;
- any unnecessary administrative burden that the initiative may impose on practices compared with alternative mechanisms;
- the aims of the initiative to initiate change rather than fund common practice; and

³⁸ The original program objective is at paragraph 1.6.

³⁹ The Government changed the PIP objective in line with this IDC's advice (see paragraph 1.9).

- recognition of other complementary measures to PIP measures if PIP is not driving change fast enough.

2.8 Such criteria provide DoHA with the basis for an assessment to test whether new incentives contribute to the overall PIP objective.

Use of the criteria to assess new incentives

2.9 Both ACAI and eHealth Incentive were developed following the IDC's identification of these criteria. The Domestic Violence Incentive was sufficiently developed for funding purposes prior to this, as it was included in the 2005–06 Budget.

2.10 While there is no documented evidence of any formal assessment, DoHA informed the ANAO that it considered the criteria in determining the suitability of the ACAI and eHealth Incentive for implementation through PIP. Consistency between the incentives aims and the current PIP objective examined above support this view. Furthermore:

- the eHealth Incentive's aim is targeted at initiating changes within general practices, consistent with the IDC criteria; and
- with regard to the ACAI, DoHA assessed delivery of the Government policy through PIP and an alternative option put forward by the Australian General Practice Network. The alternative option was not adopted as it was considered to be a less cost-effective means of delivery compared with PIP.

2.11 The IDC criteria indicates that the incentive should apply to general practices rather than individual GPs. This is not the case for ACAI, as the incentive is payable to individual GPs meeting qualifying targets in RACFs rather than practices. DoHA advised that the ACAI would potentially be less effective if paid to practices rather than general practitioners, indicating a considered basis for not meeting the related criteria.

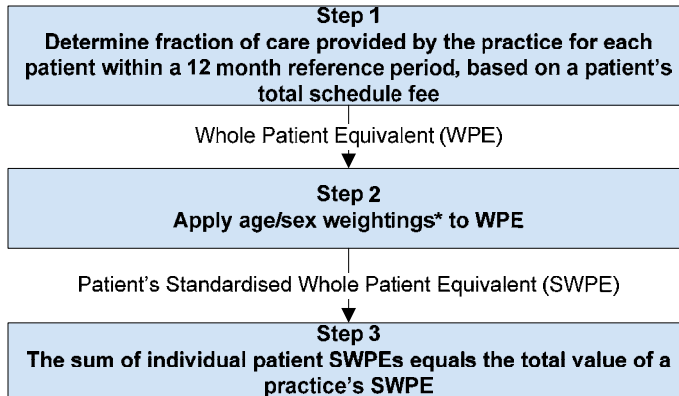
Use of Standardised Whole Patient Equivalent to measure practice size

2.12 Most PIP payments, including payments related to two of three case studies (Domestic Violence and eHealth), are paid to eligible PIP practices, based on a measure of the practice size, the SWPE. The SWPE aims to compensate practices which are providing longer consultations and out-of-

surgery visits.⁴⁰ Figure 2.1 below, outlines the major steps undertaken to calculate a practice's SWPE.

Figure 2.1

The major steps to calculate a practice's SWPE



Source: ANAO analysis.

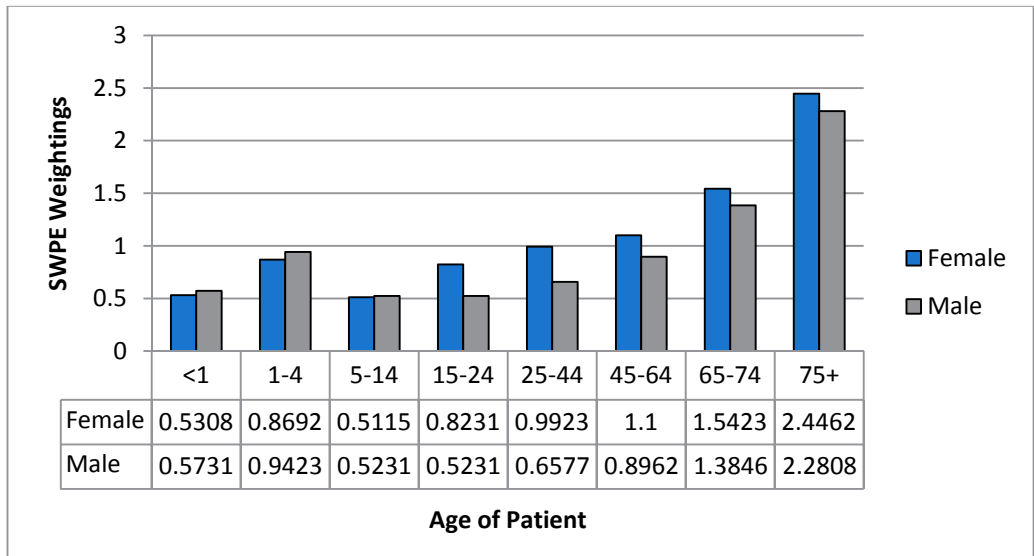
* see Figure 2.2 for May 2009 age/sex weightings

2.13 Figure 2.2 shows the weightings for determining a practice's SWPE as for the May 2009 PIP payment. Essentially, a practice will get over four times the SWPE (and associated PIP payments) for a patient aged 75 years or over, compared with a patient aged less than one year with the same MBS billings.

⁴⁰ See Appendix 4 for details.

Figure 2.2

WPE weighting factors for age and sex of patients, May 2009



Source: Medicare Australia *Practice Incentives Program (PIP)—payments and calculations*, available at <<http://www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/index.jsp>> [accessed 8 June 2009]. Weightings are updated quarterly by Medicare Australia.

2.14 The ANAO identified three key issues that warrant consideration in determining whether an incentive aimed at rewarding practices commensurate with the practice’s patient load should be placed in PIP, given the use of the SWPE as the means of calculating this measure within this program. These relate to:

- transparency for practices to determine their SWPE;
- the period of time it takes for a new practice that establishes with a full patient load to gain a SWPE that reflects this load; and
- the link between the SWPE and volume of consultations.

Transparency in determining SWPE

2.15 Practice SWPEs potentially could vary considerably depending on the percentage of care patients choose to be delivered by other practices, such as after-hours services. Scenario 1 at Appendix 5 illustrates how this occurs, showing that one after-hours visit per patient could result in a 40 per cent decrease in SWPE. To demonstrate that such variations do occur, the ANAO analysed the May 2009 SWPE for a small sample of 10 practices in the 2008 calendar year, randomly selected from categories based on practice size and RRMA location. Based on this sample, the practices’ SWPE was decreased

between 19 and 42 per cent from the SWPE which the practices would have achieved, had all of the care for their individual patients been delivered within the practice.

2.16 The use of the SWPE as the basis for most PIP payments results in practices being unable to independently determine the amount payable to their practices from participating in individual PIP incentives, as practices do not have access to patients' Medicare records to determine the percentage of general practice care delivered outside their practice. Furthermore, practices which are not accredited are unable to calculate their prospective PIP payments against the cost of becoming accredited.

Time to gain full SWPE for newly established practices

2.17 Even if a newly established practice begins operating with a full patient load (for example, if patients follow a doctor who establishes a new practice) there is a lag of 16 months before the practice has a SWPE that reflects patient load. The SWPE, therefore, effectively disadvantages GPs setting up new practices, with potential for unintended consequences in areas of GP shortage. Scenario 2 at Appendix 5 illustrates the SWPE over time of an existing practice and a newly established practice when the newly established practice takes on half the patient workload of the established practice, giving both practices the same patient profile.

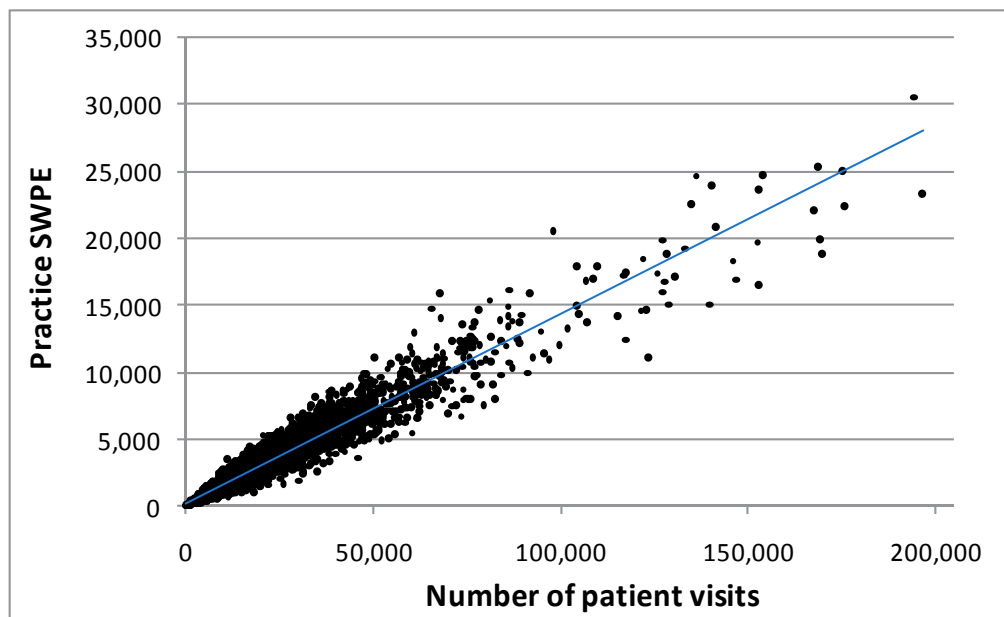
Effectiveness of the SWPE as an alternative basis to funding practices

2.18 Based on data provided by Medicare Australia for the May 2009 PIP payment, the ANAO determined that there was a strong positive statistical relationship between the number of patient visits to PIP practices and the practices' SWPEs.⁴¹ Figure 2.3 shows this relationship.

⁴¹ The estimated statistical correlation between the number of visits to PIP practices in the period 1 January 2008 to 31 December 2008 and the respective practices' SWPEs is 0.96. Statistical correlations range between '-1' and '+1'. '-1' represents the strongest negative relationship, between two sets of numbers, while '+1' represents the strongest positive relationship. A result of '0' indicates that there is no relationship between two sets of data. A result of '0.96' indicates a very strong positive relationship between two sets of data.

Figure 2.3

Patient visits vs SWPE for PIP practices at May 2009



Source: ANAO analysis of Medicare Australia data.

2.19 On average, most PIP incentives will provide greater rewards for a practice with a greater number of brief consultations, than a practice which provides treatment for their patients through a smaller number of longer consultations.⁴² This suggests that the SWPE, with its aim of rewarding practices providing longer and out-of-surgery consultations consistent with the program's quality care objective, is not meeting its original intention.

Assessment of SWPE as a basis for payments

2.20 The above analysis indicates the importance of considering whether PIP, with its use of the SWPE, is appropriate for incentives that aim to reward practices in line with patient load.

2.21 DoHA did not undertake an assessment during program planning of the consequence of using the SWPE as the basis for determining Domestic Violence Incentive payments. The assessment for using the SWPE for eHealth Incentive payment determinations focused on the estimated overall Budget

⁴² Based on least squared analysis, on average every 1000 patient visits to a practice results in an estimated addition to the SWPE of 147.

savings from introducing the incentive, and the number of practices that would have lower payments, compared with the existing incentive it was replacing, the Information Management/Information Technology (IM/IT) Incentive.⁴³

2.22 More broadly, since the formula for the SWPE was set in 1998, there has not been any assessment of the effectiveness of the SWPE as the basis for those PIP payments to practices based on a measure of practice size or patient load, and the degree to which the formula aligns with current program policy intentions.

Use of RRMA as classification for rurality

2.23 In 2008–09, 30 per cent of PIP payments related directly to the RRMA classification. The RRMA classification is used to:

- determine Rural loadings, which aim to recognise the difficulties of providing care, often with little professional support in rural and remote areas; and
- identify those practices classified as rural or remote, eligible to access GP Procedural, Practice Nurse and Domestic Violence Incentives.⁴⁴ Broadly, these incentives are aimed at providing access to services available through other means to patients in metropolitan and other urban areas.

2.24 The ‘rurality’ of each practice is determined using *Rural, Remote and Metropolitan Areas Classification (RRMA), 1991 Census Edition* (Departments of Primary Industries and Energy and Human Services and Health, November 1994). All practices whose main practice location is situated outside capital cities and other major metropolitan areas are paid a Rural loading,⁴⁵ and are able to access particular incentives either not available to, or available universally to, other accredited general practices.⁴⁶

⁴³ eHealth replaced an existing incentive, IM/IT, and a planned incentive, Electronic Decision Support.

⁴⁴ Some practices in metropolitan and other urban areas (RRMAs 1 and 2) can apply for the Practice Nurse Incentive—in particular, those locations identified as having workforce shortages, and those classified as Aboriginal Medical Services or Aboriginal community controlled health services.

⁴⁵ Only payments made to practices rather than GPs are subject to the Rural loading.

⁴⁶ Procedural GP is only accessible to rural and remote practices. The Practice Nurse Incentive is not universally accessible to metropolitan practices. Except for Aboriginal Medical Services, the Domestic Violence Incentive is only accessible to rural and remote practices.

2.25 The method for calculating the Rural loading is a percentage loading. A practice's rural payment is calculated by multiplying the practice's incentive payments by a percentage loading. This loading is then added to the practice's quarterly payment.

2.26 The basis for the RRMA classification, and associated Rural loadings for PIP, are outlined in Table 2.1, below.

Table 2.1

RRMA classification and associated Rural loadings for PIP

Zone	Class	Population	Abbreviation	Rural loadings (%)
Metropolitan Zone	Capital Cities	≥100 000	RRMA 1	0
	Other Metropolitan Centres		RRMA 2	0
Rural Zone	Large Rural Centres	25 000 – 99 999	RRMA 3	15
	Small Rural Centres	10 000 – 24 999	RRMA 4	20
	Other Rural Areas	<10 000	RRMA 5	40
Remote Zone	Remote Centres	≥ 5 000	RRMA 6	25
	Other Remote Areas	< 5 000	RRMA 7	50

Source: ANAO Audit Report No. 26 2008–09, *Rural and Remote Workforce Capacity*, p. 124, and <<http://www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/rurality.jsp>>.

2.27 RRMA has anomalies specifically affecting PIP, such as:

- a number of RRMA 6 centres having similar characteristics to those in RRMA 5, but receiving a 15 per cent lower Rural loading;
- the version of RRMA varying across DoHA programs, resulting in, for example, regions being classified as RRMA 5 for the Rural Other Medical Practitioners Program, but RRMA 1 for PIP; and
- reclassification of RRMA for some locations being implemented based on Ministerial decisions to allow access to greater Rural loadings, but not for all areas where anomalies exist.

2.28 The ANAO has previously reported that RRMA anomalies were highlighted in a review by DoHA in 2005 for the then Minister for Health and Ageing.⁴⁷ Based on a further review of RRMA in 2008 sought by the Minister for Health and Ageing, the Government announced as part of the 2009–10 Budget, that RRMA will be replaced by the Australian Standard Geographical

⁴⁷ ANAO Audit Report No. 26 2008–09, *Rural and Remote Health Workforce Capacity*, p. 124.

Classification—Remoteness Areas system, in a phased approach from July 2009.⁴⁸ While most RRMA-based programs will be changed over to the Australian Standard Geographical Classification—Remoteness Areas in 2009–10, the Government is yet to determine the timing to apply this change to PIP.

2.29 The two practice-based payments assessed in the audit case studies (Domestic Violence and eHealth) include Rural loadings, with the Domestic Violence Incentive only available to practices in RRMAs 3–7. While there was recognition that the provision of domestic violence referral services was limited in rural and remote areas compared with urban centres, in neither case did DoHA assess the consequence of using the RRMA classification on the effectiveness of the incentives achieving their aims.

Types of general practices within the program

2.30 In determining whether an incentive is suitable for inclusion in PIP, it is important that there be an understanding as to the access to the incentive by practice type. Only practices which meet the program entry requirements, including accreditation against the RACGP Standards, are able to access PIP incentives. By way of illustrating the access issues for particular practices, the ANAO examined the barriers to program entry for two such general practice program types, identified as underrepresented in PIP:

- smaller practices; and
- Aboriginal Medical Services.

Underrepresentation of smaller practices

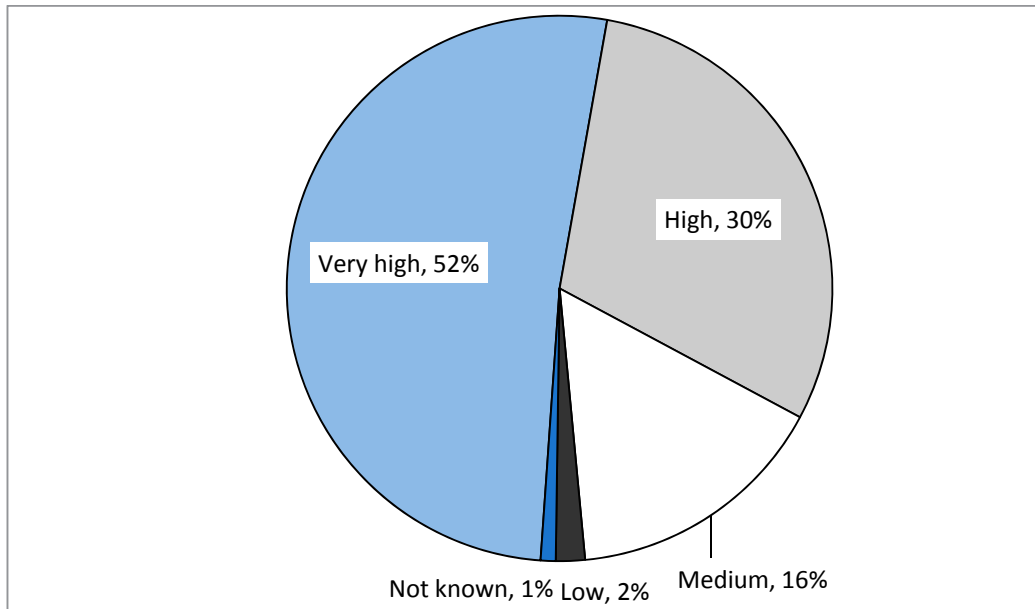
Meeting the PIP eligibility requirement of accreditation is takes time and is costly

2.31 The ANAO survey identified that a significant proportion (82 per cent) of respondents consider there to be a ‘high’ or ‘very high’ cost and work effort to meet the accreditation requirements, the key eligibility criteria for entry into PIP, as shown in Figure 2.4.

⁴⁸ See <<http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2009-hmedia04.htm>> [accessed 22 September 2009].

Figure 2.4

Cost and work effort required for general practices to become accredited



Source: ANAO survey of general practices in regards to PIP, 2009, answering the question 'How would you rate the cost and work effort required to become accredited?' (based on 518 responses).⁴⁹

2.32 There is a perception, particularly for smaller general practices, that it is not worth the time, money and effort to become accredited in order to access PIP payments. This is reflected in the PIP participation rate for solo practices being half that of practices overall.⁵⁰

2.33 Three key stakeholder groups separately informed the ANAO that there is a large discrepancy in the relative cost and time commitment by large and small practices applying for accreditation. These stakeholders raised the following issues:

⁴⁹ As identified at paragraph 1.35, 629 valid responses were received for the survey overall, with varying number of responses to individual questions. The questionnaire streamed responses, so that participants did not respond to questions that were not relevant to their practices, and not every respondent chose to respond to each question.

⁵⁰ The participation of solo practices is estimated at 34 per cent and that of all practices is estimated by the ANAO at 66 per cent, as at May 2009. Solo practices are defined as those practices with one full-time equivalent general practitioner. The overall number of practices, including the number of solo practices is based on self-reporting through the 2007-08, Annual Survey of Divisions. (Footnote 29 explains the basis for determining numbers of practices.)

- fixed costs associated with accreditation, for example, the cost of installing a ramp for access for disabled patients; and
- costs of undertaking the accreditation process; in particular,
 - costs of leading the process, which are often borne by the GP in solo practices, whereas larger, multi-doctor practices often delegate this function to practice managers,⁵¹ and
 - similar work efforts in undertaking many of the accreditation processes, for example, developing manuals and procedures, irrespective of the practice size.

Smaller practices receive relatively less PIP payment benefits

2.34 The relative PIP payment benefits from accreditation are also less for smaller practices. For the May 2009 quarterly payment, solo practices received on average, 25 per cent less PIP payments when compared with payments per FTE across all PIP practices.⁵² Table 2.2 shows that a significant difference applies, irrespective of practice location.

Table 2.2

PIP quarterly payments—May 2009

RRMA	Payments to solo practices (\$)	Payments per FTE – all PIP practices (\$)	Percentage difference (%)
Capital City	2482	3666	-32
Other metropolitan centre	2855	4097	-30
Large rural centre	4275	5805	-26
Small rural centre	4080	6887	-41
Other rural centre	5463	8729	-37
Remote centre	5690	7102	-20
Other remote centre	5699	7727	-26
Total	3541	4749	-25

Source: ANAO analysis of Medicare data.

⁵¹ The ANAO was advised that mostly practice managers attend the training offered by one of the accrediting bodies due to the higher costs associated with sending a general practitioner.

⁵² Solo practices are those with FTE GPs ≤ 1. Medicare Australia bases its FTE measure on the number of patient visits to a practice.

Assessing the access to incentives by small practices

2.35 Underrepresentation of small practices in PIP of itself does not necessarily impact on the effectiveness of some incentives being proposed for PIP, but may affect practices that provide services to particular patient groups. For example:

- patients in remote locations—the ANAO’s assessment indicates that solo practices are disproportionately represented in remote areas;⁵³ and
- patients from non-English speaking backgrounds—an accrediting body advised the ANAO that in urban areas solo practices run by GPs with such backgrounds were less likely to seek accreditation than those from English speaking backgrounds. Research undertaken in 2002 indicates that the non-English speaking background patients were more likely to seek treatment from GPs with similar backgrounds in solo practices within urban areas,⁵⁴ suggesting that such patients are less likely to attend PIP practices.

Developments with potential to assist small practices to become accredited

2.36 The Government announced as part of the 2010–11 Budget the Practice Nurse Incentive Program with practice accreditation as a primary entry criteria, similar to PIP. The new program, planned to be introduced in 2011–12, will include a one-off \$5 000 incentive to support eligible non-accredited practices to become accredited. This payment provides the potential to address some of the cost of accreditation for small practices.

Aboriginal Medical Services (AMSs)

2.37 The number of AMSs in PIP has more than tripled in the period since 2002, with AMS participation in PIP as at May 2009 accounting for 49 per cent of the total number of AMSs. This compares with the rate of accreditation

⁵³ Forty-five per cent of practices in remote areas (RRMAs 6 and 7) are estimated as being solo practices, compared with 37 per cent overall. This is based on 2007–08, Annual Survey of Divisions, using estimated allocations of divisions’ general practice populations across RRMAs. <<http://www.phcris.org.au/fastfacts/fact.php?id=6752>> [accessed 14 October 2009].

⁵⁴ Stephanie A Knox and H. Britt (2002), ‘A comparison of general practice encounters with patients from English-speaking and Non-English-speaking background’, *Medical Journal of Australia*, Volume 177, pp. 98–101.

across all practices which the ANAO estimates to be approximately 66 per cent at the time.⁵⁵

Identified barriers to AMSs becoming accredited

2.38 Through advice from key stakeholders directly to the ANAO and to DoHA, and through DoHA and Medicare Australia commissioned research,⁵⁶ unique barriers to accreditation faced by AMSs were identified, including:

- a lack of capital for AMSs to meet the infrastructure requirements against accreditation standards;⁵⁷
- pre-occupation by GPs and support staff with service provision with little time for further administrative processes, and little understanding of the benefits from accreditation;
- difficulties in demonstrating compliance, even if the AMS meets accreditation requirements;
- lack of eligibility as the service did not employ general practitioners; and
- difficulty in finding out about general practice accreditation requirements and processes.

AMSs may receive relatively less PIP payment benefits

2.39 AMSs may not receive significant benefits from PIP, providing a disincentive to AMSs becoming accredited. In particular:

- AMSs served by visiting general practitioners may have their patients referred to the GPs' own practice for management of chronic diseases and other treatments which attract PIP and SIP payments;⁵⁸ and
- the SWPE provides greater rewards for practices with older patients in comparison with other practices of similar size and workloads.⁵⁹

⁵⁵ Footnote 29 outlines the limitations of the estimate for percentage of general practices in 2010; the percentage in May 2009 is subject to similar limitations.

⁵⁶ Urbis Keys Young, *Aboriginal and Torres Strait Islander Access to Major Health Programs*, available from <http://www.medicareaustralia.gov.au/public/services/indigenous/files/aboriginal_torres_strait_islander_access_to_major_health_programs.pdf> Final Report 18 July 2006 [accessed on 26 August 2009].

⁵⁷ Such requirements identified by AMSs resulted from inadequate building space, lack of consultation room and lack of supply areas.

⁵⁸ SIP or service incentive payments are payments to GPs (rather than to practices) for completing asthma and diabetes cycles of care, and cervical screening for under-screened women.

2.40 The SWPE places a greater weight on older patients, underrepresented in the Indigenous population, as shown in Table 2.3. This supports stakeholder advice to the ANAO that the SWPE disadvantages general practices which have a high proportion of Indigenous patients. The SWPE formula was also recognised by DoHA as being more suitable and valuable to mainstream for similar reasons, in advice to the then Minister for Health and Ageing in May 2002.

Table 2.3

Age distribution by Indigenous status, 2006 Census

Indigenous Status	Age (years)								Total
	<1	1-4	4-14	15-24	25-44	45-64	65-74	75+	
Indigenous (%)	2.4	9.8	25.4	18.9	26.4	13.8	2.2	1.1	100.0
Total population (%)	1.3	5.0	13.5	13.6	28.3	25.0	6.9	6.4	100.0

Source: ANAO analysis based on Australian Bureau of Statistics 2006 Census data (Cat. No. 2068): *Indigenous Status by Age*.

Developments to assist AMSs to gain accreditation

2.41 There have been developments with the potential to assist AMSs gain accreditation and increase PIP benefits, offsetting the costs of accreditation. In particular:

- support and assistance to AMSs to gain information on accreditation from sessions conducted in early 2007, and through a 2007–08 Budget measure with funding for accreditation support grants, quality improvement and accreditation facilitators, and localised accreditation support.⁶⁰ While it is too early to determine the success of the measure on participation rates, as at May 2009 DoHA was on target to spend all of its funding appropriation for 2008–09;⁶¹ and

⁵⁹ See paragraph 2.12 for a description of the basis for determining the SWPE and Table 2.1 for the age-sex weighting factors.

⁶⁰ Through the Office for Aboriginal and Torres Strait Islander Health in DoHA, *A Better Future for Indigenous Australians—Establishing Quality Health Standards*, with funding totalling \$32.8m over four years was allocated to assist Aboriginal and Torres Strait Islander community controlled health organisations to meet the requirement to obtain clinical or other service delivery accreditation by June 2011. Localised accreditation support is provided through the National Aboriginal Community Controlled Health Organisation and State/Territory affiliates.

⁶¹ As at March 2009, 37 organisations were approved for funding under this measure and 63 organisations had applied to engage a quality improvement and accreditation facilitator.

- a PIP Indigenous Health Incentive introduced in May 2010.⁶² While the incentive may compensate for the demographic inequities in the age/sex weightings used to calculate a practice's SWPE, its impact in this regard has not been assessed at this stage.⁶³

Assessing the effect of access to the incentive by practice type—ANAO case studies

2.42 Of the three PIP incentive program developments used as ANAO case studies, DoHA assessed the impact of limiting the access to the ACAI⁶⁴ to those GPs affiliated with PIP practices. The results from the assessment showed that of all GP providers delivering services to residential aged care facilities (RACFs), 88.5 per cent were affiliated with PIP practices, with a significant majority of MBS services to RACF residents delivered by GPs affiliated with PIP practices.

2.43 DoHA did not assess the effect on particular practice types of limiting access to incentives for the other two incentives in the case studies. Such an assessment is particularly relevant for the eHealth Incentive, given that PIP incentives are only available to the 67 per cent of general practices which are accredited. In comparison, the Government has a commitment to implementing eHealth as a key part of reforming the whole health system.⁶⁵

Developing incentives to progress the PIP objective

2.44 Once government has determined that an incentive will be placed in PIP, DoHA has the responsibility for managing the program development process, leading to advice to their Minister on guidelines, including eligibility

⁶² This incentive was announced in November 2008 as part of the Commonwealth's contribution to COAG's National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-ctg-package>> [accessed 15 September 2009]. The incentive is to encourage general practices to provide better health outcomes for their Indigenous patients.

⁶³ DoHA advised that a separate SWPE for Indigenous patients is currently impractical, given the under-reporting of the Indigenous population identified through Medicare Australia's voluntary Indigenous identifier. The new Indigenous Health Incentive may assist in encouraging registration through the voluntary Indigenous identifier. <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/pip-indigenous-health-incentive-questions-answered.pdf>>.

⁶⁴ ACAI provides incentives to GPs associated with PIP practices who provide qualifying levels of MBS services to patients within residential aged care facilities.

⁶⁵ Roxon, The Hon Nicola MP, (2010), Media Release: *E-Health Foundations to be Laid*. (10 February 2010) <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr023.htm?OpenDocument&yr=2010&mth=2>>.

requirements and payment parameters. There are risks to designing an incentive with potential to progress the PIP objective. These risks relate to:

- not meeting requirements for incentives to positively impact on general practices; and
- partial take-up by general practices such that the incentive would have limited impact.

2.45 The ANAO examined whether these risks materialised in the development of incentives. Where limitations were identified, risk management and consultation, communication and coordination processes with stakeholders were examined to determine their adequacy in achieving incentives with effectiveness potential.

Progressing the PIP objective—case study incentives

2.46 In the development of the GP Aged Care Access Incentive, DoHA effectively managed the risks with potential to limit program effectiveness. In particular:

- DoHA modelled the qualifying service levels for incentives. The two service levels that were recommended to the Minister were ones that had been demonstrated to have already been achieved by a proportion of GPs (40 and 25 per cent respectively), thus demonstrating that the service levels were achievable, but not already met by the majority of GPs.
- DoHA assessed the views of key stakeholders in determining the calculation of the payment to encourage take-up. The impact on take-up from restricting access to those GPs associated with PIP processes was also modelled.

2.47 The development processes for the other two case study incentives (eHealth and Domestic Violence Incentives) have limited their contributions to the PIP objective, as outlined below.

eHealth Incentive

2.48 The PIP eHealth Incentive was announced as a 2008–09 Budget measure with expected annual expenditure of \$83 million. The Incentive, which replaced the IM/IT and proposed Electronic Decision Support Incentives, aims to encourage general practices to keep up to date with the latest developments in eHealth, through developing the capacity to exchange patient information and promoting the use of electronic clinical resources.

2.49 While being announced in May 2008, DoHA's consultations with the National eHealth Transition Authority (NEHTA)⁶⁶ and Medicare Australia on the role of these agencies in the implementation of specific requirements of the Incentive were delayed, owing to the evolving nature of the national eHealth approach at the time. This impacted on the rollout and function of fully interoperable secure messaging software for the exchange of patient information.

2.50 Applications were required from practices by 30 April 2009 for the first payment in August 2009. In order to qualify for the first payment, PIP practices needed to meet three requirements outlined in Table 2.4.

Table 2.4

eHealth requirements

Requirement	
1	Practices required a secure messaging capability that allows the exchange of patient clinical and medical information, provided by an eligible supplier. In practice, by 31 July 2009, general practices needed to sign up for the supply of practice software from a supplier that had agreed to: <ul style="list-style-type: none"> • participate in the NEHTA consultation process leading to secure messaging specifications and compliance timelines; and • subsequently comply with specifications and implementation timelines.
2	Practices required (or applied for) from Medicare Australia by 30 April 2009, a location/site Public Key Infrastructure (PKI) ⁶⁷ certificate for the practice and each practice branch. Practices also needed to ensure that each medical practitioner from the practice had (or had applied for) an individual PKI certificate. PKI certificates were to be used to securely send and/or receive information via the practice's messaging system where possible.
3	By 30 April 2009, practices needed to provide their medical practitioners with access to a range of key electronic clinical resources .

Source: <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/ehealth-guidelines.pdf>>.

⁶⁶ NEHTA is a not-for-profit company established by the Australian, state and territory governments in 2005, to develop national e-health standards and infrastructure requirements for the electronic collection and secure exchange of health information. See <<http://www.nehta.gov.au/>> [accessed 10 September 2009].

⁶⁷ PKI is an IT infrastructure that enables the secure exchange of data. PKI is a set of software tools plus hardware, network services and management techniques. Medicare Australia has been issuing PKI certificates to practices and medical practitioners for electronic billing and claiming purposes since 2003—these enable health professions to access Medicare Australia's online systems. Medicare Australia is expected to continue issuing these certificates until July 2010. For more information on PKIs, please see: Medicare Australia, *Public Key Infrastructure*, available from <<http://www.medicareaustralia.gov.au/provider/vendors/pki/index.jsp#N100FC>> [accessed 4 September 2009].

2.51 In effect, however, only Requirement 3 places conditions on general practices to make changes to their operations in line with the PIP objective.⁶⁸

2.52 With regard to Requirement 1, the secure messaging software has limited interoperability until suppliers redevelop their software against NEHTA specifications, and these versions are taken up across health and medical services, such as specialists and pathology laboratories. NEHTA advised that specifications have been determined and published by Standards Australia in March 2010,⁶⁹ but no timeline has been agreed as to when eligible suppliers need to comply with specifications.

2.53 The risk of delay in software suppliers adopting NEHTA specifications was identified in August 2008, but no specific action plan was developed to address this risk. NEHTA was actively engaged late in the process on the use of its specifications as a key design factor in the required messaging software. NEHTA's subsequent feedback to DoHA in January 2009 indicated that the specifications, while drafted, had not been tested with industry, nor used in any products, and that consultation and take-up by industry would take between one and two years. DoHA advised that it addressed this risk by requiring eligible software providers to comply with the specifications within the anticipated implementation timelines.⁷⁰ However, as the timelines have not been agreed to date, DoHA's approach to constraining the delay has been limited.

2.54 Under Requirement 2, once general practices receive their Medicare Australia PKI certificates, there is no obligation for either the practice or their GPs on their use. Medicare Australia has been issuing PKI certificates which facilitate electronic billing and claiming, as well as access to a range of other Medicare Australia online services, to practices and medical practitioners since 2003.

2.55 DoHA advised the ANAO that the inclusion of the PKI requirement was to encourage practices to accept the principle of digital certification as a necessary part of practice technology. It was expected that Requirement 2

⁶⁸ GPs in practices must be able to explain how they access and use the electronic clinical resources.

⁶⁹ Standards Australia Australian Technical Specification ATS 5820–2010, *E-health web services profile*. id., Australian Technical Specification ATS 5821–2010, *E-health XML secured payload profiles*. id., Australian Technical Specification ATS 5822–2010, *E-health secure message delivery*. See <<http://www.e-healthstandards.org.au/drafts.asp?area=publications>> [accessed 18 May 2010].

⁷⁰ See Table 2.4, Requirement 1.

would also significantly support NEHTA's work towards a national authentication system based on PKI. However, Medicare Australia's PKI certificates are designed for a specific purpose—communication with Medicare Australia—rather than to enable the secure exchange of patient information as envisaged under Requirement 1.

2.56 PKI certificates required by practices to receive the incentive that fully supported secure messaging software developed under the NEHTA specifications, was raised with DoHA by Medicare Australia in December 2008. DoHA drew this issue to NEHTA's attention, with the parties agreeing on the importance of a seamless transition process to replace the Medicare Australia PKI certificates once the NASH⁷¹ solution was built. Secure messaging software based on NEHTA specification will be fully operable once NASH PKI certificates are available to practices and GPs.⁷²

Domestic Violence Incentive

2.57 The PIP Domestic Violence Incentive was announced as part of the then Government's 2004 election commitment, receiving four years of funding (totalling \$8.9 million) in the 2005–06 Budget, for practice nurses and Aboriginal health workers. Rural and remote PIP practices that employ nurses or Aboriginal health workers for a minimum period per week, and have these staff available and appropriately trained to undertake domestic violence referrals, are eligible for the Domestic Violence Incentive. The first payments were made to practices for the incentive in May 2008.

2.58 The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) was responsible for the delivery of domestic violence referral training to practice staff,⁷³ delivered through an outsourced training provider, Lifeline. Face-to-face training was rolled out nationally in February 2008, with online training implemented in mid-2008.

2.59 DoHA was responsible for the Domestic Violence Incentive, and for promotion and support arrangements to assist practice staff to attend face-to-

⁷¹ NEHTA is responsible for the National Authentication System for Health (NASH) Program to deliver NASH PKI certificates. The NASH Program through NASH-accredited bodies will deliver smartcards with PKI certificates to 500 000 health care providers (individual and organisations).

⁷² NEHTA advised that it is currently finalising the process for the provision of NASH PKI certificates. It forecast that this capability would be available between April and July 2011.

⁷³ FaHCSIA had the overall policy responsibility for the 'Women's Safety Agenda', of which the PIP Domestic Violence incentive was an element.

face training, the latter outsourced under a funding contract for \$234 000 to the Australian General Practice Network, for activities including payments to participating divisions of general practice to promote the training workshops to eligible practices in their divisions.

2.60 In 2009–10, only 223 practices, representing 17 per cent of the 1288 practices with potential to be eligible for the payment (that is, RRMA 3–7 PIP practices receiving Practice Nurse Incentives) received Domestic Violence Incentive. Furthermore, as at the end of 2009–10, DoHA had expended \$783 000 or 8.2. per cent of its four-year expenditure allocation for the incentive.

2.61 Risks to potential take-up were identified early in program development. These related to: safety concerns for practice staff; timing of, information on, and accessibility to, training delivery; and level of rewards for practices to participate in the incentive. While DoHA undertook activities to address these, the residual risks were not sufficiently monitored to ensure that the activities were effective in enhancing the potential for take-up.⁷⁴ Improved communication and coordination arrangements, primarily between DoHA and FaHCSIA, but also with Lifeline and the Australian General Practice Network, would have assisted in better managing these risks.

Risk management approach to program development

2.62 Managing risks is an integral part of management and quality assurance for policy projects. Part of such an approach includes conducting and documenting initial risk assessments. The importance of this activity in managing policy projects is recognised in the ANAO Better Practice Guide: *Some Better Practice Principles for Developing Policy Advice*.⁷⁵

Departmental risk management requirements and tools

2.63 DoHA has a risk management framework (comprising Secretary's instructions, corporate business rules and allocation of responsibility) that requires risks to be assessed as part of the policy development activities. This is supported by a *Risk Management Toolkit*, which guides users to identify for each area of activity and for each risk:

⁷⁴ Details on these risks and DoHA's activities to manage the risks are outlined at Appendix 6.

⁷⁵ ANAO Better Practice Guide (2001), *Some Better Practice Principles for Developing Policy Advice*, p. 2.

- the consequences, sources and current controls;
- the effectiveness of the controls;
- the risk rating, based on consequence and likelihood; and
- further treatments to mitigate the risks.

2.64 Overall, DoHA provides guidance in line with better practice for risk management in program development. The ANAO examined the extent to which this guidance had been applied to the three case study incentives.

Risk management in program development—case study incentives

2.65 In each of the three case study incentives, DoHA has identified and assessed the risks to developing an effective incentive during the program development stage, including the means to manage these risks. In particular, in regard to the:

- Domestic Violence Incentive, DoHA developed a management plan in March 2006, and subsequently in November 2008 identified and assessed risks associated with take-up of the incentive by practices;
- ACAI, DoHA identified risks associated with delays in the implementation of the incentive, following its announcement by Government as part of the 2008–09 Budget. Further, risks to the effectiveness of the incentive (such as the availability of the incentive only to GPs associated with PIP practices, and the sufficiency of the incentive to improve service delivery to RACF patients) were identified through consultation with stakeholders and assessed to determine the level of risk; and
- eHealth Incentive, DoHA identified and assessed the risk of a delay implementing the incentive immediately following the 2008–09 Budget. Risks relating to delays in developing secure messaging software fully supported by PKI certificates required under the incentive were subsequently brought to DoHA’s attention⁷⁶ but not formally assessed.

2.66 Following the assessment of the risks, DoHA generally implemented actions to mitigate the effect of the risks. The key factor that subsequently affected the ability of eHealth and Domestic Violence Incentive’s contributing

⁷⁶ See paragraphs 5.51–5.56 for details.

to the PIP objective, was limited monitoring and assessment by DoHA as to the effectiveness of its actions in mitigating risks and adopting new approaches in circumstances where the residual risk remained unacceptably high. The effect from this shortcoming in following up risks and their occurrence has been:

- a delay in any significant increase in general practice IT capability from the eHealth Incentive (with estimated expenditure of \$83 million per annum) in line with PIP's objective; and
- late implementation and poor take-up by practices of the Domestic Violence Incentive, with only 3.7 per cent expenditure against that budgeted over a four-year period.

Consultation, coordination and communication with key stakeholders during program development

2.67 The Better Practice Guide *Implementation of Programme and Policy Initiatives* addresses the importance of stakeholder management, including early consultation in planning an implementation.⁷⁷ Engaging with key stakeholders at strategic points in program development is essential as it assists in:

- the program eligibility requirements being effective in meeting the program objectives—in particular, there are no unforeseen barriers to implementation; and
- the program guidelines being understood by all potentially eligible applicants.

Departmental approach to engage with stakeholders

2.68 The guidance provided to DoHA managers on policy formulation and advice highlights the importance of a consultation plan that identifies the following:

- the role of consultation in achieving the program objective;
- relevant stakeholders, their particular interest and information/perspective that they can bring to the policy development;

⁷⁷ Department of the Prime Minister and Cabinet and ANAO (2006), *Implementation of Programme and Policy Initiatives*, p. 35.

- the means of undertaking the consultation (for example, one-on-one meetings) most likely to be successful with particular stakeholder groups; and, subsequently
- the consultation process, including resources, timeframes, agenda items (for meetings), and documentation to be presented for the consultation.⁷⁸

2.69 The ANAO assessed the extent to which DoHA plans and implements effective consultation, coordination and communication with key stakeholders during program development, drawing on examples from the case studies.

Consultation, coordination and communication—case study incentives

2.70 While there were no consultation plans in place for the three case study incentives examined by the ANAO (the Domestic Violence, GP Aged Care Access and eHealth Incentives) there were elements which contributed to consultation, coordination and communication with key stakeholders as part of program development. In particular:

- key stakeholders were identified in the draft risk assessments for each of the payments;
- a communication strategy for the Domestic Violence Incentive, jointly developed by DoHA and FaHCSIA, for the purpose of advising practices on the training available to practice nurses/Aboriginal health workers was developed; and
- NEHTA developed an eHealth communication and consultation plan to engage with medical software suppliers to ‘discuss and refine with industry the specifications and compliance approach for secure messaging under the eHealth PIP’.

2.71 Furthermore, there was engagement with the Minister, and arrangements to assist consultation with the following key stakeholders:

- general practice industry representatives;
- Medicare Australia; and

⁷⁸ DoHA (2007), *Policy Formulation and Advice – Advanced*, (presented by CIT Solutions Pty Ltd on behalf of the Australian Public Service Commission for DoHA).

- other relevant government agencies.

Engagement with general practice representatives

2.72 DoHA established the PIP and Enhanced Primary Care Review Advisory Group (PERAG) to initially advise and assist it to undertake a review to develop changes to simplify and improve PIP (and the enhanced primary care package).⁷⁹ The group comprised representatives from the Australian Medical Association, Royal Australian College of General Practitioners (RACGP), Australian General Practice Network, and Rural Doctors Association of Australia, and met regularly between August 2004 and August 2007. In the view of its members, PERAG provided a valuable forum for consultation. However, four national groups involved in aspects of general practice not represented on PERAG advised of limited consultation on PIP by DoHA and its impact. Examples identified where consultation, particularly with practice manager and practice nurse groups, could have assisted program review and development included:

- the practicalities associated with SIPs relating to particular MBS items; and
- the clarity in some of the guidelines issued.

2.73 From September 2007 to April 2009, there was no formal consultative group convened by DoHA for the PIP. For developing the ACAI and eHealth Incentive, DoHA wrote to the groups previously represented on PERAG with drafts of the proposed incentive guidelines; final guidelines and other actions reflect consideration and take-up of their views, where practical. In the view of these stakeholders, this level and timing of consultation had not been optimal particularly for the eHealth Incentive, as it:

- limited the profession's input to the design of the incentive to maximise value-for-money; and
- did not allow sufficient time for stakeholders to prepare their constituent members to assist a structured rollout of the incentive.

2.74 In May 2009, DoHA established the PIP Advisory Group, comprising representatives from stakeholders involved in the PERAG, as well as the

⁷⁹ As outlined in paragraph 1.8, following consideration of the General Practice Red Tape Taskforce recommendations, the Government agreed that DoHA should undertake this review of PIP (and the enhanced primary care package).

Australian College of Rural & Remote Medicine, as permanent members. The Advisory Group is expected to meet twice a year, with additional meetings scheduled on an 'as needs' basis, for the following purpose:

To provide timely advice and assistance to the Primary Care Practice Support Branch, DoHA, on the development and implementation of initiatives or changes to existing initiatives available through the PIP and the General Practice Immunisation Incentive.

2.75 DoHA informed the ANAO of its intention to include other relevant stakeholders in consultations relating to future changes to incentives. Consistent with this approach, Medicare Australia, the National Aboriginal Community Controlled Health Organisation and the Australia Indigenous Doctors Association, were invited to participate in the group on discussions on developing the PIP Indigenous Health Incentive.

2.76 The PIP Advisory Group provides the potential to address gaps in representation and to ensure timely consultation with industry stakeholders going forward.

Engagement with Medicare Australia

2.77 As the body responsible for delivering PIP payments to general practices and general practitioners, early engagement with Medicare Australia on program development is critical for both Medicare Australia and DoHA as it provides opportunities to address, among other issues:

- timing and other practicalities in implementing or changing the payment, such as the costs of IT changes;
- interpretation of the guidelines including eligibility criteria; and
- clarity of the communication with potential recipients of the new or changed payment arrangements.

2.78 DoHA and Medicare Australia have formal agreements that address consultation between the agencies on program planning. DoHA met with Medicare Australia regularly during program development of the incentives

examined in case studies, covering a range of issues, consistent with the formalised arrangements.⁸⁰

2.79 The program planning consultation with Medicare Australia related to two of the three case studies (the Domestic Violence Incentive and ACAI) was largely effective. While there were concerns raised by both agencies on issues particularly relating to the timing for the incentives' commencement,⁸¹ solutions and changes were put forward to deal with issues as they arose.

2.80 With regard to the eHealth Incentive, the timing of the payment implementation relative to the finalisation of the incentive guidelines and advice to practices created a concern for Medicare Australia that it would be unable to meet expected demand for issuing PKI certificates. This was resolved by limiting the requirement for practices to use Medicare Australia PKIs with secure messaging software to a requirement for practices to apply for such PKI certificates. DoHA engaged with Medicare Australia and NEHTA on their role in the implementation of specific requirements at a late stage relative to the time at which practices were due to comply with the eHealth requirements to be eligible for the August 2009 payment. This impacted on its ability to resolve issues such as the operability of secure messaging software with required PKI certificates.

Coordination with other government agencies

2.81 With respect to the three case studies examined, there were two key government stakeholders, other than Medicare Australia:

- FaHCSIA, regarding training for the Domestic Violence Incentive;⁸² and
- NEHTA, regarding consultations with software vendors for setting secure messaging specifications and compliance timelines, relating to the eHealth Incentive.⁸³

⁸⁰ The formalised arrangements (currently the 2009 BPA, and previously the 1998 SPA, outlined in paragraphs 1.26 to 1.27) outline requirements to consult on a range of issues, including: Medicare Australia costings, business rules which address payment purpose, eligibility requirements, roles and responsibilities, payment details and timing, application forms, payment guidelines, and letters to practices. Appendix 8 provides an overall assessment of the PIP BPA.

⁸¹ One of the key issues of concerns relating to timing for payment commencement relates to the lead time that Medicare Australia requires to implement IT system changes, even ones which DoHA view as straight-forward. Payment implementation within Medicare Australia is examined in paragraphs 5.5 to 5.16. The audit scope does not include a detailed examination of the cost and effort required in making IT changes to Medicare Australia systems; this issue will be subject to future performance audit planning.

⁸² See paragraph 2.58.

2.82 As identified at paragraph 2, Appendix 6, FaHCSIA and DoHA had a structured approach to communication and coordination through a steering committee and a supporting operational group which met on a regular basis following funding of the Domestic Violence Incentive in the 2005–06 Budget up to January 2009.⁸⁴ While the information exchange through these groups was useful, the delivery of training through distance education—the key means it identified in 2005 to provide the more equitable and accessible means of delivering training—was not progressed in a timely manner. Furthermore, evaluation of the training undertaken for FaHCSIA identified that these groups were not fully effective in jointly planning training localities, affecting take-up of face-to-face training by PIP practices. Together these factors contributed to the low take-up of the incentive overall.

2.83 As identified at paragraph 2.53, DoHA engaged NEHTA at a relatively late stage of the eHealth Incentive development on its role in the secure messaging software requirement, affecting the time at which specifications for this software would be agreed with industry and reflected in products. NEHTA advised that, after its initial late engagement with DoHA, previously established channels of communication between the two agencies were used in managing the required engagement with the software suppliers and in ensuring that DoHA was kept informed of the progress of NEHTA's negotiations with industry on developing software specifications. NEHTA further informed the ANAO that it has also improved its governance and communication arrangements with both DoHA and Medicare Australia.

Improving program development processes

2.84 DoHA has governance processes in place to support the development of incentives through consultation and coordination with key stakeholders. DoHA's management of these processes has not been consistent, limiting the potential of two incentives to encourage changes in general practice, at least in the short term. The ANAO suggests that for all its PIP incentive developments, DoHA undertake a structured approach that engages stakeholders early in the development phase, and monitors the effectiveness of consultation to address this risk.

⁸³ See paragraph 2.48.

⁸⁴ The Steering Committee met again in September 2009 to discuss the outcome of an evaluation of the training.

2.85 DoHA's current approach to program planning does not assess the consequence of placing a payment in PIP across the range of practices at which the initiative is aimed. An assessment at the design consideration stage, modelled on a range of practices with varying characteristics, would assist DoHA to understand which parts of the practice population are most likely to benefit, or be influenced by, an incentive placed in PIP and using parameters, such as SWPE and RRMA.

Recommendation No.1

2.86 To better inform its advice to government on the development and use of the Practice Incentives Program (PIP), the ANAO recommends that DoHA develop the capability to model the affect of PIP design features on the likely uptake and success of proposed incentive payments.

DoHA response

2.87 The Department agrees with the recommendation.

3. Program Achievement, Reporting and Evaluation

This chapter assesses PIP's achievements against its objectives, setting of and reporting on KPIs and associated targets, and evaluation of the program and its incentives.

Introduction

3.1 Since its inception in 1998, PIP has had a range of objectives and aims relating to, for example, a blended payment approach, and improving services to general practice patients, while minimising 'red tape' for practices. PIP also comprises a significant number of incentives, each with their own aims. These complexities highlight a need for DoHA to implement a strategic approach to undertaking its program management activities to measure, assess and report on the effectiveness of PIP.

3.2 To examine the extent to which DoHA determines and reports on PIP outcomes, the ANAO assessed:

- PIP achievements against its objectives;
- DoHA's setting and reporting against KPIs and associated targets; and
- DoHA's evaluations of PIP at the broad program and individual incentive level.

Achievements against PIP objectives

PIP objectives

3.3 PIP's objectives since commencing in 1998 are as follows:

- **original (1998):** PIP aims to recognise general practices that provide comprehensive, quality care and are accredited or working towards accreditation against the Royal Australian College of General Practitioners' Standards for General Practice. PIP is part of a blended payment approach for general practice that aims to compensate for the limitations of fee-for-service arrangements, which provide greater rewards to practices with high volume, brief consultations; and
- **current (from February 2006):** PIP aims to provide a flexible, cost-effective mechanism for the Government to encourage both short and

long-term changes to general practice, to support quality care, and to improve access and health outcomes with a minimum of red tape.

3.4 The objectives set for PIP are broad-ranging and encompass a number of aims. In order to determine the extent to which PIP achieved its objectives, the ANAO assessed the following aspects: accreditation of general practices; contribution to a blended payment approach; minimisation of 'red tape'; improved services for patients through quality care and better access; and changes in, and improvements to, general practice.

Accreditation of general practices

3.5 Accreditation of general practices against the RACGP's *Standards for General Practice*, was a key part of the aim of the original PIP objective, and remains a key eligibility requirement for practices to enter the program.⁸⁵ Figure 3.1 shows the number of practices participating in PIP since its inception.

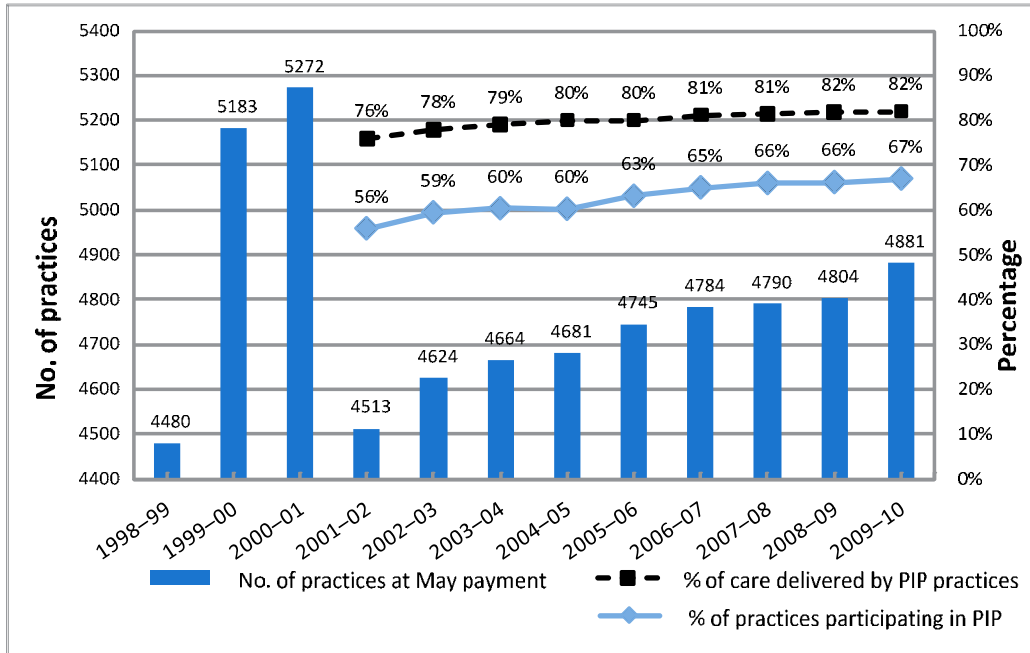
3.6 The drop in the number of practices participating in PIP from 5272 in 2000–01 to 4513 in 2001–02, reflects the introduction of the eligibility requirement relating to accreditation against the Standards.

3.7 Since accreditation became the requirement for PIP eligibility, PIP participation provides a substitute measure for general practice accreditation. Figure 3.1 shows that the number of practices participating has steadily increased from 4513 at May 2002 to 4881 at May 2010. Furthermore, as a proportion of general practices, participation in PIP has increased from 55 per cent to 67 per cent since 2001–02.⁸⁶ The growth is only partly attributable to the increase in PIP participation by practices; it also reflects a decrease across the period in the number of general practices, from 8084 in 2001–2002 to 7261 in 2007–08, owing to increases in practice sizes.⁸⁷

⁸⁵ See paragraphs 4.1–4.2, for further details on accreditation.

⁸⁶ Productivity Commission (2010), *Report on Government Services 2010*, p. 11.42 reports that PIP participation can be used as a proxy for accreditation rates. Further, over the last three years, its estimates of accreditation rates among general practices are within two per cent of PIP participation rates by practices as shown in Figure 3.1. The ANAO estimates of PIP participation were used in the above figure because of their availability as time series since 2001–02.

⁸⁷ <<http://www.phcris.org.au/fastfacts/fact.php?id=6752>> [accessed 14 October 2009].

Figure 3.1**Participation of general practices in PIP**

Source: ANAO analysis of:

- for number of practices at May payment—HIC and Medicare Annual Reports, 1998–99 to 2008–09;
- per cent of practices participating in PIP—Medicare Australia and HIC Annual Reports, 2001–02 to 2007–08 for number of practices participating in PIP at May payment. Footnote 29 explains the basis for determining for total number of practices in Australia;
- per cent of care delivered by PIP practices for whole of financial year—DoHA annual reports; and
- Medicare Australia 2009–10 data.

3.8 An alternative means of determining the level of participation has been used by DoHA in most of its annual reports since 1999–2000.⁸⁸ This is based on the percentage of general practice care delivered through PIP participating general practices.⁸⁹ Figure 3.1 also shows that there has been an increase in this measure, averaging 0.8 per cent increase per annum, since 2001–02.

3.9 Both measures of PIP participation indicate a slowing rate of take-up over the last two years with, for example, the percentage of care delivered through PIP practices only increasing by 0.2 per cent per annum over this period.

⁸⁸ This measure was not reported in 2006–07, but 2006–07 results were included in the 2007–08 annual report. Paragraphs 3.34–3.39 have further details on reporting.

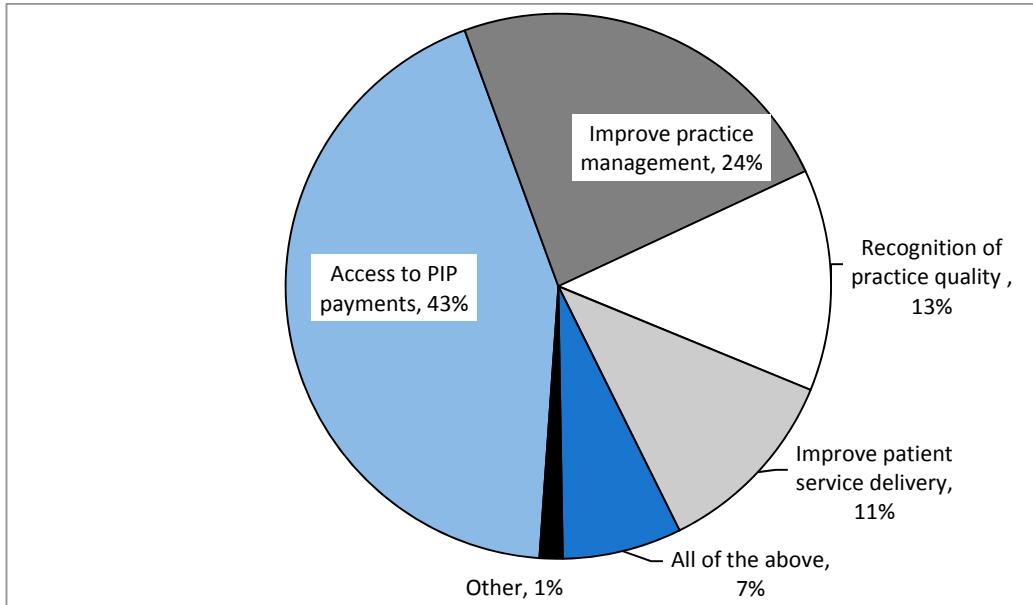
⁸⁹ The percentage of general practice care is determined by standardised whole patient equivalents (SWPEs). Paragraphs 2.12–2.13 outlines how the SWPE is calculated, and detailed at Appendix 4.

3.10 The Australian Commission on Safety and Quality in Health Care,⁹⁰ reported on the rates of accreditation by health service type. General practice was the only health service type, other than those with mandatory requirements, that achieved significant rates of accreditation. In particular, the Australian Commission on Safety and Quality in Health Care reported that, as at January 2008, 83 per cent of general practices were accredited, compared with less than three per cent for all other health service types with voluntary accreditation requirements.⁹¹ The Commission attributed the high rates of general practice accreditation partly to the financial incentives provided through PIP.⁹² This view is supported through the survey undertaken by the ANAO as part of the audit, with 50 per cent of respondents nominating ‘access to PIP payments’ as the main reason for accreditation (when ‘all of the above’ is included), of which 86 per cent of these nominated this as the only reason (see Figure 3.2).

⁹⁰ The Australian Commission on Safety and Quality in Health Care was established on 1 January 2006 by Australian state and territory governments. The Commission aims to develop a national framework and work program, to improve safety and quality across the Australian health care sector, including the development of nationally agreed standards for safety and quality improvement.

⁹¹ Australian Commission on Safety and Quality in Health Care (2008), *Windows into Safety and Quality in Health Care 2008*, p.78. Other health care services with voluntary accreditation requirements include dental practices, physiotherapy private practices, and optometry practices.

⁹² *ibid.* p. 80.

Figure 3.2**Reasons for general practices becoming accredited**

Source: ANAO survey of general practices in regards to PIP, 2009, answering the question 'What is the main reason for your practice becoming accredited?' (based on 518 responses).⁹³

3.11 The Australian Commission on Safety and Quality in Health Care's assessment of accreditation rates across health service types and the increasing participation in PIP by practices, albeit at a slowing rate more recently, suggests that PIP has resulted in increased general practice accreditation rates.

Contribution to a blended payment approach

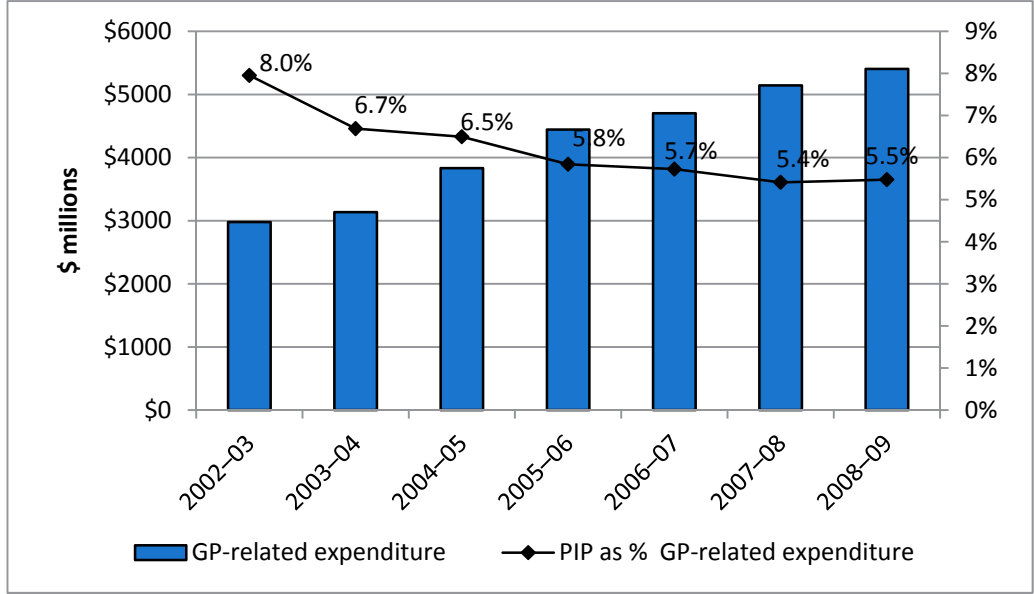
3.12 PIP was established as part of a 'blended payment' approach for general practice, which aims to compensate for the limitations of fee-for-service associated with the Medicare Benefits Schedule (MBS), and to recognise general practices which provide comprehensive quality care. A successful blended payment approach balances financial incentives for the longer term management of patients with specific needs, with benefits to general practices based on the volume of fee-for-service visits.

3.13 DoHA established a KPI that measured how effective PIP has been in contributing to a blended payment scheme, and this was reported in 2001–02

⁹³ Footnote 49 explains varying numbers of responses to individual survey questions.

and 2002–03.⁹⁴ This indicator measured PIP payments as a percentage of Australian Government funding for general practices. Using a similar measure of funding for general practices based on PIP payment expenditure and MBS expenditure on general practice and general practitioner (GP) -related items (GP-related expenditure), the ANAO estimated the contribution by PIP since 2002–03. The results are shown in Figure 3.3.

Figure 3.3
Government funding for general practices/practitioners and PIP's contribution, 2002–03 to 2008–09



Source: ANAO analysis of Medicare Australia data. Included in GP related expenditure is PIP expenditure and GP and general practice MBS item expenditure (currently Groups A1, A2, A5, A6, A7, A11, A14, items 721 to 779 from Group A15, Groups A17, A18, A19, A20, A22, A23, M1, M2 and M5).

3.14 While PIP expenditure rose by 25 per cent to \$295.9m in the six years since 2002–03,⁹⁵ MBS expenditure on general practice and GP items increased by 86 per cent.⁹⁶ As a result, PIP's proportion of GP-related government expenditure has decreased over the six-year period, from 8.0 per cent in 2002–03 to 5.5 per cent in 2008–09. Changes to PIP, such as Budget savings

⁹⁴ DoHA, *Annual Report 2001–02*, Canberra, 2002, p. 108; and DoHA, *Annual Report 2002–03*, Canberra, 2003, p.98.

⁹⁵ Figure 1.2 shows PIP payments to general practices and general practitioners since 1998–99.

⁹⁶ Expenditure on these MBS items rose from \$2742 million in 2002–03 to \$5108 million in 2008–09. This a 70 per cent increase once standardised for resident population changes.

measures, the relative level of PIP incentive take-up by general practices, government decisions changing the MBS, and changes to the GP workforce, are likely to have contributed to this decline.

3.15 DoHA has advised that since 2003 the focus on the blended payment aspect decreased, to place greater emphasis improving quality of care as the primary goal of the PIP. Nonetheless, until the Government changed the PIP objective in 2006, the blended payment aspect remained part of the Government's original objective. Furthermore, in the three years to 30 June 2006, PIP as a proportion of GP-related expenditure decreased by 2.2 per cent, with only a marginal decline since that time. This decreasing trend of PIP as a proportion of GP-related expenditure suggests that PIP's contribution to a blended payment approach, where fee-for-service and practice payments are intended to be mutually reinforcing, is reducing.

Addressing 'red tape'

3.16 The Productivity Commission's 2003 report on the administrative cost impact on GPs from Government programs estimated that 32.8 per cent of such costs were attributable to PIP.⁹⁷ The General Practice Red Tape Taskforce established by Government in response to this report recommended to Government in December 2003 on the need to streamline GP administrative arrangements across government programs, and sought a second-stage review to simplify PIP and enhanced primary care items.⁹⁸ A range of changes designed to address 'red tape' by simplifying the PIP program and its administration were considered and subsequently reported to the Minister (see Table 3.1).

⁹⁷ See paragraph 1.7.

⁹⁸ Enhanced primary care MBS items are those associated with extended care planning and management of chronic and complex medical conditions.

Table 3.1**Measures to address PIP ‘red tape’**

Measures	Status
Quality Prescribing Incentive: Practices notified of their targets for this incentive three months earlier, giving more time to plan for qualifying activities	Implemented November 2004
Service Incentive Payments (SIPs):	
– Diabetes: increased discretion in applying cycle of care	Implemented February 2005
– Diabetes: greater flexibility in period in which cycle of care can be completed	Implemented May 2005
– Asthma: third consultation	Implemented November 2006
– Mental Health: three separate visits no longer required ⁹⁹	Implemented May 2005
– guidance to GPs about role of practice nurses in management of chronic disease SIPs	Implemented through funding to divisions of general practice.
After-hours Incentive: The hours of direct after-hours care required from smaller practices to qualify for Tier 2 payments lessened.	Implemented February 2006
Information Management/Information Technology (IM/IT): to ensure more streamlined practice administration, new IM/IT requirements introduced relating to electronic patient records and secure systems.	Implemented November 2006
PIP payment structure: new PIP structure consisting of three streams (Quality, Capacity, and Rural Support).	Implemented August 2009 The revised payment structure will be reflected in PIP Online forms and statements. ¹⁰⁰
Streamlined administrative arrangements:	
– practices no longer have to submit evidence of public liability insurance and medical indemnity insurance for their GPs as part of application process	Implemented November 2005
– Accreditation advice provided directly to Medicare Australia from accrediting bodies	Not implemented as considered breach of privacy principles.
– Improved practice statements and online access to do business with Medicare Australia using PKIs.	Planned full implementation (PIP Online) October 2010

Source: ANAO analysis of DoHA and Medicare Australia information.

3.17 While most of the measures recommended to reduce ‘red tape’ have been implemented at this stage, there is still a perception among general practices of significant administration burden from this program. In the ANAO survey of general practices, respondents who identified that their practice had been receiving PIP for five years or more were asked about the change in cost

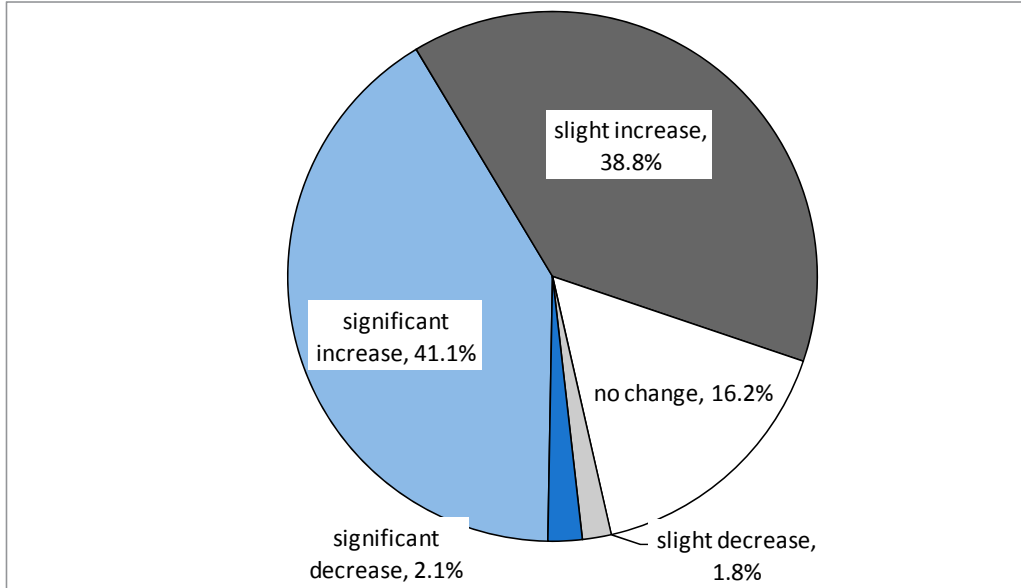
⁹⁹ GP Mental Health Care Medicare items developed as part of the COAG Mental Health package replaced this SIP, which was gradually withdrawn from 30 April 2007.

¹⁰⁰ See paragraph 5.26 for more information on PIP Online.

and work effort to receive PIP payments over the last five years. Figure 3.4 shows the results.

Figure 3.4

Change in cost and work effort to receive PIP, over past five years



Source: ANAO survey of general practices in regards to PIP, 2009, answering the question 'Has the cost and work effort for your practice to receive PIP payments changed over the last 5 years? Please rate the change in cost and work effort' (based on 395 responses).¹⁰¹

3.18 Of the respondents to this survey question, four per cent considered that the cost and work effort had decreased, with 80 per cent considering that there had been at least a slight increase.

3.19 Of the 395 respondents, 133 provided comment relating to this question. The reasons are shown in Table 3.2.

¹⁰¹ Footnote 49 explains varying numbers of responses to individual survey questions.

Table 3.2**Reasons nominated for increases in cost and effort to participate in PIP**

Reason	Percentage (%)
Meeting accreditation requirements, particularly against increasing requirements of the Standards	31
Administration of PIP payments	16
Related to meeting IT/eHealth payment requirements	12
Related to meeting requirements of other PIP payments	11
Cost/effort of participation—not further specified	30
<i>Total—reasons nominated</i>	<i>100</i>

Source: ANAO survey of general practices. Number of respondents — 133.

3.20 While the number of respondents nominating a reason was relatively small, it suggests that increasing accreditation requirements have a similar effect on cost and effort to participate in PIP as do the administration and the direct requirements of the PIP payments themselves.

3.21 DoHA informed the ANAO that as each PIP payment has its own set of requirements, the administrative burden for practices participating in each payment could be regarded similarly as that of practices participating in separate government programs—as such the cost and effort per payment should not be considered onerous, but rather essential to ensure accountability. Furthermore, the average PIP payment to practices has increased by 15 per cent over the last four years, to compensate for any actual increases in cost and effort to participate in the program.

Improved services for patients

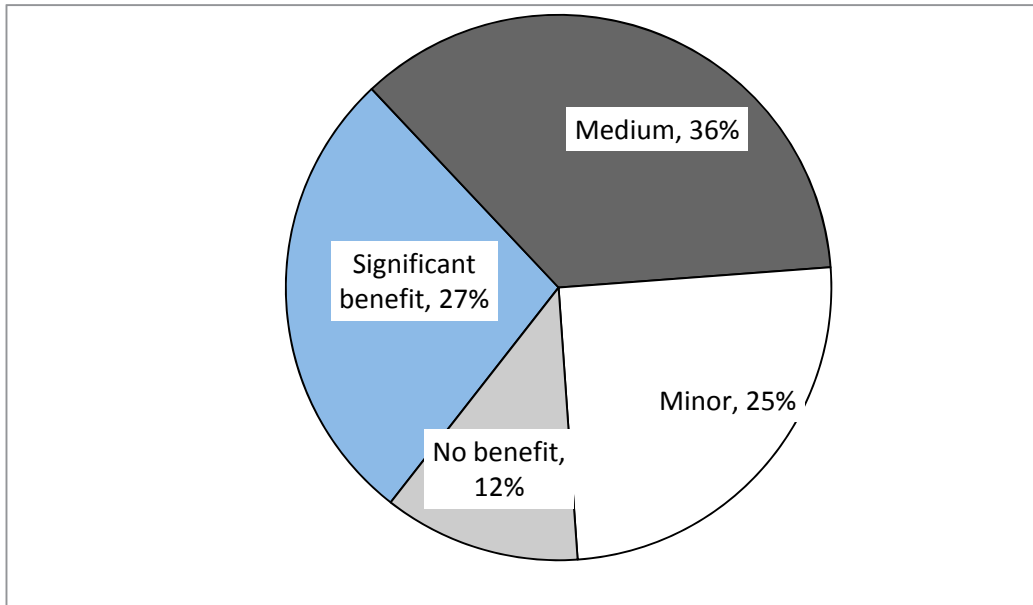
3.22 One of the key aims of the current PIP objective is to provide patients with quality care and improved access. There are no specific KPIs collected and monitored by DoHA to measure the effect of PIP in achievements against these aims. Rather, DoHA relies on participation rates for individual incentives that it regards as contributing to these aspects of patient services. Participation rates can only be relied upon as measures of effectiveness, if there is a proven link between activities required by practices or GPs to be eligible for the incentive and improved service outcomes for patients.

General practices' views on PIP's contribution to quality care and improved access

3.23 The ANAO survey sought from PIP general practices their view on the benefits from participation in PIP relating to: support for providing patients with quality care and improved access. The results are shown in Figure 3.5.

Figure 3.5

Benefits from participation in PIP to quality care and improved access



Source: ANAO survey of general practices in regards to PIP, 2009, answering the question: 'Please identify and rate the following in terms of benefits from your practice's participation in PIP—support for providing patients with quality care and improved access.' (based on 484 responses)¹⁰²

3.24 Figure 3.5 indicates that 88 per cent of PIP practices responding to the survey consider that these aspects of patient services were improved from participating in PIP, albeit at a minor level for about 28 per cent of these respondents. While the survey did not seek comments directly related to these questions, a small number of practices nominated that they were already providing high levels of patient services before participating in PIP; PIP allowed them to update IT systems and pay for after-hours services.

¹⁰² Footnote 49 explains varying numbers of responses to individual questions.

Other evidence of contributions to quality of care from PIP

3.25 DoHA identified for the ANAO the incentives that it considers contribute to quality of care from PIP. Of these, the ANAO assessed those incentives which were either identified by the IDC in its report to government¹⁰³ as contributing to quality health care or had been included under the 'quality stream' of payments as reflected in revised quarterly payment advice to practices, planned for implementation in October 2010. Table 3.3 identifies these incentives and summarises the findings from the ANAO assessment to determine whether there was evidence of the incentive resulting in improved quality of care; the findings are examined in Appendix 7. Overall, these findings suggest that PIP contributes to patient quality of care.

Table 3.3

Incentives assessed for evidence of contributions to quality of care

Incentive	Evidence that incentive results in improved quality of care	Appendix 7 reference for assessment
Information Management/ Information Technology (IM/IT)	Potential benefits, but no evidence to quantify or determine whether benefit significant other than high participation rates	Paragraphs 1 to 3
Quality Prescribing	Evidence of improvements, but effect limited by low take-up	Paragraphs 4 to 5
Diabetes	Evidence to indicate improvement to quality of patient care	Paragraphs 6 to 9
Asthma	Evidence to indicate improvement to quality of patient care	Paragraphs 10 to 11
Practice Nurses	Evidence of improvement to quality of patient care	Paragraphs 12 to 13

Source: ANAO analysis and DoHA advice and information.

Other evidence of improvements in access from PIP

3.26 DoHA identified for the ANAO those incentives that it considers contribute to access to primary health care from PIP. Table 3.4 summarises these incentives and the findings from the ANAO assessment to determine whether there was evidence of the incentive resulting in improved access to primary health care (the ANAO's analysis is provided in detail in Appendix 7).

¹⁰³ See paragraph 1.9 for the basis of the IDC and its report.

On balance, these findings suggest that PIP contributes to improved patient access to care.

Table 3.4

Incentives assessed for evidence of contributions to access to care

Incentive	Evidence that incentive results in improved access to care	Appendix 7 reference for assessment
Practice Nurse	Evidence of positive contribution to access to care	Paragraph 14
After hours	Some evidence of contribution to availability of after-hours care, but limited relative to the expansion of MBS after-hours items	Paragraphs 15 to 16
Teaching	Evidence of positive contribution to access to care, albeit indirectly	Paragraph 17
Rural/remote loading	Evidence of positive contribution to access through supporting financial viability of practices, but loading does not reflect availability of general practice services	Paragraphs 18 to 27
Procedural GP	Evidence of positive contribution to access, concentrated in RRMA 5–7	Paragraph 28
Domestic Violence	Limited take-up. No evidence as yet on contribution to access to care	Paragraphs 29 to 30
GP Aged Care Access	Evidence of positive contribution to access, based on early data	Paragraph 31 to 33

Source: ANAO analysis and DoHA advice and information.

Encouraging changes in general practice

3.27 PIP aims to encourage short and long-term changes in general practice. There are no specific KPIs collected and monitored by DoHA to measure the influence of PIP in facilitating changes in general practice (other than participation rates for individual incentives).

3.28 The ANAO identified that the Information Management/Information Technology (IM/IT) incentive provided the potential to aid positive changes in general practice.

IM/IT Incentive contribution to changes in, and improvements to general practice

3.29 The IM/IT Incentive specified computerisation requirements for participating practices—in effect, increasing participation in this incentive could indicate a contribution to practice improvement in this aspect of operations. In addition, in order to improve the efficiency of general practice

functions, increased computerisation requirements were introduced for this incentive in November 2006. Table 3.5 shows the participation rates for the IM/IT incentives at the commencement and cessation of the new/changed requirements.

Table 3.5

IM/IT PIP incentives and participation rates at start and end of new/changed requirements

IM/IT requirement	Characteristics	Participation rates (% of PIP practices)	
<i>Original (from August 99)</i>		<i>August 1999</i>	<i>August 2006</i>
Tier 1	Provide data to Commonwealth	100%	100%
Tier 2	Electronic prescribing	55%	97%
Tier 3	Data connectivity	76%	96%
<i>From Nov 2006</i>		<i>November 2006</i>	<i>May 2009</i>
Basic	Maintains electronic patient records and maintains IT security	81%	90%
Enhanced	Records clinical details on electronic patient records	78%	88%

Source: ANAO analysis of Medicare data.

3.30 The increasing participation rates from the commencement of each of the incentive changes suggests that IM/IT Incentive requirements have been successful in increasing computerisation and its use in general practice, and on this basis, contributing to practice improvements.

Performance Reporting

3.31 Annual reports and Portfolio Budget Statements (PBSs) are the:

‘principal formal accountability mechanisms between government and departments and from departments through (or on behalf of) government to the Parliament’.¹⁰⁴

3.32 The performance information¹⁰⁵ collected and presented through these two avenues are the foundation of a department’s accountability and

¹⁰⁴ Department of Prime Minister and Cabinet, June 2009, ‘Requirements for Annual Reports for Departments, Executive Agencies and FMA Act Bodies’, available from <http://dpmc.gov.au/guidelines/docs/annual_report_requirements.pdf> p.2 [accessed 26 October 2009].

transparency. A PBS sets out ‘performance targets for departmental outputs and contributions to outcomes’ and annual reports are the main source for reporting on program performance, most importantly, program effectiveness and overall achievement.¹⁰⁶

3.33 In order to support accountability and transparency, KPIs should be set which measure not only take-up, but also the extent to which the program or incentive has achieved its objective; that is, effectiveness measures. Quantitative targets should also be set and reported against, to identify whether or not expected results have been achieved for the government outlays. In addition, consistency of reporting across years allows an assessment over time of the program/incentive performance. These factors were assessed for:

- PIP overall program performance; and
- performance of individual incentives.

PIP overall program performance indicators and associated reporting

Performance indicators and aspects measured

3.34 As identified in Table 3.6, since the commencement of the program, DoHA has used five different program indicators, two of which were only used for limited periods of time, (‘percentage of practices participating in PIP’, and ‘proportion of Australian Government funding for general practice as provided through the PIP’); these particular indicators are ones of effectiveness against aspects of the original objective, which has been replaced.

¹⁰⁵ Performance information may be quantitative or qualitative and should be verifiable. In accordance with the Department of Prime Minister and Cabinet, June 2009, performance information is: ‘evidence about performance that is collected and used systematically which may relate to appropriateness, effectiveness and efficiency and the extent to which an outcome can be attributed to an intervention’.

¹⁰⁶ Department of Prime Minister and Cabinet, June 2009, *Requirements for Annual Reports for Departments, Executive Agencies and FMA Act Bodies*, available from <http://dpmc.gov.au/guidelines/docs/annual_report_requirements.pdf> pp. 2, 17 [accessed 26 October 2009] and ANAO, Better Practice Guide, May 2002, *Performance Information in Portfolio Budget Statements*, available from <[http://www.anao.gov.au/uploads/documents/Performance Information in Portfolio Budget Statement s.pdf](http://www.anao.gov.au/uploads/documents/Performance%20Information%20in%20Portfolio%20Budget%20Statement%20s.pdf)> p. 34 [accessed 26 October 2009].

Table 3.6**PIP overall performance indicators, targets and reporting**

Indicators	Type	Targets	When reported
Number of practices participating in PIP	Take-up	'Increase over previous year' in 2005–06 and 2006–07; No targets other years.	Annually, since 1998–99
Payments made	Take up	Not identified	Annually, since 1998–99
Percentage of care/patients covered by PIP practices (as measured by SWPE)	Potential as a measure of effectiveness against aspects of the current PIP objective, but yet to be realised (see paragraph 3.34).	Targets set from 2007–08; 'Increase over previous year' in 2007–08 and 2008–09; Specific targets set in 2009–10 and 2010–11.	Annually, since 1999–2000
Percentage of practices participating in PIP	A proxy measure for accreditation, and is therefore a measure of effectiveness against one aspect of the original PIP objective.	Not identified	1998–99 only
Proportion of Australian Government funding for general practice as provided through the PIP	A measure of contribution to a blended payment approach for general practice and therefore a measure of effectiveness against one aspect of the original PIP objective.	Not identified	2001–02 and 2002–03 only

Source: ANAO analysis of DoHA and Medicare Australia (and the former Health Insurance Commission) annual reports, and Health and Ageing Portfolio Budget Statements.

3.35 Of the other three indicators, two are take-up ('number of practices participating in PIP' and 'payments made'). The third indicator ('percentage of care/patients covered by PIP practices', as measured by SWPE) is DoHA's measure of patient coverage by PIP practices.

3.36 DoHA advised that this third indicator is an effectiveness indicator. Nonetheless, there are no direct links between the indicator and any of the sub-objectives that the program currently aims to achieve. 'Percentage of care by PIP practices' is a proxy measure for care by accredited practices.¹⁰⁷ Forty-two per cent of ANAO survey respondents nominated improved practice management and patient service delivery for becoming accredited¹⁰⁸ — 'percentage of care by PIP practices' therefore provides potential as a measure

¹⁰⁷ See previous section regarding PIP coverage as a proxy for that of care by accredited practices.

¹⁰⁸ See Figure 3.2 ('all of the above' also included in percentage).

of these aspects of the PIP objective. DoHA informed the ANAO, however, that it relies on individual incentives rather than accreditation to contribute to the PIP objective.

Annual reporting against overall PIP PBS indicators and targets

3.37 DoHA has reported against overall PIP PBS indicators and targets. Until the 2009–10 PBS, no pre-determined quantitative targets have been set. Three of the five indicators state ‘increases’ over previous years for a small number of years as a target, making it difficult to determine from the performance information reported whether expected results had been achieved.

Reporting overall program performance on a consistent basis

3.38 The three current overall indicators have been reported consistently by agencies almost since the start of the program (that is, ‘number of practices participating in PIP’, ‘payments made’ and ‘percentage of care/patients covered by PIP practices’). The remaining indicators (‘percentage of practices participating in PIP’ and ‘percentage of Australian Government funding for general practice as provided through the PIP’) have both been reported over a limited periods.

3.39 In regard to DoHA’s limited reporting against the ‘percentage of practices participating in PIP’, the ANAO notes that there is difficulty in determining the number of general practices in Australia.¹⁰⁹ Furthermore, the percentage of care/patients covered as measured by SWPE is a better measure of PIP coverage, if not of practice take-up.

Individual incentive performance indicators and associated reporting

Performance indicators and aspects measured

3.40 The indicators used by DoHA to assess individual incentive performance are either number or percentage of practices participating. These are take-up rather than effectiveness measures. As indicated in paragraph 3.22, these are only useful as measures of effectiveness in contributing to the PIP objective if there is substantive evidence linking the activities required by the incentives with outcomes in line with aspects of the PIP objective (sub-

¹⁰⁹ The ANAO used the total number of general practices in Australia based on self-reporting through the Annual Survey of Divisions of General Practices. See Footnote 29.

objectives); this link has not been measured for all the incentives, nor has it been reported for any of the incentives.

3.41 There are output indicators that could be used by DoHA to more closely link with outcomes aligned with the PIP objectives. Examples could draw on the indicators used in the *Report on Government Service 2010*, such as ‘people with diabetes mellitus who have received an annual cycle of care within general practice’¹¹⁰ to identify the overall percentage of these that have been provided through the Diabetes SIP.

Annual reporting against individual PIP incentives PBS indicators and targets

3.42 DoHA has reported through its annual reports for the 10 years to 2008–09, the required indicators for individual PIP incentives, as set out in the Health and Ageing Portfolio PBS for the PIP program.¹¹¹

3.43 Up to the 2009–10 PBS, with the exception of a few isolated cases, quantified targets for individual incentives have not been set in the PBS. In the PBSs for 2009–10 and 2010–11, all indicators for individual payments have associated numeric targets.

Comprehensive reporting against performance of individual PIP incentives

3.44 The ANAO assessed DoHA’s and Medicare Australia’s¹¹² annual reporting against the performance of each individual PIP incentive. Medicare Australia’s reporting focuses on the number of practices participating in an incentive or payment within an incentive, (for example, tiers of After-hours Incentive), while DoHA’s reporting is largely against the percentage of eligible PIP practices participating in the incentive.

3.45 Table 3.7 below summarises the findings from both DoHA’s and Medicare Australia’s annual reports, identifying the number of years out of the total years when the incentive was available to practices that indicators of the number and participation rates for practices were reported. (For example, to 30 June 2009, the Asthma Incentive had been available for eight years, but participation rates only reported in three of those years.) Table 3.7 also identifies that the 2009–10 and 2010–11 PBSs are not comprehensive in their

¹¹⁰ Productivity Commission (2010), *Report on Government Services 2010*, p. 11.31.

¹¹¹ Some minor discrepancies identified in DoHA’s reporting against KPIs were noted in 1999–2000 and 2004–05 annual reports. For example, the number of asthma sign-ons was not reported in 2004–05.

¹¹² This includes an assessment of the Health Insurance Commission’s (Medicare Australia’s predecessor) annual reports.

coverage; on this basis, there is no requirement for upcoming DoHA annual reports to include reporting on PIP incentives not identified in the PBS.

Table 3.7

DoHA and Medicare Australia reporting 1998–99 to 2008–09, on performance indicators of PIP incentives; indicators for 2009–10 PBS

Incentive	Number of practices	Participation rates	Performance indicators in 2009–10 and 2010–11 PBSs
	(number of years reported/ total years incentive available)		
IM/IT/eHealth	9/10	1/10	Practices participating
Care Planning	1/8	2/8	Not applicable
After-hours	9/11	0/11	-
Teaching	9/10	3/10	Practices participating
Quality Prescribing	9/10	6/10	-
GP Procedural	6/6	0/6	Increase or maintain practices participating
Practice Nurse	6/8	4/8	Practices participating
Asthma	2/8	3/8	-
Diabetes	5/8	4/8	-
Cervical Screening	5/8	4/8	-
Mental Health	2/5	0/5	Not applicable
Domestic Violence	2/2	0/2	-
Indigenous Health ^a	Not applicable	Not applicable	Practices signed on

Source: ANAO analysis of DoHA and Medicare Australia annual reports.

Note: a) – This incentive started in May 2010.

3.46 Table 3.7 identifies that there is only partial reporting against indicators of individual payments, further limiting the accountability and transparency of individual incentive performance. Moreover, the current reporting does not facilitate assessment of the performance trends of individual payments, as there is no consistent reporting on a year-by-year basis.

3.47 Practice participation rates for individual PIP incentives since their commencement are now available through Medicare Australia's website.¹¹³ If DoHA intends to rely on this source as a means of reporting on the performance of individual incentives, it would be beneficial to include a relevant reference in its annual reports.

3.48 Overall, the performance reporting against individual incentives under the PIP program is not comprehensive, and does not allow for trend analysis over time.

PIP program evaluation

3.49 The importance of program evaluation as a critical element of the policy cycle is highlighted in DoHA's guidance to its managers on policy formulation and advice. This guidance is drawn from better practice identified by the UK National Audit Office. In particular, DoHA's guidance states that:

all programs and policies should be evaluated as regularly and systematically as possible.....Program evaluation is essentially an assessment of a program, or part of it, in order to aid judgements about its appropriateness, efficiency and effectiveness.¹¹⁴

3.50 Given that PIP comprises a significant number of individual incentives, each with varying aims, the ANAO assessed the use of the evaluation outcomes to inform policy development, and whether DoHA had a planned approach to undertaking program and incentive evaluations, including the extent to which the program as a whole and individual incentives have been subject to evaluation.

Outcome of program/incentive evaluations

3.51 To determine whether the evaluations have been effective in contributing to the policy cycle, the ANAO assessed the extent to which the

¹¹³ PIP and SIP Data Tables <https://www.medicareaustralia.gov.au/statistics/div_gen_prac.shtml> [accessed 27 October 2009].

¹¹⁴ DoHA (2007), *Policy Formulation and Advice – Advanced*. Presented by CIT Solutions Pty Ltd on behalf of the Australian Public Service Commission for DoHA. pp 72, 187, 189. The guidance refers to UK National Audit Office report, *Modern Policy-Making: Ensuring policies deliver value for money*, Report of the Comptroller and Auditor General, November 2001 <http://www.nao.org.uk/publications/nao_reports/01-02/0102289.pdf> [access checked 4 November 2009].

payment/program evaluations and reviews have informed program development.

3.52 To a large extent there had been changes to PIP incentives and their administration arising from the reviews and evaluations. A range of changes outlined in Table 3.1 arose from the Red Tape Review Taskforce and subsequent reviews by DoHA and the IDC. Furthermore, the IDC recommended changes accepted by government on the PIP objective.¹¹⁵

3.53 Other examples of how payment evaluations have affected policy development are outlined below:

- the recommendations from the evaluations on the chronic disease management incentive payments (diabetes, asthma and mental health) for greater flexibility in the operation of cycles of care were taken up by government, and changes implemented;
- the Practice Nurse Incentive was expanded to a greater number of areas of urban workforce shortage, reflecting the significant achievement of this payment identified in the Nursing in General Practice Initiative (NiGPI)¹¹⁶ evaluation; and
- recommendations and advice to government in April 2009 on changes to a number of PIP payments from a review initiated by the Department of Finance and Deregulation (Finance) formed the basis of some changes announced as part of the 2010–11 Budget.

3.54 Overall, the evaluation and reviews on the PIP program and their individual payments have been effective in their contribution to the policy cycle.

A planned approach to program and payment evaluation

3.55 A planned approach to program evaluations would, as part of program development, outline the expected timing of evaluation activities, the coverage of these evaluations, and the resources needed for evaluations including KPIs and associated benchmarking and measurement regimes. Program evaluations could also provide information to determine the effectiveness of individual

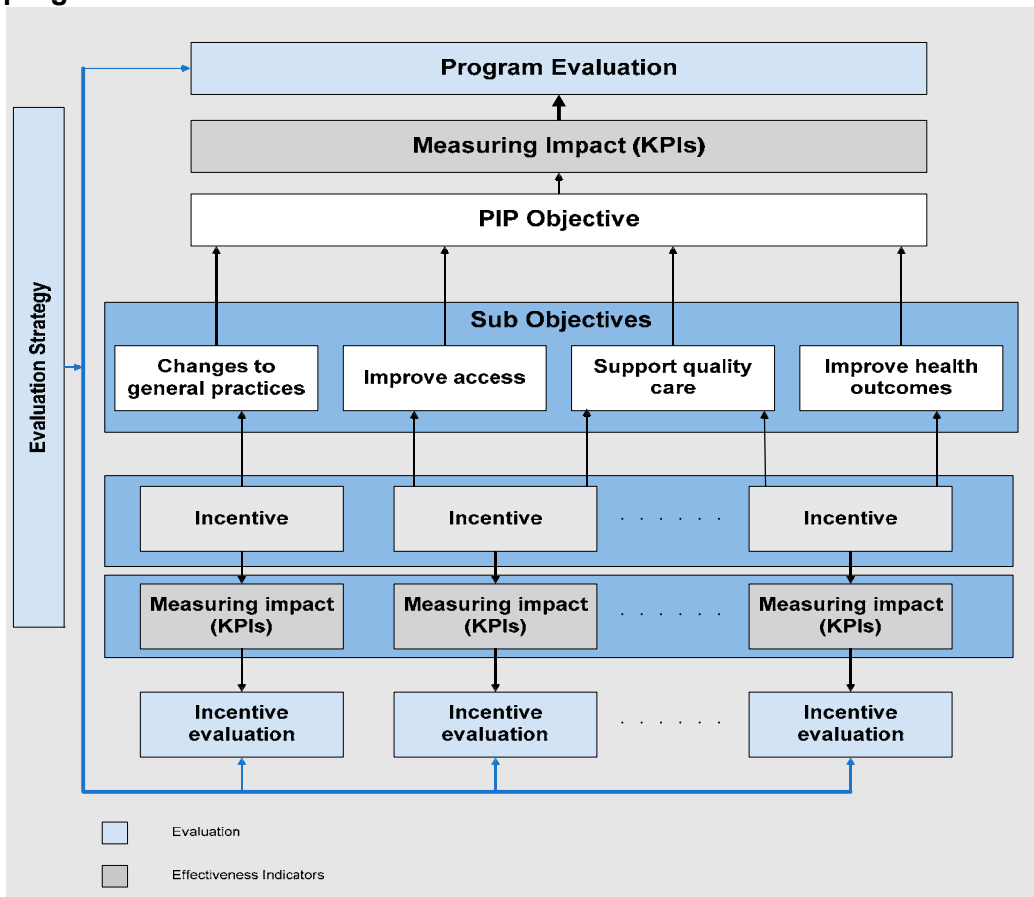
¹¹⁵ See paragraph 3.3 (current objective).

¹¹⁶ The Practice Nurse Incentive was funded as part of the broader NiGPI. See paragraph 3.56.

incentives in contributing to the PIP objective. Figure 3.6 illustrates this relationship.

Figure 3.6

Relationship between PIP objective, incentives, effectiveness KPIs, and program evaluation



Source: ANAO.

3.56 There is no overall strategy for conducting evaluations of the PIP as a whole, nor on individual payments. Some PIP payments have been the subject of lapsing program reviews and, as such, the timeframe for their reviews has been incorporated into the program funding, as follows:

- Diabetes Incentive, funded for four years in the 2001–02 Budget, as part of the National Integrated Diabetes Program¹¹⁷ with funding of

¹¹⁷ The PIP Diabetes Incentive draws its funding allocation from this program.

\$43.4 million over four years. A lapsing program review of this program was finalised in August 2005;

- Cervical Screening Incentive, funded for four years from the 2000–01 Budget for \$71.9 million. A lapsing program review was finalised on these payments in October 2005;
- Mental Health Incentive, funded for four years in the 2001–02 Budget, as part of the Better Outcomes in Mental Health Care Initiative with funding of \$120.4 million over four years. A lapsing program review of this program was finalised in October 2004;
- Asthma Incentive, funded for four years in the 2001–02 Budget, as part of the Asthma Management Program with funding of \$48.4 million over four years. A lapsing program review of this program was finalised in October 2004; and
- Practice Nurse Incentive, funded for four years in the 2001–02 Budget, as part of the NiGPI with funding of \$104.3 million over four years. A lapsing program review of this program was finalised in June 2005.

3.57 Evaluations undertaken on the program as a whole resulted from drivers outside a planned policy cycle approach. In particular:

- the program review included as part of the considerations of the Red Tape Review Taskforce was in response to the March 2003 Productivity Commission report on General Practice Administrative and Compliance Costs;
- the review undertaken by DoHA in early 2005 to further streamline the PIP requirements to reduce red tape arose from the Government's considerations of the Red Tape Review Taskforce findings and recommendations;
- the review by an IDC in late 2005 resulted from government considerations of the above DoHA review, which identified the need to examine the effectiveness of the PIP/SIP payments, PIP's ongoing appropriateness, and any overlaps with existing programs; and
- the review of PIP undertaken by Finance with DoHA in late 2008 was in response to a government decision, with the aim of maintaining improvements to health outcomes for all Australians within a sustainable budget.

3.58 The consequences of a lack of a strategic approach for program and incentive evaluation relate to coverage, timing and limited effectiveness indicators.

3.59 While a number of incentives have been subject to review through whole-of-program reviews rather than specific incentive reviews, the Teaching, Quality Prescribing, and Procedural GP Incentives have not been subjected to reviews against appropriateness, efficiency, and effectiveness criteria. Since these incentives have commenced, their expenditure has been \$117 million. In addition, some reviews have been limited in their scope. For example, the IDC, in its assessment of the After-hours Incentive, did not address a key concern known at the time—namely, potential ‘abuse’ of Tier 3 participation with low billings against after-hours MBS items.

3.60 There have been extended periods during which incentives have not been subject to evaluation. For example, the Rural and Remote payments, which began in its current form (Rural loading) in 2000, was only subject to review by Finance in 2008.

3.61 A lack of effectiveness indicators identified, benchmarked at the commencement of an incentive, and monitored throughout the program has limited incentive assessment. The ANAO identified this as an issue in assessing the achievements of the program against its objectives. This issue has also been raised through program and incentive reviews. In particular, the IDC review advised Government in early 2006:

to ensure that PIP remains relevant and consistent with the Government’s broader health agenda, key performance indicators should be set for all payments, proposed milestones and review dates and reporting on the performance of all PIP components introduced as part of the annual Departmental Portfolio Budget Submission (PBS). This would include achievement against programme targets, alignment with existing and emerging Government priorities and intended directions for PIP.

3.62 Both the evaluations of the National Integrated Diabetes Program and the Cervical Screening incentives recommended that:

- a set of key performance indicators be established that have relevance to the (National Integrated Diabetes Program) and its four components as part of any process that modifies the program; and
- benchmark data be collected against the performance indicators as part of the program modification and that these benchmark data be used for the next program evaluation.

3.63 In addition to assisting in identifying and measuring KPIs across the life of the incentive and in providing timely advice to government on aspects of program effectiveness, a more strategic approach to program evaluation would allow DoHA to build on the proven benefits of evaluations in contributing to the policy cycle, as examined at paragraphs 3.52 to 3.53.

Improving program reporting and evaluation

3.64 DoHA's current reporting and program evaluation approach does not effectively support program accountability, transparency of achievements and the long-term maintenance of program effectiveness. Better effectiveness KPIs that are identified through a program evaluation strategy, and regularly measured and reported, should assist the assessment of PIP achievements.

Recommendation No.2

3.65 To improve the ability to assess the effectiveness of the PIP, the ANAO recommends that DoHA:

- (a) develop an evaluation strategy for the overall program and its individual incentives that includes the identification and monitoring of key performance indicators; and
- (b) publicly report against relevant high-level indicators on an annual basis.

DoHA response

3.66 The Department agrees with the recommendation.

4. Program Eligibility—Accreditation of General Practices

This chapter assesses how DoHA: assesses the ongoing impact of accreditation against the RACGP Standards as the program entry criteria; gains assurance over the quality of accreditation processes; and has managed the governance arrangements supporting accreditation.

Introduction

Program entry requirements

4.1 Accreditation is a central part of the PIP eligibility requirements. Practices wanting to join PIP are required to be accredited, or registered for accreditation (and achieve accreditation within 12 months), as a 'general practice' against the Royal Australian College of General Practitioners (RACGP) *Standards for General Practices* (the Standards). Practices must maintain this status through a reaccreditation process which is set by the RACGP and occurs every three years.¹¹⁸ DoHA relies on third parties to set the basis for accreditation assessment (the Standards), with assessments undertaken by accrediting bodies outside of government.

4.2 Additional accreditation requirements have been introduced since 2001 to include:

- medical deputising services,¹¹⁹ where these services are used by PIP practices in order to meet Tiers 1 and 2 After-hours Incentive requirements;¹²⁰ and
- large branches of practices. Some practices operate more than one location through a branch structure. From 1 May 2006, branches of a

¹¹⁸ PIP Eligibility Requirements <<http://www.medicare.gov.au/provider/incentives/pip/files/2709-8-pip-guidelines.pdf>> [accessed 22 January 2010].

¹¹⁹ National Association for Medical Deputising Australia Ltd, *Definition of a Medical Deputising Service*, 2008, available from <<http://www.namds.com/pdf/NAMDS%20MDS%20defn%20April08.pdf>> [accessed 31 August 2009].

¹²⁰ The timing for introducing accreditation for was as for general practice to be eligible for PIP. Due to a delay in the finalisation of the definition of medical deputising services within the Standards, the requirement was not enforced until 2003.

practice that provided 3000 or more services¹²¹ per annum, needed to be accredited or registered for accreditation, in order for the services of that branch to be included in the PIP payment calculations.

Reasons for accreditation against the RACGP Standards as PIP entry criteria

4.3 In determining that practices participating in PIP would need to become accredited, the then Australian Government considered that accreditation would:

‘...ensure quality outcomes from quality practices. At the same time it will enhance public confidence in general practice in Australia’.¹²²

4.4 This rationale for adopting the accreditation criteria has been maintained, with DoHA advising that the current government supports accreditation as a key for ensuring access to high quality primary health care services.

4.5 Given that accreditation is a central element of the program, the ANAO examined how DoHA:

- assesses the ongoing impact of accreditation against the Standards as program entry criteria;
- gains assurance over the quality of accreditation processes; and
- has managed the governance arrangements supporting accreditation.

Assurance on the impact of accreditation against RACGP Standards as program entry criteria

Background to the Standards

4.6 The 3rd edition of the Standards published in 2005 and accredited by the International Society for Quality in Health Care (ISQua)¹²³ in 2007 is the current

¹²¹ The services relate to MBS items delivered by practice GPs.

¹²² Wooldridge, Dr M (Minister for Health and Aged Care) 1999, *Date set for PIP accreditation requirement*, media release, Canberra, 7 September, available from <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-mediareel-yr1999-mw-mw99086.htm> [accessed 8 July 2009].

¹²³ ISQua is a non-profit, independent organisation which aims to improve safety and quality in health care. Its work includes accreditation of health standards and of health service certifying/accrediting bodies.

version. The Standards cover a wide range of factors within general practice with specific focus on the principles of quality and safety, including: practice services; rights and needs of patients; safety, quality improvement and education; practice management; and physical factors.

4.7 The RACGP Standing Committee on Standards is responsible for setting the Standards and releases an updated version every four to five years. Over the years, the Australian Government, through DoHA, has provided funding to the RACGP to develop the Standards and an accreditation system for general practice. Most recently, the RACGP was contracted by DoHA in 2004 to review the 2nd edition of the Standards and develop the 3rd edition, among other deliverables, for \$926 655.¹²⁴

Monitoring and evaluation of the impact of accreditation against the Standards as PIP entry requirements

4.8 DoHA does not conduct periodic assessments of the effectiveness of accreditation against the Standards as entry criteria for PIP. Such an assessment is particularly important given the multi-layered objectives of PIP and the numerous incentives with varying characteristics that are contained under the program. Undertaking such assessments periodically can take account of the changing characteristics of general practices, variations in the Standards between editions, and lessons learnt through the application of Standards in accreditation processes.

4.9 The development of the Standards by industry improves its acceptance across the general practice community and obtaining accreditation (through ISQua) also provides an independent assessment of the assurance that can be gained through adopting the Standards. It remains important, however, that DoHA put in place measures to periodically assess the ongoing impact of accreditation as program entry criteria. In that respect, stakeholders have

¹²⁴ The contract required the RACGP to submit a final report for the Quality Framework, a final report for the Standards Development and to remove its nominees from the AGPAL Board, as it was considered by the Commonwealth to present a conflict of interest (AGPAL is one of two accrediting bodies).

identified issues relating to the degree of assurance gained through adopting the Standards, as summarised in Table 4.1.¹²⁵

Table 4.1

Stakeholder concerns on the auditability and applicability of the RACGP Standards for General Practice (3rd Edition)

Features of the Standards	Auditability of the Standards	Applicability of the Standards
Joint Accreditation System of Australia and New Zealand (JAS-ANZ)	JAS-ANZ considered that the structure of the Standards is not sufficiently identifiable from guidance on achieving the Standards, affecting the auditability of the Standards.	—
Royal Australian College of General Practitioners (RACGP)	—	The RACGP recognised that the Standards do not support some practice types operating outside office settings, including GPs specialising in care through visiting services to residential aged care patients.
Australian College of Rural and Remote Medicine (ACRRM)	—	ACRRM advised that the Standards do not directly apply to general practices run by general practitioners employed by rural hospitals with rights of private practice in hospital locations.

4.10 Accreditation against the Standards already presents barriers to some general practices participating in PIP, or doing so in an efficient manner, and has the potential to limit the ability of an incentive to achieve its intended outcome (refer to Chapter 2). Given the identified risks to the auditability and applicability of the Standards, this highlights the importance of DoHA having in place mechanisms to assure itself of the ongoing impact of accreditation against the Standards as program entry criteria. This can inform the need to influence changes to the Standards and/or the need to tailor specific additional requirements, such as those outlined in paragraph 4.2.

¹²⁵ In July 2010, the RACGP advised that its Standards Liaison Committee provided a mechanism to work with accreditation agencies to ensure standardised interpretation of the Standards. This committee included members from the National Expert Committee on Standards for General Practice and representatives from the two accrediting bodies. Furthermore, the RACGP accepted that there may be, in very rare circumstances, some practices that might not be able to achieve all Standards in the current edition. It noted that the Standards were developed with robust stakeholder consultation, including field testing to ensure both applicability and feasibility within general practice settings.

Assurance on quality of accreditation processes

Accrediting bodies

4.11 There are two bodies that can accredit general practices against the Standards for the purposes of meeting the PIP entry requirements, namely: Australian General Practice Accreditation Limited (AGPAL); and Quality Practice Australia Pty Ltd (QPA). A comparison of the background and operations of AGPAL and QPA is contained in Table 4.2.

Table 4.2

Comparison of the two bodies that accredit general practices

Features	Australian General Practice Accreditation Limited (AGPAL)	Quality Practice Australia Pty Ltd (QPA)
Genesis	AGPAL was established in 1997 with an Australian government grant of \$2.35 million.	Following a request by the then Minister to introduce competition and offer general practices choice of accreditation provider, QPA was formed in 1999.
Framework	Not-for-profit.	For-profit.
Affiliation	AGPAL is an industry-organised body governed by members of the health profession including the Royal Australian College of General Practitioners (RACGP).	QPA is a corporate entity.
Government requirement for accrediting body itself to be accredited	No compulsory requirement. In 2005, AGPAL undertook accreditation on a voluntary basis against the International Society for Quality in Health Care's (ISQua's) Accreditation Standards.	Compulsory government requirement. QPA is accredited by JAS-ANZ under Procedure 16.
Affect of different accreditation regimes on general practices	AGPAL requires general practices to certify on an annual basis that they maintained compliance with the <i>Standards for General Practices</i> .	QPA requires general practices it accredits, to formally agree to maintain the <i>Standards for General Practices</i> over the three-year period.
Relationship with PIP	AGPAL accredits the majority of general practice accreditations (75 to 85 per cent ¹²⁶) for PIP.	QPA accredits the minority of general practice accreditations for PIP.

Source: ANAO analysis.

4.12 Opening up the market to allow other organisations, such as QPA, to become accrediting bodies was a positive step towards promoting competition

¹²⁶ Estimated range based on advice from AGPAL and QPA.

and providing general practices with choice. The implementation of this model, however, has resulted in an inconsistent approach and gaps in some areas, including:

- The accrediting bodies are subject to accreditation by two different organisations using different approaches. Further, accreditation by JAS-ANZ is compulsory for QPA and any other new organisation to enter the field, while accreditation is optional for AGPAL.
- There is no single framework that accrediting bodies must follow when conducting accreditation assessments.
- There is no independent complaints or appeals body for practices to approach after they have exhausted the accrediting body's internal processes and those of their accrediting organisation. Additionally, there is limited information available to inform patients on what they can expect from an accredited practice and the means to complain if there is a perceived breach against the Standards.

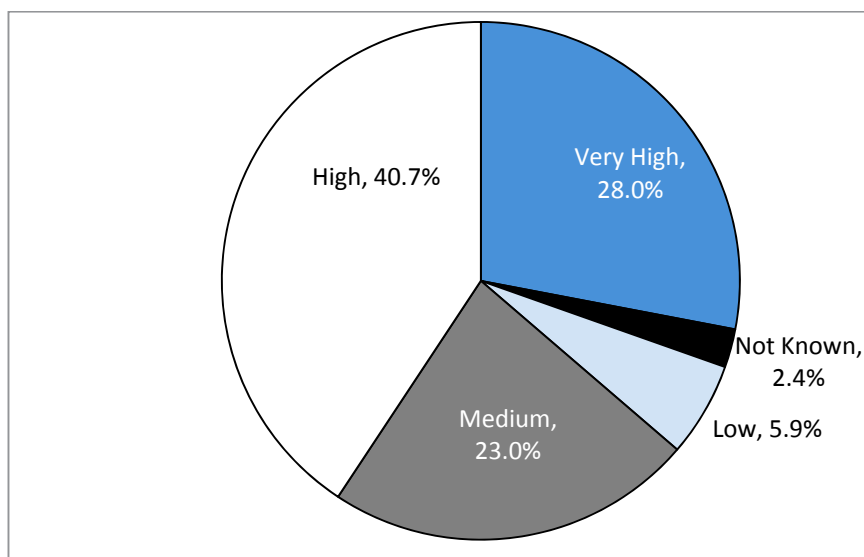
4.13 Furthermore, on agreeing to establish competition in the market in August 1999, the then Minister sought a review of the arrangements by 1 January 2003 to ensure that it did not disadvantage practices with particular characteristics. DoHA has not undertaken this review.

Risk of inconsistency in accreditation outcomes

4.14 In general, most of the ANAO's PIP survey participants supported the quality, rigor and fairness of the assessment undertaken in the accreditation process. As shown in Figure 4.1, almost 69 per cent of respondents rated these aspects of the assessment as 'high' or 'very high', with only six per cent rating them as 'low'.

Figure 4.1

General practices' ratings of the quality, rigor and fairness of assessment undertaken for the accreditation process



Source: ANAO survey of general practices in regards to PIP, 2009, answering the question 'Please rate the quality, rigor and fairness of the assessment undertaken in the accreditation process' (based on 518 responses).¹²⁷

4.15 Notwithstanding the assurance DoHA can gain through the accrediting bodies' own processes and from the survey results, two risks can affect the quality of accreditation; namely, inconsistency in accreditation outcomes, and practices dropping adherence to the Standards across the accreditation cycle.

4.16 Aspects of these risks have materialised, for example:

- DoHA was informed in 2005 that an accreditation provider was accrediting practices but allowing exemptions from certain standards. As the provider was not acknowledging exemptions in accreditation certificates, the frequency of occurrence cannot be ascertained.¹²⁸
- Both AGPAL and QPA have raised concerns regarding the quality of the others' audits and application of the Standards. For example, one provider cited instances where practices that had not passed their

¹²⁷ Footnote 49 explains varying numbers of responses to individual questions.

¹²⁸ DoHA advised that, on becoming aware of the issue, they wrote to the accrediting body to reiterate that certificates should be provided only for full accreditation without exemption or amendment to the Standards.

assessment were subsequently accredited by the alternative provider, raising the potential for ‘accreditation shopping’ by general practices.¹²⁹

- Twenty-six respondents to the ANAO’s PIP survey (or five per cent) commented on perceived inconsistencies in the surveying of general practices for accreditation.

Monitoring and evaluation to provide assurance on quality of accreditation processes

4.17 As part of the contract to develop the 3rd edition Standards the RACGP, in consultation with DoHA and other industry representatives, identified arrangements for improved quality assurance for accrediting bodies through a licensing agreement, accreditation by a third party accreditation provider, and an independent mediator to resolve complaints about the quality of the accreditation process if the provider and their accreditation provider were unable to resolve such complaints.

4.18 To date, the outcomes of these arrangements have not been fully realised. AGPAL has signed the licensing agreement but has chosen to use a different accreditation provider to that required by QPA. QPA has not agreed to the license requirements. Moreover, an independent mediator has not been established.

4.19 DoHA does not have a formal mechanism to capture and monitor the quality of accreditation processes. AGPAL and, to a lesser extent QPA, provide feedback to DoHA on accreditation issues. This information is not, however, captured and analysed to contribute to such processes. Furthermore, there has been no formal evaluation as to the reliability, validity and consistency of the accreditation processes as means of ensuring that practices meet the Standards for entry into PIP.

4.20 By way of comparison, the managers of some other government programs that require accreditation against standards for program eligibility have greater access to information to monitor the quality of accreditation processes undertaken by third party providers. For example, with respect to the Disability Employment Services programs, FaHCSIA requires:

¹²⁹ ‘Accreditation shopping’ does not extend the time a practice has to become accredited while receiving PIP payments. The policy states that practices that are withdrawn from PIP for among other reasons, not obtaining accreditation, must have full accreditation before an application to rejoin PIP can be considered.

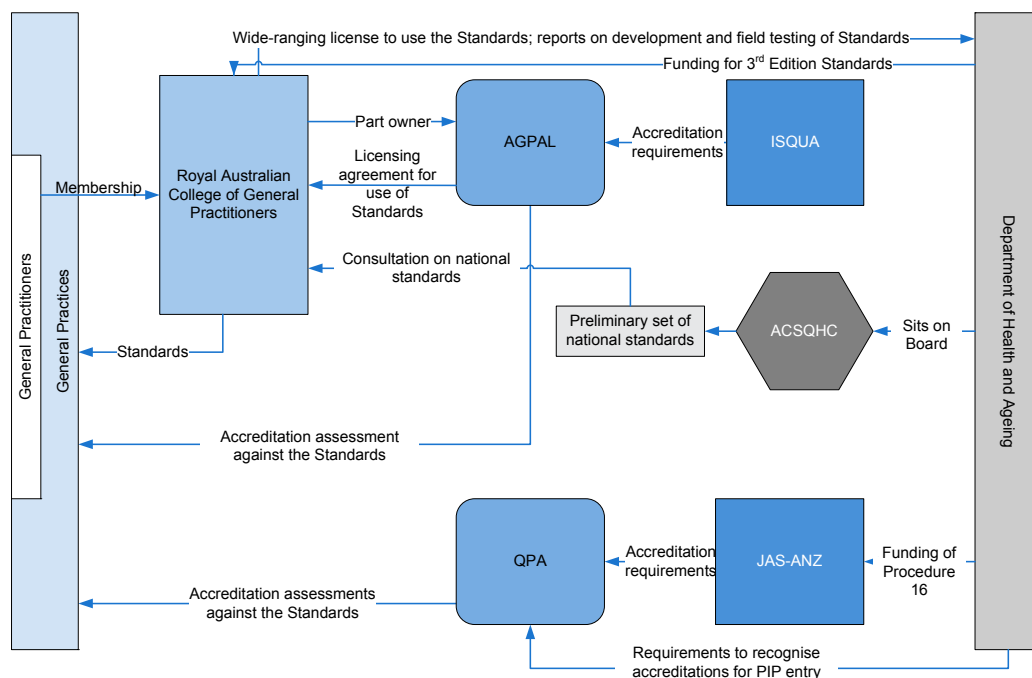
- audit reports on accreditation processes undertaken by the accrediting bodies;
- information on accrediting bodies' quality strategy;
- quarterly performance reports from JAS-ANZ, the agency responsible for conformity assessments on accrediting bodies; and
- monthly reports from the independent complaints-handling body on systemic issues raised by service users.¹³⁰

Governance of the accreditation arrangements

4.21 Governance arrangements for accreditation are a means for DoHA to gain assurance on both accreditation against the Standards for PIP entry purposes, and on the operation of the market for accreditation services to assist adequate access by general practices.

4.22 Figure 4.2 below outlines the governance arrangements relating to the general practice Standards and associated accreditation against the Standards.

¹³⁰ ANAO Audit Report No.11 2008–09 *Disability Employment Services*, Chapter 4.

Figure 4.2**Governance relationships for general practice accreditation**

Source: ANAO analysis.

Previously proposed governance framework for general practice accreditation

4.23 Periodic review of elements central to a program's operation is important for informing advice regarding the ongoing effectiveness of the initiative and identifying areas for improvement. Accreditation, as the primary eligibility criteria for PIP, has not been reviewed for eight years.

4.24 In June 2002, DoHA established an Advisory Committee on General Practice. The committee was tasked with identifying and providing advice to DoHA on strategies to address issues in the general practice accreditation arrangements. Subsequently, DoHA developed ministerial advice in March 2003, addressing:

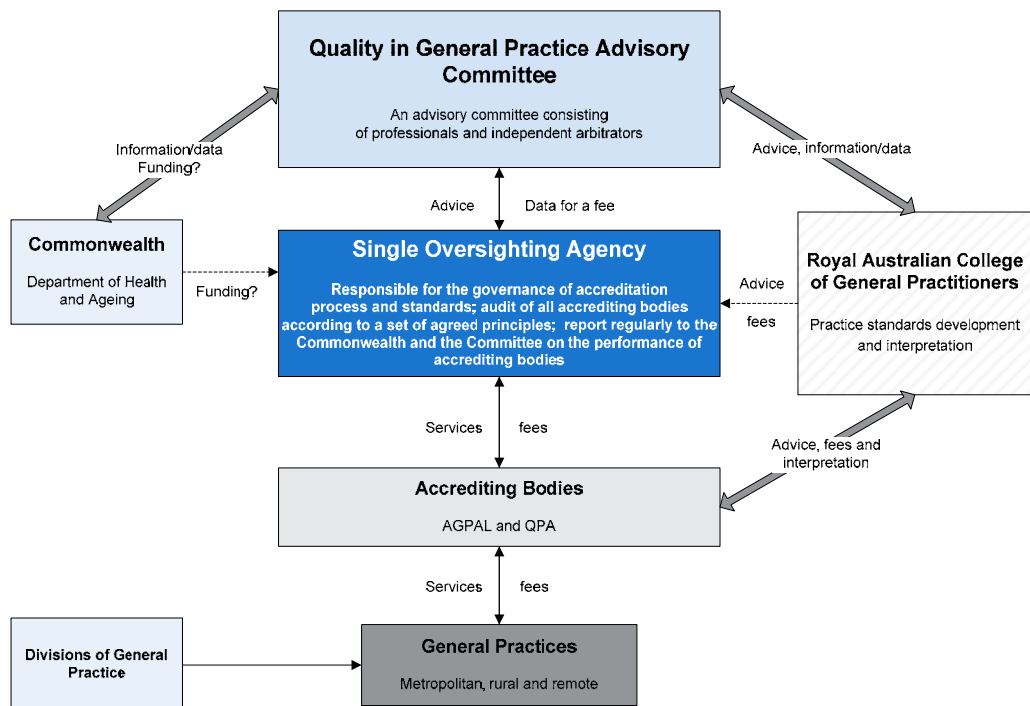
- varying requirements for over-viewing the operation of accrediting bodies through the identification a single over-sighting agency;
- the lack of an independent arbiter of complaints from general practices on the work of accrediting bodies and from patients/health consumers on practices' adherence to the Standards;

- the role of the RACGP and its relationship to the accrediting bodies and their accreditor;
- a means of capturing information for monitoring and evaluation of accreditation processes and outcomes, and for providing DoHA with relevant reports to assist in increasing its assurance on PIP entry criteria and processes; and
- equitable access to accreditation across general practices.

4.25 DoHA recommended for ministerial consideration a revised governance framework for general practice accreditation, including a Quality Advisory Committee and a single body to oversight all accrediting bodies with respect to Procedure 16, which would report regularly to DoHA and provide the means to arbitrate on complaints. Figure 4.3 below illustrates DoHA's formerly proposed framework for general practice accreditation.

Figure 4.3

DoHA's proposed framework for general practice accreditation



Source: ANAO reproduction of the diagram included in DoHA's advice to the Minister, March 2003.

4.26 The advice was not considered by the Minister at the time. While there was a request from the office of the subsequent Minister for Health for the

advice to be resubmitted, there is no evidence that this was followed through by DoHA.

4.27 Since DoHA provided advice to the Minister on addressing general practice accreditation issues, the Australian Commission on Safety and Quality in Health Care (ACSQHC) has been formed and its role and function need to be taken into account in any improvements to the current accreditation governance framework.¹³¹ In addition, the advice did not address the need for an independent, periodic, risk-based monitoring and evaluation regime to determine the ongoing performance of accreditation against the Standards as PIP entry criteria.

Improving DoHA's assurance through improved governance arrangements

4.28 There are current limitations on DoHA's assurance on PIP eligibility requirements. Therefore, it is timely for DoHA to develop the means to inform itself of the effectiveness of having accreditation as a key program entry requirement and the quality of the general practice accreditation process. One means of achieving this would be to review the accreditation governance arrangements. Following on from this review, DoHA would be in a position to update its previous advice on an accreditation governance framework for consideration by the Australian Government. This advice should take account of the work that the Australian Commission on Safety and Quality in Health Care is developing on accreditation across the health system more generally and that of the RACGP in developing the 4th edition of the Standards,¹³² and focus on the:

- (a) benefits of an independent, periodic, risk-based monitoring and evaluation regime for accreditation against the Standards to assess the auditability and applicability to relevant general practice settings;
- (b) reviewing the approach to, and currency of, the credential requirements for accrediting bodies including developing a single framework for conducting accreditation assessments; and

¹³¹ Following the formation of ACSQHC, the National Safety and Quality Standards for Healthcare (NSQH Standards) were established. In July 2010, the RACGP advised that, while it was working collaboratively with ACSQHC to ensure that both Standards (NSQH and the RACGP *Standards for General Practice* (4th Edition)) are aligned, general practice does not currently fall under the statutory jurisdiction of the ACSQHC for accreditation.

¹³² The RACGP advised that the 4th edition of the Standards will be released in October 2010.

- (c) monitoring the operation of the accreditation market to identify and address barriers for general practices accessing accreditation services.

Recommendation No.3

4.29 To support DoHA's management of PIP entry criteria and the Government's expectations of general practice accreditation, the ANAO recommends that DoHA develop the means to inform itself of the quality of general practice accreditation.

DoHA response

4.1 The Department agrees with the recommendation.

5. PIP Service Delivery

This chapter examines the extent to which the arrangements between DoHA and Medicare Australia promote effective service delivery to general practices and provide DoHA with assurance that eligible practices are paid correctly.

Introduction

5.1 PIP payments to general practices and GPs are drawn from the *Primary Care Practice Incentives* appropriation for which the Secretary of DoHA has responsibility. Based on authorisation from the relevant Minister, agreements have been drawn up under section 7A of the *Medicare Australia Act 1973* to articulate service arrangements between the DoHA and Medicare Australia relating to PIP. The current agreement, signed May 2009, is in the Business Practice Agreement (BPA) relating to PIP. This BPA forms part of the MOU between the agencies that covers all services delivery required of Medicare Australia by DoHA.

5.2 To determine the effectiveness of the service arrangements, the ANAO assessed:

- the extent to which the PIP BPA provides a framework for the effective delivery of PIP payments;
- the implementation of new payments within Medicare Australia; and
- the assurance that DoHA is provided against its responsibilities for public money under the *Financial Management and Accountability Act 1997* (FMA Act).

The Business Practice Arrangement relating to PIP

5.3 The ANAO assessed the DoHA–Medicare Australia PIP BPA against criteria drawn from better practice principles for inter-agency agreements and for contract management. The criteria covered key elements for such an agreement, such as: the objective of the agreement; the roles and responsibilities of each party; details of services to be provided; governance arrangements; funding arrangements; dispute resolution processes; key performance indicators; and reporting. The BPA fully met most of the criteria, and largely met the remainder. The results against the criteria are outlined at Appendix 8.

5.4 Overall, the PIP BPA, as part of the broader MOU between DoHA and Medicare Australia, provides an appropriate framework to support effective delivery of PIP.

Implementing new PIP incentives

5.5 In implementing new PIP incentives, Medicare Australia requires some lead time upon the receipt of key documentation from DoHA. This lead time assists Medicare Australia to: schedule tasks internally to ensure that the PIP IT systems are amended to process payments for the new incentive; and ensure that information is provided to, and received from, general practices and GPs to allow them to participate from the initial payment period.

5.6 To support its assessment of Medicare Australia's implementation of new PIP incentives, the ANAO drew on the three PIP incentives introduced between May 2008 and August 2009—Domestic Violence, GP Aged Care Access, and eHealth.¹³³

5.7 Drawing from the three case studies, there are steps common to each implementation. Broadly there are four types of steps:

- joint responsibility of DoHA and Medicare Australia—the 'business rules' for each incentive, which outlines each agency's responsibility, developed jointly, as well as the Medicare Australia costings for implementation and ongoing administration, developed by Medicare Australia and signed off by DoHA;
- DoHA responsibilities—these include the development of the incentive guidelines, application forms, and letters to PIP practices about the new incentive;
- Medicare Australia internal processes—these include the development of IT systems to support the incentive, training of staff and application processing; and
- engagement with program participants—Medicare Australia is responsible for sending letters, guidelines and applications to PIP practices, handling enquiries and making payments.

¹³³ In undertaking the audit, the ANAO considered the 12 incentives that comprised the PIP up to August 2009. The three most recently introduced at the time of audit fieldwork, namely, Domestic Violence, Aged Care Access and eHealth Incentives, were examined in greater detail and formed case studies to support audit analysis.

5.8 These steps are outlined at Appendix 9.

5.9 For the three incentives, Medicare Australia developed the following planning documents that contribute to an overall project management approach: costings for implementation and on an ongoing basis which include major milestone timeframes, (known as the External Costing Request); IT implementation plan incorporating business requirements, IT development costs, deliverables, timelines and task dependencies; and risk management plans.¹³⁴ Given the interdependencies of the steps involved in the implementation, an overall project plan would have assisted timely communication with practices and GPs, and clarity for providers on service delivery responsibilities.

Timely communication with providers

5.10 In both the ACAI and eHealth Incentive implementations, communication with GPs and PIP practices did not provide them sufficient response time, impacting on payments and participation in the short term.

5.11 To reduce 'red tape' for GPs, in the ACAI implementation Medicare Australia chose a bank account already registered with Medicare Australia into which to make payments to each eligible GP. GPs were then contacted by Medicare Australia to ensure that this was their preferred bank account for the ACAI payment. This resulted in almost 94 per cent of GPs receiving their payments on time for the first payment period. However, IT system problems delayed letters to GPs seeking correct bank account details until nine days prior to the first payment processing date. As a result, over 200 eligible providers (over six per cent) did not receive the payments of some \$400 000 on time because Medicare Australia did not have any bank account details or made the payment to a bank account into which Medicare Australia was not authorised to make a payment under this incentive (that is, a practice's bank account rather than the GP's). In both cases, Medicare Australia subsequently needed to undertake resource-intensive remedial action.

5.12 The time at which practices were advised of requirements to participate in the eHealth Incentive for the initial payment in August 2009 was only six weeks prior to the due date for applications and for implementing the

¹³⁴ These Medicare Australia planning documents are in addition to the business rules jointly developed by DoHA and Medicare Australia which outline key respective responsibilities for the implementation.

electronic clinical resource requirement.¹³⁵ Based on representations to DoHA by the RACGP at the time and supported by the ANAO survey findings, a number of practices needed further clarification on this requirement, which was not immediately available through the PIP enquiry line. This was due to delays in the provision of policy information to Medicare Australia,¹³⁶ and in DoHA and Medicare Australia reaching agreement on the 'Questions and Answers' document used by PIP enquiry line staff in responding to queries from practices. While there was an expectation by DoHA of an 80 per cent take-up of this incentive, participation did not increase to near this rate until the second payment period,¹³⁷ suggesting that practices needed greater than six weeks to ready themselves for the new requirements.

Clarity for providers on service delivery

5.13 At the time of implementing the incentives, Medicare Australia needed up to ten weeks in order to clear forms and letters for providers. In order to expedite communication with providers on incentives, practices were sent advice on the ACAI and eHealth Incentives on DoHA letterhead, and the eHealth application form was issued under the DoHA logo. While the advice on the eHealth Incentive identified Medicare Australia as the contact for enquiries, the letterhead created confusion. As a result, some providers directly contacted DoHA rather than Medicare Australia.

5.14 As part of the transition to a portfolio-wide approach to the development of forms and letters, Medicare Australia advised that the agencies of the Human Services portfolio are currently jointly reviewing the related processes with the view of adopting better practice.

Development in an overall project management approach for implementing new incentives

5.15 During the course of the audit, Medicare Australia developed an overall project management approach for the implementation of the PIP Indigenous Health Incentive which was introduced in May 2010. Although this incentive was outside the scope of this audit, the project plan addressed key

¹³⁵ Paragraph 2.48 outlines requirements for the eHealth Incentive.

¹³⁶ Late engagement by DoHA for consultations on the eHealth Incentive, discussed in Chapter 2, resulted in delays in finalising the eHealth Incentive guidelines.

¹³⁷ The eHealth participation rate for the first payment period was 69 per cent, increasing to 76 per cent for the second payment period.

elements including: governance arrangements; timeframes, costs and resources; communication with practices including a mail-out schedule; roles and responsibilities; risk management; and monitoring and reporting arrangements.

5.16 The ANAO notes that Medicare Australia's current approach to the implementation of new incentives, as reflected in the Indigenous Health Incentive, is an improvement on its previous practice, and is more consistent with better practice. In particular, the new project management methodology provides the potential to address the internal scheduling effects arising during the implementation of the GP Aged Care Access Initiative and eHealth Incentives. Furthermore, sharing the plan with DoHA would provide the basis for advising on the dates by which Medicare Australia needs key documentation from the department to meet timelines in line with government decisions.

DoHA's assurance on the accuracy of PIP payments to practices

5.17 DoHA is responsible for the administered funding appropriated for PIP. Under the FMA Act, it is therefore responsible for ensuring that the payments are in line with the Government's intentions for the program. As Medicare Australia delivers PIP payments to practices and their GPs, DoHA needs assurance as to the accuracy of these payments.

5.18 In order to determine the extent of assurance on which DoHA can rely, the ANAO examined the quality assurance and program compliance aspects of the following areas related to Medicare Australia's delivery of PIP payments:

- application processing;
- ensuring practice details are up-to-date;
- payment processing; and
- compliance auditing.

5.19 More broadly, the ANAO also assessed the extent to which liaison between DoHA and Medicare Australia supports the assurance that DoHA can gain on the delivery of PIP payments.

Application processing

5.20 PIP is a relatively mature program and, since 2002–03, it has averaged a net increase of 30 general practices per annum, less than one per cent of practices eligible for PIP. Medicare Australia currently receives between 15 and 20 applications from new practices per quarter. Most applications processed result from existing PIP practices applying for individual incentives including new incentives.

5.21 Many incentives need application forms, including application to participate in the program itself. Some incentives, however, are based on MBS billings, (for example, ACAI) or other information, such as that from the National Prescribing Service, for the receipt of the Quality Prescribing Incentive payment.¹³⁸ Of those incentives which require application forms, half are available on Medicare Australia's website, with the balance available through hard copy via the PIP enquiry line. All application forms need to be mailed or faxed back to Medicare Australia.

5.22 Practices applying for entry to PIP and for individual incentives need to provide supporting documentation for accreditation status for program entry and after-hours arrangements for eligibility for the After-hours Incentive. Other information (for example, public liability and providers' professional indemnity insurance for program entry, and staff qualifications and rosters for the Practice Nurse Incentive) is accepted by Medicare Australia on the basis of a signed declaration by relevant medical providers and practice owners.¹³⁹

5.23 Medicare Australia processing staff assess applications from practices and enter the data manually into the PIP IT system. The IT system has standard letters available for use by staff to advise practices of the outcome of the assessment, as well as to seek further information.

Quality control for application processing

5.24 Medicare Australia advised that team leaders undertake a quality check on 100 per cent of applications from practices seeking to: enter the program; and enrol in individual incentives outside the initial application process.

¹³⁸ National Prescribing Service Limited is an independent, not-for-profit organisation funded by DoHA to support the best use of medicines to improve health and wellbeing. In the PIP context, PIP practices need to undertake a specified number of activities recognised or provided by the National Prescribing Service to qualify for the Quality Prescribing Incentive payment.

¹³⁹ Medicare Australia relies on compliance audits to check that practices have complied with requirements. Medicare Australia's approach to PIP compliance audits is examined at paragraphs 5.51–5.59.

However, there is no recording of the frequency and source of errors identified through the checks to inform quality improvement measures.

5.25 The Continuous Data Quality Improvement (CDQI) Program provides the framework across Medicare Australia's payment processing for undertaking quality control testing on a sampled basis, recording the frequency and source of errors, and reporting on results. Medicare Australia initiated a CDQI review for PIP in late 2008 which progressed through the course of the audit. By July 2009, the review identified common error types in processing PIP applications and practice updates; examples of error types included insufficient or inaccurate information from practices being overlooked by processing staff, and data entry errors. Medicare Australia informed the ANAO that the system changes needed to fully implement CDQI processes in PIP (such as sample selection for quality checking, quality control reporting and audit trails to identify the source documents required to undertake quality control) have not progressed, given other internal funding priorities.

5.26 An initiative, planned for release in October 2010, PIP Online, will allow practices to apply for entry to PIP and for PIP incentives, bypassing the need for manual entry into the PIP IT database by Medicare Australia staff. This will minimise the potential for one source of error, namely, data entry. PIP Online will also log changes made to the PIP IT database, with capacity to develop a range of reports based on audit logs. While these proposed changes will not provide the automated functionality of those required to implement the CDQI procedures for PIP, it will allow manual sampling of changes for quality control purposes.

5.27 To improve DoHA's ongoing assurance on the processing of PIP applications, the ANAO suggests that Medicare Australia consult with DoHA on the implementation timeframe for the IT changes for CDQI procedures, and following their implementation, provide DoHA with system-generated quality control reports.

Outcome of ANAO testing of assessments

5.28 The ANAO randomly sampled 70 general practices across size and rural classes who received May 2009 payments amounting to \$1 135 359. Based on an assessment of eligibility for payments, the ANAO identified supporting evidence for 98.9 per cent of payments, with a 95 per cent confidence interval of between 96.7 and 100 per cent. This indicates a high level of accuracy for application processing.

Ensuring practice details are up-to-date

5.29 Medicare Australia needs a range of up-to-date information from practices to ensure ongoing program and incentive eligibility and to accurately determine payments. Such information includes evidence on current accreditation status, given that a practice can register for PIP before becoming accredited and practice re-accreditation is needed every three years to maintain eligibility for PIP.¹⁴⁰ In addition to ensuring that practices maintain their requirements for incentives (for example, after-hours care arrangements, and staffing for the Practice Nurse Incentive), Medicare Australia needs up-to-date information on medical providers working at the practice to make payments accurately. For example, if a provider leaves a PIP practice, their billings will contribute to the practice's SWPE until the Medicare Australia processing team is otherwise advised.

5.30 Medicare Australia has separate processes for ensuring practice accreditation information, and other details such as medical provider and practice activities related to incentive requirements are up-to-date. These processes are outlined below.

Ensuring practice accreditation requirements are current

5.31 Each quarter, Medicare Australia identifies those practices whose accreditation is due for renewal in the coming quarter; these practices are identified from the practices' accreditation expiry dates previously entered into the PIP database. For those practices that have not provided accreditation renewal details on their own initiative, Medicare Australia reminds practices before the accreditation expiry date, of their obligations. Subsequent PIP payments are placed on hold if practices do not provide evidence of reaccreditation by the expiry date,¹⁴¹ and only released if, and when, this information is received by Medicare Australia.

5.32 A similar process is undertaken for those practices which entered PIP on the basis of registration for accreditation and had not at the time attained accreditation—the main difference is that these practices are identified each month rather than each quarter.

¹⁴⁰ See paragraph 4.1.

¹⁴¹ Medicare Australia requires a copy of the accreditation certificate from practices.

5.33 There is currently no documented quality control checking processes on updating the accreditation status information. The primary means of ensuring that accreditation information in the PIP database is correct is through advising practices of the outcome of the accreditation renewal process using form letters that draw information directly from the database. There is a reliance on the initiative of practices to contact Medicare Australia to amend any errors.

5.34 For the process of identifying those practices due for accreditation renewal, the accreditation expiry date is critical information. PIP database information was assessed for a sample of 92 practices.¹⁴² Of these, 26 practices (28 per cent) did not include accreditation expiry dates. The letters sent to practices on their previous renewal of accreditation, would not highlight to practices that these dates had not been recorded.

5.35 The 'accreditation expiry date' will be a compulsory field in the upcoming PIP Online system. Medicare Australia advised that the PIP Online system and confirmation statements will also include quality control checking on data entry by internal and external users and quality control reports, potentially addressing other sources of errors in updating accreditation details.

Ensuring details other than accreditation are current

5.36 The PIP application form and guidelines state that practices are required to inform Medicare Australia of any practice changes that affect PIP incentive eligibility and payments. In the nine years to May 2010, the main means for Medicare Australia to gain updated information on a practice, such as changes to medical providers, practice details and activities impacting on eligibility requirements for individual incentives, has been through practices initiating contact with Medicare Australia via the PIP enquiry line¹⁴³—a process usually triggered on receipt of a practice's quarterly payment statement. Once the change is entered into the IT system, a letter is sent to the practice to confirm that the change has been accurately recorded and properly authorised. Changes relating to practice ownership, location and

¹⁴² This was a randomly drawn sample, originally comprising 100 practices. As eight of these practices had payments on hold, the assessment was undertaken on the remainder.

¹⁴³ A secondary means is from changes identified through the compliance audit process (see paragraphs 5.51–5.52).

amalgamation have 100 per cent of cases quality checked, but there are no documented procedures for internal checking of other changes.¹⁴⁴

5.37 The means of updating information until recently was time-consuming for staff in receiving and making the system change, as well as recalculating payments. Prior to the February 2010 quarterly payment, upon advice of a change that favoured the practice, Medicare Australia would manually recalculate up to the previous two quarterly payments, and pay the practice the difference. This procedure has now ceased with a policy change through DoHA, and practices are advised to ensure that Medicare Australia is informed of all such changes within a short period after their occurrence. In addition, the introduction of the PIP Online Administration System planned for October 2010, will allow practices to update their details electronically, further streamlining Medicare Australia's administrative procedures.

5.38 In May 2010, confirmation statements pre-populated with practice details were distributed to PIP practices, with practices required to affirm or amend the practice details held by Medicare Australia. DoHA advised that practices that failed to complete the confirmation statement by the due date will be subject to a compliance audit by Medicare Australia. There are plans to repeat this process on an annual basis as required of Medicare Australia under the PIP BPA. Prior to this, confirmation statements were last required from practices in May 2001. Confirmation statements subsequently planned for May 2002 and May 2005 were cancelled at DoHA's request to minimise administrative burdens on practices at the time.

5.39 Based on the ANAO testing of 70 general practices,¹⁴⁵ the supporting documentation for 40 per cent of After-hours and Practice Nurse Incentive payments as at May 2009, was found to have been received by Medicare Australia between five and ten years previously, increasing the risk of inaccuracies in practice information held by Medicare Australia for PIP payments. This represents 15 per cent of the total payments for May 2009 sampled. Moreover, compliance audits have identified that these two incentives have the highest rates of non-compliance,¹⁴⁶ highlighting the

¹⁴⁴ Similar to the quality controls for application processing, PIP Online will provide the potential for reporting based on audit logs of updating information. This will allow manual quality control sampling.

¹⁴⁵ Paragraph 5.28 outlines the results of testing this sample for application processing.

¹⁴⁶ See Table 5.2.

importance of regular reconfirmation of practice details, particularly for these incentives.¹⁴⁷

Payment Processing

5.40 Each quarter, information is drawn from the PIP database and from the MBS billings for patients of providers nominated by PIP practices as working in the practice, to determine the quarterly PIP payments. In addition, data is drawn on an annual basis from information provided by the National Prescribing Service on the number of recognised activities providers in PIP practices have undertaken in the 12-month period, to determine eligibility for the Quality Prescribing Incentive.

5.41 Three working days before the release of the quarterly payment, Medicare Australia provides DoHA with a request for the release of funds to make the payment. This request also includes spreadsheets that identify: for each practice, the SWPE, RRMA and amounts proposed to be paid for individual incentives and the total payment; and for each provider, the amount to be paid by incentive type. DoHA uses this information to check the internal consistency of the data provided, and on a satisfactory outcome of this assessment, releases the payment. The information and assessment gives DoHA a degree of assurance that the funding for which it has responsibility is being spent in accordance with the Government's intention.

Payments on hold

5.42 As part of its request for the release of funds for the PIP quarterly payment, Medicare Australia also advises DoHA of the number of payments being held. There are a range of reasons that practice payments are placed on-hold, mainly:

- a practice is non-compliant for one or more payments. Payments for which the practice remains eligible are release once action is completed; for example, an outstanding debt is recovered or waived;
- the quarterly payment to the practice is significantly above or below that of the previous quarterly payment. This accounts for approximately 40 per cent of practices whose payment is being held.

¹⁴⁷ With the development of the Practice Nurse Incentive Program and Medicare Locals, announced in the 2010–11 Budget, the PIP Practice Nurse Incentive will be abolished at the end of 2011. Tier 1 of the After-hours Incentive will cease by July 2011, with Tiers 2 and 3 by July 2013.

The SA office investigates each of these cases, including contacting the practices when needed. Common reasons for the variation include change in medical providers and closure of the practice. Where the practice is determined to be still eligible for PIP, Medicare Australia releases the payment;

- the practice's accreditation has expired and at the time of the payment, the practice had not advised of receiving reaccreditation. If a practice subsequently provides evidence of reaccreditation, payment is resumed;¹⁴⁸
- the practice entitlement to a payment is under review following the results of an audit finding; and
- the practice is undergoing a change of ownership, and/or amalgamation, with the payment being withheld until the status of the SWPE is clarified.

5.43 Table 5.1 details the number of practices whose payments were on-hold and the payment amount, for the period November 2008 to August 2009.

Table 5.1

Payments On-hold per Quarterly Payment Period

Quarterly Payment Period	Practices with Payments On-hold		Payments On-Hold	
	Number	% of Total	\$	% of Total
November 2008	387	8.0	2 590 391	4.2
February 2009	393	8.2	2 241 207	3.2
May 2009	392	8.2	2 224 872	3.1
August 2009	354	7.4	1 476 558	2.1

Source: ANAO analysis of Medicare Australia information.

5.44 Holding payments provides DoHA with some level of assurance that Medicare Australia is ensuring that only eligible practices are receiving payments at a particular point in time. However, it does create uncertainty for DoHA as to whether funds will be needed for release in the future, particularly

¹⁴⁸ If the reaccreditation date is either before, or within a month of, the due date, held payments are released. If the date of reaccreditation is greater than a month after the expiry of the previous accreditation certificate, payments will resume, but not receive payments for the period in which the practice was not accredited. There is a similar process for practices who entered PIP on the basis of registration for accreditation, but have not advised of attaining accreditation within the 12-month period.

given that some practices have payments held for extended periods. For example, of the practices whose payments were held from the August 2009 payment, 32 practices (nine per cent) had payments on-hold for five or more consecutive quarters. In order to partly address this uncertainty, at the end of each month Medicare Australia provides DoHA with a payment reconciliation statement. This statement is used by DoHA to assess funds requested against payments (including those released after the quarterly payment) and to query any discrepancies. Furthermore, at DoHA's request in July 2007, Medicare Australia reviewed its accrual process to provide DoHA with some assurance on its accrual adjustment.

5.45 Prior to August 2006, Medicare Australia withdrew practices from PIP if payments were on-hold for three consecutive payment quarters, requiring practices to reapply to receive future payments. At the request of DoHA, Medicare Australia ceased this procedure in August 2006 to address a Teaching Incentive issue. Practices eligible for Teaching Incentive payments were being withdrawn from the Incentive if universities did not submit claim forms to Medicare Australia within the allocated time. In July 2010, Medicare Australia developed a bulk Teaching Incentive claim form to assist universities and practices to report on multiple teaching sessions in a more timely manner. Subsequently, DoHA requested that Medicare Australia re-instate the process, which took effect from May 2010. This action will limit the number of practices with payments on-hold for extended periods, and decrease the amount of funds withheld.

Accuracy of the determination of the SWPE

5.46 While DoHA assesses the internal consistency of practice payment information provided by Medicare Australia before the release of funds for quarterly payments, it does not undertake an assessment as to the accuracy of practice SWPEs determined from patient billings. To assess the accuracy of Medicare Australia's processing, a representative sample of 10 practices from the 70 practices used for checking supporting documentation was selected by the ANAO. Based on information requested from Medicare Australia, the ANAO's estimate of the May 2009 SWPE was within 0.25 per cent of that used

for the quarterly payment.¹⁴⁹ Within the limitations of the ANAO testing, the results provide some comfort as to the accuracy of Medicare Australia's estimation of practice SWPE for determining payments.

Compliance auditing

5.47 As part of the PIP BPA, Medicare Australia is required to:

- conduct an annual audit of practices participating in PIP. The percentage of practices to be audited, as part of the Annual PIP Audit Program, will be determined in consultation with DoHA (PIP audits will also consist of: following up cases where practices are not complying with the eligibility criteria; recovering monies inappropriately paid under the PIP; and providing feedback to DoHA about audits undertaken, their results and action taken); and
- investigate cases where there are reasonable grounds to suspect that a practice participating in the PIP has ceased to comply with relevant eligibility criteria.

5.48 The former Strategic Partnership Agreement between DoHA and Medicare Australia, which was replaced in May 2009 by the MOU and associated PIP BPA, also identified similar audit requirements, but specified that two per cent of PIP practices would be audited each year.

5.49 Given the limited requirements for practices to provide documentation when applying for, or reconfirming, eligibility for PIP and its individual incentives, compliance audits are a key means of ensuring that practices are entitled to the payments being made. Some incentives (such as SIPs and ACAI) are based on MBS items which, in turn, are subject to compliance audits focused on the Medicare program. The Quality Prescribing Incentive has not been subject to any Medicare Australia compliance audits, as Medicare

¹⁴⁹ For each of the patients of medical practitioners associated with the selected PIP practice as for the May 2009 quarterly payment, Medicare Australia provided a (de-identified) listing of the MBS billings for the 2008 calendar year by a practice provider and overall, the date of birth and sex. This resulted in some 34 000 records, which the ANAO used to estimate the SWPE for each of the 10 practices. The result was then compared with that used in the May 2009 payment. The variation is likely to have resulted from patients or providers submitting MBS items to Medicare Australia for the reference period after the May 2009 cut-off date, as Medicare Australia provided the requested data four months after the payment cut-off.

Australia relies on the quality of information provided by the National Prescribing Service.¹⁵⁰

5.50 The ANAO examined the approach for undertaking audits for the period 2005–06 to 2008–09, and their follow-up action.

Approach to PIP compliance audits

5.51 Across the period assessed, Medicare Australia developed an annual compliance audit plan, which was subject to consultation with DoHA. In each year, some 180 practices (3.75 per cent of the total practices)¹⁵¹ selected to ensure coverage across states/territories and across urban and rural/remote locations, were subjected to field audits. These field audits covered a range of eligibility requirements. The conduct of the audits focused on practices located in particular regions or within specific corporate groups.

5.52 The balance of the audits planned were desk reviews, seeking specific documentation on particular aspects of eligibility from practices. While a limited number of practices identified as being of higher risk were specifically targeted in 2005–06,¹⁵² in subsequent years desk audits were based on random selection of practices. In the three years to 30 June 2008, desk reviews largely covered requirements known to have higher levels of non-compliance. In 2008–09, the desk review was focused on the professional indemnity insurance requirement for PIP eligibility, an area in which no instances of non-compliance had been identified in the previous three years. The number of desk reviews planned was aimed at ensuring that a total of five per cent of PIP practices were audited in 2005–06 and 2006–07, and 10 per cent in 2007–08 and 2008–09.¹⁵³

5.53 Audits were undertaken by Medicare Australia in line with the annual plan. The coverage and non-compliance rates from these are shown at Table 5.2.

¹⁵⁰ The National Prescribing Service is a government-funded body that includes on its board a government appointed director. In order to qualify for the Quality Prescribing Incentive, practices must undertake activities recognised, or provided by the National Prescribing Service.

¹⁵¹ From 2009–10, under the PIP BPA the number of practices audited is not set; it is determined on an annual basis through consultation with DoHA.

¹⁵² Practices at higher risk were identified based on complaints and previous audit results.

¹⁵³ The increase in the percentage of practices audited resulted from a recommendation from the 2006–07 PIP Compliance Audit Report, identifying high levels of non-compliance relating to the After-hours and Practice Nurse Incentives.

Table 5.2**Audit coverage by eligibility component/incentive—number of practices**

Eligibility requirements	2005–06	2006–07	2007–08	2008–09	Total	Non-compliance practices (%)
Accreditation	181	182	183	183	729	0.4
Public liability insurance	181	207 ^a	183	183	754	0
Professional indemnity insurance	181	207 ^a	183	506 ^a	1077	0.2
IM/IT	181	182	181	170	714	0.8
After-hours	209 ^a	41 ¹⁵⁴	288 ^a	180	718	14.9
Teaching	56	77	56	0	189	0
Practice Nurse	108 ^a	170 ^a	249 ^a	78	605	9.5
Cervical Screening (sign-on)	167	73	0	0	240	0
Diabetes (sign-on)	165	205 ^a	0	0	270	0
Asthma (sign-on)	162	84	0	0	246	0
Procedural GP	11	11	1	6	29	0
Domestic Violence	n/a	n/a	n/a	0	0	0
<i>Total practices audited</i>	<i>244</i>	<i>243</i>	<i>475</i>	<i>506</i>	<i>1468</i>	<i>12.5</i>
<i>Non-compliant practices^b (per cent)</i>	<i>15.2</i>	<i>5.3</i>	<i>18.7</i>	<i>8.7</i>	<i>12.5</i>	

Source: ANAO analysis of Medicare Australia information.

Note a)—Includes both field and desk audits.

b)—Based on practices non-compliant in at least one requirement.

5.54 Table 5.2 shows that non-compliance rates are considerably higher for the Practice Nurse and After-hours Incentives, largely contributing to one in eight practices being non-compliant in at least one requirement for which they were receiving PIP payments. The annual audit reports summarised results from individual compliance audits conducted throughout the financial year, and, identified the key reasons for non-compliance as follows:

- for the Practice Nurse Incentive,
 - staff working insufficient hours or sessions, and

¹⁵⁴ The limited after-hours coverage in 2006–07 resulted from a request from DoHA to Medicare Australia to suspend auditing compliance with After-hours Incentive requirements to enable these to be reviewed by DoHA. The suspension covered the period July 2006 to February 2007.

- eligible staff either not employed for at least part of the payment period; and
- for the After-hours Incentive, practices
 - not meeting home visit requirements,
 - providing insufficient hours to meet Tier 2 and 3 in-practice care requirements, and
 - providing care outside the practice that did not cover the 24-hour period.

5.55 The ANAO notes that both the Practice Nurse and After-hours Incentives had high rates of documentation supporting their payments which was over five years old. Changes in practice arrangements and personnel may have contributed to non-compliance against the requirements for these incentives, supporting the need for regular reconfirmation of practice details.¹⁵⁵

Identifying and targeting higher risk practices

5.56 In order to demonstrate the value and practicality of identifying practices at high risk in detecting non-compliance, the ANAO sampled 34 practices across a range of size and location classes, that were receiving the After-hours Incentive (Tier 3) at May 2009, and whose providers together had billed 26 or fewer MBS after-hours services in 2008–09. The ANAO phoned these practices between 7pm and 10pm on a weekday evening. In all but two of the calls, the phone was connected to an answering machine, with the remainder being unanswered. To minimise potential disruption to medical providers, the ANAO did not subsequently call nominated after-hours numbers. The results are shown at Table 5.3.

¹⁵⁵ See paragraph 5.39.

Table 5.3**Results of ANAO after-hours calls to practices receiving PIP payments to provide in-house 24-hr care to patients**

Response on recorded message		Number of practices	Percentage
Call practice doctor on after-hours number (given)	1 st choice provided	4	11.8
	Last choice provided ^a	12	35.3
Call hospital	Urban location ^b	2	5.9
	Rural location ^c	5	14.7
Phone triage service or locum ^d		3	8.8
Call/attend after-hours service if doctor does not answer after-hours number ^e		2	5.9
Phone 000 and/or go to the local hospital ^b		2	5.9
No answer ^b		2	5.9
No practice doctor available at this time ^e		2	5.9
<i>Total in sample</i>		<i>34</i>	<i>100.0</i>

Source: ANAO testing and assessment based on information from Medicare Australia

Note a)—Patients were advised to contact '000' and/or go to the hospital before being provided with an after-hours phone number for the practice.

b)—Practices may have advised patients by other means to contact practice medical providers.

c)—If practices are on call through the hospital to attend practice patients, the requirements are met.

d)—If the practice providers attend the patient after being contacted through the triage service, or the locum is a provider registered with the practice, the requirements are met.

e)—If practice providers are not available to attend patients 24 hr/day, the requirements are not met.

5.57 Of the practices contacted after-hours, answering machines provided callers with an after-hours number of a practice doctor in only half the cases. While patients may have various means of accessing 24-hour care from practice doctors, the results from the sampled practices demonstrate a potentially higher risk of non-compliance. (The level of risk took into account the very low billings for after-hours MBS items, the lack of direct contact initially with practice providers and, in some cases, no indication of access to a practice doctor.)

5.58 In 2008–09, After-hours Incentive payments (including Rural loadings) of \$490 000 were made to the practices sampled. This equates to \$2800 per after-hours MBS service provided by these practices, highlighting the importance for Medicare Australia to identify practices of higher risk using secondary data sources such as MBS billings.

5.59 During the course of the ANAO audit, Medicare Australia developed its 2009–10 PIP compliance audit program. In this, Medicare Australia

identified audits on the After-hours, Practice Nurse and Domestic Violence Incentives, proposing to target practices whose MBS after-hours and practice nurse item billings do not appear to be commensurate with their PIP requirements.¹⁵⁶ By this means Medicare Australia has the potential to focus its compliance audit on practices with higher risk of non-compliance.

Follow-up action to non-compliance by Medicare Australia—recoveries

5.60 Once instances of non-compliance are identified, under Section 47 of the FMA Act, DoHA has an obligation to raise a debt and seek recovery of payments unless the debt is not legally recoverable or it is not economical to pursue recovery. The PIP BPA delegates responsibility to Medicare Australia to recover monies incorrectly paid. Medicare Australia's responsibility in this regard has been supported by legal advice sought by DoHA.

5.61 Table 5.4 outlines the recoveries identified and actioned by Medicare Australia.

Table 5.4

Identified and actioned PIP payment recoveries 2006–07 to 2008–09

	2006–07	2007–08	2008–09	Total
Recoveries identified (\$)	189 086	707 679	483 465	1 380 230
Recoveries actioned (\$)	92 898	291 556	306 169	690 623
Percentage actioned (%)	49	41	63	50

Source: ANAO analysis of Medicare Australia data.

5.62 The percentage of recoveries was relatively low in 2006–07 and 2007–08. Medicare Australia advised that it exercised its discretion not to raise debts for the following reasons, as identified in Medicare Australia's internal communications and between DoHA and Medicare Australia:

- recoveries identified subsequently not actioned, as practices successfully appealed; and
- at the time, there was recognition that there was a lack of clarity in the interpretation of aspects of the After-hours (Tier 2) Incentive requirements, both by the PIP practices and by Medicare Australia

¹⁵⁶ The 2009–10 compliance audit program also includes audits on eHealth and Teaching Incentives.

itself. As a result, DoHA revised and reissued the business rules for agreement with Medicare Australia relating to the eligibility of this payment, and clarified requirements with PIP practices on other aspects of the After-hours Incentive.¹⁵⁷

5.63 Subsequently, DoHA has sought from Medicare Australia information on the reasons for Medicare Australia pursuing particular actions for each case of non-compliance identified through the audit processes. Such a request is consistent with DoHA's ongoing need for ensuring clarity in incentive requirements, as well as gaining assurance on the fulfilment of its debt recovery responsibilities.

Follow-up action to non-compliance by DoHA—communication and program changes

5.64 Under the PIP Schedule to the 1998 SPA, Medicare Australia (then the Health Insurance Commission) agreed to provide DoHA with six-monthly reports on audits that included the number of practices audited, the outcomes of the audits and the follow-up actions, for example, recovery of funds.

5.65 Until 2006–07, Medicare Australia met its audit reporting obligations by providing DoHA with copies of the reports of individual audits undertaken by Medicare Australia. On request from DoHA, Medicare Australia also provided DoHA with copies of the individual audit reports for 2007–08. For the years 2006–07 to 2008–09, Medicare Australia provided DoHA with summary reports, but these were provided to the department up to nine months following the end of the financial year. This limited the timeliness with which DoHA was able to address identified issues for which it was responsible.

5.66 Nevertheless, these reports (particularly the individual reports) provided DoHA with a valuable source of information to monitor the program. DoHA assessed each report, and took action to address underlying issues through consideration of program and guideline changes, and communication with key stakeholders. For example, following on from audit results, DoHA reminded practices of their obligations or clarified the requirements, with regards to After-hours and Practice Nurse Incentives in line with audit findings in nine of the 14 newsletters issued to PIP practices from August 2006 to November 2009.

¹⁵⁷ See paragraph 5.66.

5.67 The subsequent May 2009 BPA includes an obligation on Medicare Australia to provide DoHA with an annual audit report and reports of individual audits. The BPA has been successful in giving DoHA access to the summary reports on a more timely basis. In particular, Medicare Australia advised that it has put in place mechanisms to ensure that DoHA receives summary reports by September following the end of the financial year, in line with the BPA.

5.68 The BPA has given DoHA access to some, but not all, individual audit reports. DoHA advised that Medicare Australia has not met its obligations to provide these reports within the timeframes specified in the BPA, limiting DoHA's capability to identify issues in a timely way. Medicare Australia has advised that it has established internal arrangements to ensure that individual audit reports from July 2010 are sent to DoHA in line with the BPA.

Liaison to support assurance on PIP payment delivery

5.69 Consistent with the PIP BPA (and previous with the PIP Schedule to the SPA), DoHA and Medicare Australia have met regularly covering issues relating to program delivery, and providing DoHA with a key means of ensuring that payments are delivered in line with the Government's intentions. Issues raised and addressed through this forum, include the following examples:

- clarification of eligibility requirements relating to, for example: the requirements for out-of-surgery visits for the After-hours Incentive; and Teaching Incentives as to whether the maximum number of teaching sessions per day should be applied to the practice or to practitioner;
- held payments, including the number of practices with payments held over three years, and ensuring that held payments are correctly accrued to individual incentive expenditures;
- anomalies in provider numbers against PIP practices, with assessment by DoHA showing that a range of provider numbers are assigned to multiple practices; and
- discrepancies in information provided on ACAI payments, identified in DoHA's assessment of Medicare Australia's reports.

5.70 The liaison meetings between DoHA and Medicare Australia have been effective in facilitating an exchange of information. These meetings together with the provision of reports before, and following, the release of payments,

and on compliance audits, provide DoHA with some assurance on the delivery of PIP payments.

Improvements to PIP service delivery

5.71 Medicare Australia's management of incentive implementations, the currency and accuracy of the information on which it relies to make payments, and its approach to compliance auditing, have together limited the assurance with which it can provide DoHA on PIP service delivery. A range of initiatives have been recently implemented or substantially progressed, with the potential to address these issues.



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Auditor-General

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15 September 2010

Appendices

Appendix 1: Comments of bodies with a special interest in the report

Department of Families, Community Services, Housing and Indigenous Affairs (FaHCSIA)

The Domestic Violence Practice Incentives Program is one of a number of national initiatives developed and delivered over recent years to provide assistance to the victims of family and domestic violence, and to offer real opportunities for violence in Australia to be reduced.

The development and delivery of domestic violence training to practice nurses and Aboriginal health workers was unique in concept, very complex in consolidation and has proved challenging to implement. The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is working with the partners delivering this project, to rapidly increase the impact of the program to assist victims of family and domestic violence in Australia.

FaHCSIA supports the audit's findings and has no additional comments.

National eHealth Transition Authority (NEHTA)

Medicare Australia raised the issue of potential incompatibility of Medicare PKI certificates with NASH certificates at the time the current eHealth PIP was being developed. However, this was seen as a "potential" incompatibility given the design of the NASH certificates had not at that time been determined. In terms of addressing this problem it was agreed between the Department of Health and Ageing and NEHTA that as long as a seamless transition process to replace Medicare PKI certificates with NASH certificates was put in place this would not be an issue. NEHTA provided DoHA with a commitment that as part of the NASH processes a seamless transition would occur for all health professionals who already had a Medicare PKI Certificate. This would translate into a simple "replacement" type process with no burden on practices/individuals who had taken up Medicare PKI Certificates under the eHealth PIP.

NEHTA considers the eHealth PIP to be a very significant and vital program in terms of driving eHealth and achieving the Government's ambitions as set out in its National eHealth Strategy.

Royal Australian College of General Practitioners

1. Comments against paragraphs in the proposed report

33. The College acknowledges the Australian Government's ongoing commitment to the accreditation of general practices, and the funding provided by the Government which assisted the RACGP in reviewing the RACGP Standards for General Practices (2nd Edition).

34. It is important to note that the principal aims of the RACGP Standards are to promote safety and quality of patient care provided in general practice settings and to support continuous quality improvement processes in general practices. The Practice Incentive Program (PIP) is not the only driver for practice accreditation, but given that accreditation is the key eligibility requirement for general practices wishing to participate in the PIP, the College recognises the importance of ensuring the quality of accreditation processes, including the consistency of assessment of general practices and their overall compliance with the Standards across the accreditation cycle.

General practitioners have indicated to the RACGP that the current payments made via the PIP do not adequately compensate practices for the significant costs of the accreditation and quality improvements required by the current processes. As a result, some practices do not consider the PIP to be an incentive. Any major increase in the demands of accreditation, without proper consultation with the profession, may see a significant reduction in the number of general practices engaging with practice accreditation.

The RACGP also notes that out of all of the medical specialties, general practice is the only medical specialty to have developed its own practice standards and to have established rigorous processes for accreditation.

35. As summarised below, the College notes the three key features identified by the ANAO as limiting DoHA's assurance on the overall quality of current accreditation processes which include:

- Differing accreditation frameworks utilised by Australian General Practice Accreditation Limited (AGPAL) and General Practice Australia (GPA)
- Lack of verification of assertions made by general practices regarding adherence to the Standards across the accreditation cycle
- Ambiguity regarding the auditability of the Standards and their applicability to all general practice settings.

The RACGP accepts that there may be, in very rare circumstances, some practices that might not be able to achieve all Standards in the current edition. However, the ANAO is advised that the Standards are developed with robust stakeholder consultation, including field testing to ensure both applicability and feasibility within the general practice setting, including nonconventional general practice settings such as care delivered from vehicles rather than practice buildings. The RACGP Standards for

general practices promote safety and quality in general practice, and are acceptable and achievable to general practices in Australia.

The College also recognises that the current accreditation system lacks the ability to ensure practices maintain the Standards for the duration of the accreditation cycle. The College is currently developing a preferred approach to this issue, which is further noted in Recommendation II, Section 2, of this letter.

4.4 The College is of the view that accreditation against the RACGP Standards for general practices contribute to the provision of high quality care in general practice. Furthermore, the RACGP concurs with the government that accreditation is the key for ensuring access to high quality primary health care services.

4.7 The RACGP notes that the ANAO refers to the 3rd edition of the Standards. The College advises that the Standards are currently being revised by the RACGP's National Expert Committee on Standards. It is expected that the 4th Edition will be released in October 2010 and will be officially launched at the College's annual conference 'GP 10' in October.

4.8 The RACGP notes that DoHA does not currently conduct interval periodic assessments of the compliance of accreditation against the Standards. However, Medicare Australia does conduct compliance assessments in relation to some elements of PIP, for example access to care out side normal opening hours. The College could initiate a discussion with DoHA regarding the expected costs and benefits of periodic interval assessments of the compliance of accreditation against the Standards. Additionally, the College advises that it is considering pursuing possible funding options to conduct a longitudinal study into the overall effectiveness of general practice accreditation in terms of quality improvement.

4.12 The RACGP advises the ANAO that it has a mechanism to work with accreditation agencies to ensure the standardisation of interpretation of the Standards via the College's Standards Liaison Committee (SLC). The composition of the SLC includes members of the National Expert Committee on Standards for General Practice and representatives from both general practice agencies AGPAL and GPA.

The College recognises the different features between the two accrediting agencies, AGPAL and GPA as identified by the ANAO. While both accreditation agencies are currently accredited (AGPAL is accredited by the International Society for Quality in Health Care - ISQua and GPA is accredited by the Joint Accreditation System of Australia and New Zealand - JAS-ANZ), the College notes that it is a compulsory government requirement for GPA to be accredited and currently, there is no such requirement for AGPAL, who voluntarily sought accreditation in 2005. Given these inconsistencies, the College is of the view that it should be a compulsory requirement for both accrediting agencies to be accredited. Furthermore the College recommends that all accrediting agencies are accredited against the one set of Standards.

4.14 Clearly, the majority of the ANAO's PIP survey participants support the quality, rigor and fairness of the assessment undertaken in the accreditation process. While there is always the potential for improvement, Australia is regarded as a world leader in terms of general practice accreditation, and the positive results in the ANAO's survey indicate that general practices are satisfied with the established accreditation processes.

4.27 The College notes that the proposed framework for general practice accreditation (Figure 4.3) as recommended by DoHA was not progressed and, subsequently, the Australian Commission on Safety and Quality in Health Care (ACSQHC) was formed. Following the formation of ACSQHC, the National Safety and Quality Standards for Healthcare (NSQH Standards) were established. While, the RACGP and the ACSQHC are working collaboratively to ensure that both Standards (NSQH Standards and the RACGP Standards for General Practices 4th Edition) are aligned, it is important to note that general practice does not currently fall under the statutory jurisdiction of the ACSQHC for accreditation. Furthermore, when addressing issues relating to general practice accreditation, the College advised that it is in a position to provide valuable guidance and advice to the relevant agency responsible for the governance of accreditation and Standards relating to general practice.

4.29 While the College supports the advice provided by the ANAO regarding the need for DoHA to introduce quality assurance processes in relation to PIP, the College firmly believes that DoHA must work in collaboration with the RACGP when considering such matters to ensure acceptability, feasibility, and sustainability for the evaluation processes, in relation to general practice.

2. Formal Comments and Recommendations

- I. The College is committed to ensuring general practice in Australia provides safe patient care. The RACGP Standards for general practices promote safety and quality in general practice, and are acceptable and achievable in Australian general practice.
- II. The College is developing a preferred approach to ensure that practices maintain their compliance with the Standards for the duration of the accreditation cycle, and would welcome the opportunity to discuss this further with DoHA.
- III. The College recommends that DoHA provide funding for the College to develop formal 'Accreditation Guidelines' for compulsory use by both accrediting agencies and accompany the 4th edition of the Standards, to aid consistent interpretation of the Standards.
- IV. The College recommends that the DoHA consider further funding a longitudinal study investigating the overall effectiveness of general practice accreditation, delivered by the RACGP.

- V. The College strongly recommends that it is fully involved in the development and operation of any auditing framework introduced to address any issues pertaining to general practice accreditation.
- VI. The College recommends that the Government introduce a compulsory requirement that all accreditation agencies must be accredited. The College believes that accreditation agencies should be accredited against the one set of Standards.
- VII. The College recommends that Government introduce a compulsory requirement that all accreditation agencies use the current RACGP Practice Accreditation Standards.

Australian General Practice Accreditation Limited (AGPAL)

QPI¹⁵⁸ supports the view that the work of the ACSQHC (the Commission) should be taken into account when DoHA considers a proposed framework for general practice accreditation. In fact, the establishment of a 'single overseeing agency' within DoHA would very much replicate the arrangements being crafted for the Commission. Such duplication is unnecessary.

In any review of the approach to the credential requirements for accrediting bodies, QPI would not support the development of 'a single framework for conducting accreditation assessments'. The government, through random audits of accrediting bodies, should be able to satisfy the requirement that a general practice has supplied sufficient and correct evidence to meet the RACGP standards. Enforcing an assessment methodology on each accreditor does not, in itself, make the process more robust or convincing. Such a condition is NOT applied to any other accreditation organisation undertaking accreditation services to health organisations that are in receipt of government funding. The public and private hospital sectors are a prime example.

¹⁵⁸ ANAO comment: Quality in Practice Pty Ltd (QPI) is a subsidiary of AGPAL and provides accreditation for a range of primary care providers (other than general practices) such as optometry, physiotherapy practices and medical imaging services. AGPAL commonly goes by the name of QPI/AGPAL.

Appendix 2: Payment Eligibility Requirements

Table A 1

Key eligibility criteria for PIP payments—November 2009

Payment Type	Key eligibility criteria
eHealth	<p>Practices must:</p> <ol style="list-style-type: none"> 1. have practice software from a supplier that has agreed to participate in consultation processes with the National eHealth Transition Authority to develop and implement secure messaging standards and specifications; 2. have (or have applied for, from Medicare Australia) a location/site Public Key Infrastructure (PKI) for the practice and each practice branch, and ensure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and 3. provide practitioners from the practice with access to a range of key electronic clinical resources (for example, e-Therapeutic Guidelines Complete, Australian Medicines Handbook, Medicare Benefits Schedule).
After-hours Care	<p>All practices must at a minimum ensure their patients have access to care from a doctor, 24 hours a day, seven days a week.</p> <ul style="list-style-type: none"> • Tier 1 practices meet the minimum requirements; • Tier 2 practices meet the minimum requirements and must provide practice patients with at least 10 or 15 hours of after-hours cover per week on average, depending on practice size; and • Tier 3 practices must meet the minimum requirements using only GPs from within the practice.
Teaching	<p>All practices that provide teaching sessions (up to two sessions per day per medical student per GP) are eligible for the payment provided:</p> <ul style="list-style-type: none"> • sessions are a minimum of three hours duration; • the student is enrolled in an Australian medical university and the sessions are part of their curriculum; and • the university has asked the GP to be responsible for the student's learning experience.
Quality Prescribing	<p>Practices are required to participate in three activities (recognised or provided by the National Prescribing Service) per full-time GP per year, on average, by 30 April each year. One of the activities must be a clinical audit of prescribing for specific drug groups using materials approved or produced by the National Prescribing Service.</p>
Practice Nurse	<p>Practices are required:</p> <ul style="list-style-type: none"> • to be located in rural and remote areas, located in urban areas identified by DoHA as having workforce shortage, or an Aboriginal Medical Service/Aboriginal community controlled health service in any location; and • employ or retain a practice nurse, Aboriginal health worker, or in urban locations, other allied health workers, for a minimum number of sessions per week based on practice size.

Payment Type	Key eligibility criteria
Cervical screening	
Sign on	To receive the sign-on payment, practices are required to register for the incentive and undertake to engage with the state/territory cervical screen registers.
Outcome	To receive the outcome payment, practices registered for the incentive are required to reach the practice screening target, 50 per cent of the practice's female patients aged 20-69 years are screened in a 30 month reference period.
SIP	To receive the service incentive payments (SIPs), GPs must work in a practice registered for the incentive, and take cervical smears from under-screened women aged 20-69 years.
Diabetes	
Sign on	To receive the sign-on payment, practices are required to register for the incentive and use a patient register and recall and reminder system for their patients with diabetes mellitus.
Outcome	To receive the outcome payment, practices registered for the incentive, must have at least two per cent of their patients diagnosed with diabetes mellitus and their GPs must have completed a diabetes cycle of care for at least 20 per cent of these patients.
SIP	To receive the service incentive payments, GPs must work in a practice registered for the incentive, and complete cycles of care for patients with established diabetes mellitus.
Asthma	
Sign on	To receive the sign-on payment, practices are required to register for the incentive and use a patient register, and recall and reminder system; agree to use the asthma cycle of care; and agree to have their details forwarded to relevant bodies so that the practice can receive information about the asthma cycle of care.
SIP	To receive the service incentive payments, GPs must work in a practice registered for the incentive, and complete cycles of care for patients with moderate or severe asthma.

Payment Type	Key eligibility criteria
Procedural GP	<p>Practices are required to be located in a rural or remote area. Payments are made to the practice, for procedural services provided by individual GPs, as follows:</p> <ul style="list-style-type: none"> • for Tier 1, a GP must provide at least one service that meets the definition of a procedural service (that is, obstetric, surgical or anaesthetic); • for Tier 2, the GP must meet Tier 1 requirements and provide after hours procedural services on a regular or rostered basis throughout the 6 month reference period; • for Tier 3, the GP must meet the Tier 2 requirements and provide surgical, anaesthetic and/or obstetric services totalling 25 or more eligible procedures in the 6 month reference period; and • for Tier 4, a GP must meet the Tier 2 requirements and deliver 10 or more babies in the 6 month reference period or meet the obstetric needs of the community.
Domestic violence	<p>Practices are required:</p> <ul style="list-style-type: none"> • to be located in rural and remote areas; and • ensure that an appropriately trained and qualified practice nurse or Aboriginal health worker is available to act as a referral point for a minimum number of sessions per week. The number of sessions are based on practice size. Lifeline, contracted by Department of Families, Housing, Community Services and Indigenous Affairs, provides the training and issues the qualifications.
GP Aged Care Access	<p>All GPs in practices participating in PIP are eligible for an incentive payment once they have provided the following number of Medicare-claimable services in Commonwealth-funded residential aged care facilities (RACF):</p> <ul style="list-style-type: none"> • for Tier 1, 60 MBS claims related to treatments in RACF during the financial year; and • for an additional Tier 2 payment, 140 MBS claims related to treatments in RACF during the financial year.
Rural loading	<p>Practices located in rural and remote areas as defined by the rural, remote, metropolitan area (RRMA) classification have the Rural loading applied automatically to PIP payment made to practices.</p>

Source: DoHA Guidelines.

Appendix 3: Key changes to PIP payments

Table A 2

Key changes to PIP payments

Payments	Dates of implementation/ major changes	Description
eHealth	August 2009	Payment began
IM/IT	August 1999	Payment began - 3 tiers: 1. data to Commonwealth; 2. electronic prescribing; 3. data connectivity.
	November 2006	Changed to 2 tiers: 1. maintenance of electronic patient records & IT security; 2. key clinical details recorded on electronic patient records.
	May 2009	Final payment
After-hours care	August 1999	Payment began – 3 tiers: 1. practices ensure after-hours care; 2. practice GPs provide specified cover; 3. all after-hours care provided from within practice.
	July 2001	Patients must have access to home (and other out-of-surgery) visits where necessary and appropriate.
	February 2006	Practices with ≤2000 SWPE need only provide 10 hrs after-hours care/week by practice GPs, rather than 15+ hrs for tier 2 payment.
Quality Prescribing	May 2000	Payment began.
Teaching	May 2000	Payment began – based initially on sessions in first half of 1999–2000.
Practice Nurses	February 2002	Payments began for nurses and Aboriginal health workers in RRMA 3–7 and other areas of need.
	November 2003	Payments extended to other allied health workers, and further urban areas with GP shortages.
	April 2006	Extended to all urban areas of workforce shortage.
Asthma	November 2001	Payments began with Asthma 3+ Visit Plan of three patient visits over 1-4 months, undertaking: • diagnosis and assessment; • development of a written asthma action plan; • patient education and review of action plan.
	November 2006	3+ Visit Plan replaced by Cycle of Care, introducing greater flexibility including decreasing the number of visits required from three to two, with 12 months to complete the cycle.
Diabetes	November 2001	Payments began – starting progressively, with first outcome payment in May 2003.

Payments	Dates of implementation/ major changes	Description
	November 2005	Certain examinations to be undertaken within 5–7 months rather than six months.
	November 2006	Greater discretion for GPs in undertaking the diabetes cycle of care (for example, foot examination no longer required for patients without feet).
Cervical Screening	November 2001	Payments began.
	Various	Changes to thresholds and MBS items.
Procedural GP	May 2004	Payments began.
	Feb/Nov 2006	Increased payments.
	July 2007	Greater eligibility for GPs who participate in an obstetrics roster but do not deliver 20+ babies per annum.
	November 2009	Payments moved from prospective to retrospective.
Domestic Violence	May 2008	Payment began.
GP Aged Care Access	February 2009	Payment began.
Rural loading	1 July 1998	Payment associated with RRMA location began.
	May 2000	Percentage loading of practice payment depending on RRMA, phased in to ensure no disadvantage.
Care Planning	July 1999	Payment began,
	November 2002	Final payment for the 12 months to June 2002 made at this time.
Mental Health	November 2001	Payments began.
	May 2005	Greater discretion for GPs to combine assessment and planning consultations.
	February 2006	Cap abolished on the number of SIPs to GPs for completing the 3 steps in a year.
	May 2007	Practices move to using COAG Mental Health MBS items. Sign-on payments withdrawn.

Source: PIP newsletters—<<http://www.medicare.gov.au/provider/incentives/pip/news-archive.jsp>>.

Appendix 4: Calculating a practice's SWPE

Steps to calculate a practice's SWPE

Step 1: Calculation of the Whole Patient Equivalent of each patient

1. The first step of the SWPE formula involves calculating the Whole Patient Equivalent (WPE) value of each individual patient attending the practice. This is a fraction of the care provided by the practice for each patient. The fraction is based on the schedule fee value of non-referred consultations received by a patient at the practice within the 12-month reference period. The value of these consultations is then divided by the total schedule fee value of all non-referred consultations received by the patient within the reference period. For example, in a 12-month period, a patient has two short consultations with Practice X at \$32 per consultation and four long consultations with Practice Y at \$61 per consultation. The total schedule fee value of the consultations for the patient for 12 months is \$308. Practice X would be assigned with a WPE of 0.2 ($\$64/\308), while Practice Y's WPE would be 0.8 ($\$244/\308).

Step 2: Weighting of the WPE

2. The WPE of the patient in the PIP practice is then weighted based on an age-sex factor to determine the patient's SWPE. On average, males and females require different amounts of general practice care at different stages of their life. The weights used for the SWPE calculations are based on Medicare Australia and Department of Veterans' Affairs' data related to GP consultations received by patients in age-sex categories. These weights are updated quarterly by Medicare Australia.

Step 3: Sum of the SWPE

3. The individual SWPEs are then added together to provide the SWPE value of the practice.

Appendix 5: Scenarios illustrating the operation of the SWPE

Scenario 1: SWPE results when patients visit a general practice, other than their usual practice

1. In this scenario, two practices, A and B, are identical in every way, except that patients from practice A have one after-hours attendance at a general practice other than their usual practice (an outside the practice). Table A 3 outlines how the SWPE is calculated for both practices and the effect of the after-hours attendances on a practice's payments from attendances outside the practice.

Table A 3

Scenarios illustrating SWPE variation between identical practices

Factors to determine SWPE	Practice A	Practice B
Number of patients	3216	3216
Patients in each age/sex category	201	201
Visits to practice in 12 month reference period	5 per patient at \$30/visit	5 per patient at \$30/visit
Visits outside practice in 12 month reference period	1 per patient at \$100/visit	-
Whole Patient Equivalent for each patient	$\$150/\$250=0.6$	$\$150/\$150=1.0$
Practice SWPE at August 2009	2002	3336
Eligible payments at August 2009	<ul style="list-style-type: none"> • After hours - Tier 1 • eHealth • Practice Nurse • Quality Prescribing • Teaching (20 sessions) • Cervical screening sign-on • Cervical Screening outcomes • Asthma sign-on • Domestic Violence 	<ul style="list-style-type: none"> • After hours - Tier 1 • eHealth • Practice Nurse • Quality Prescribing • Teaching (20 sessions) • Cervical screening sign-on • Cervical Screening outcomes • Asthma sign-on • Domestic Violence
RRMA (Rural loading)	RRMA 3 (15 per cent)	RRMA 3 (15 per cent)
August 2009 payment	\$16 498	\$25 960

Source: ANAO analysis based on PIP payment guidelines.

2. In line with the above payment amounts, Practice B's total PIP payment including Rural loading is \$25 960 or 57 per cent more than Practice A's total of \$16 498.

Scenario 2: SWPE results from change in practice ownership arrangements

3. SWPEs are based on practice attendance over 12 months ending in the quarter four months before each payment date. This scenario demonstrates the SWPE outcome over an extended period (and subsequent effects on most of a practice's PIP payments) on newly establishing practices that start with a full patient load.
4. Table A 4 illustrates the SWPE results on practices when a GP in an existing Practice A, with a stable SWPE of 2000, sets up another practice in the location on 1 July 2008, Practice B, and half the practice A patients become Practice B patients. An assumption has been made that both practices have the same demographic patient distribution—essentially Practice A has been split into two equal halves.

Table A 4

Scenario illustrating SWPE arising from practice changes

Pre-partnership/ associateship change	Reference period	Original Practice A SWPE	New Practice B SWPE
May payment quarter 2008	1 Jan 07– 31 Dec 07	2000	N/A
Post partnership/ associateship change	Reference Period	Original Practice A SWPE	New Practice B SWPE
August payment quarter 2008	1 April 07– 31 March 08	2000	0
November payment quarter 2008	1 July 07– 30 June 08	2000	0
February payment quarter 2009	1 Oct 07– 30 Sept 08	1750	250
May payment quarter 2009	1 Jan 08– 31 Dec 08	1500	500
August payment quarter 2009	1 April 08– 31 March 09	1250	750
November payment quarter 2009	1 July 08– 30 June 09	1000	1000

Source: ANAO analysis.

5. Table A 4 shows that Practice B gain a SWPE (and PIP payments) that reflect patient load only from the quarterly payment that occurs a full 16 months after the practice is established.¹⁵⁹

¹⁵⁹ There is a means by which Practice B could have a SWPE of 1000 from the first payment after it is established —under a DoHA PIP policy determination, if the doctors agree that Practice B can take their patients' service history from Practice A, and Medicare Australia is informed of this agreement, then the SWPE for each practice will remain at 1000 for the August 2008 payment onwards.

Appendix 6: Factors affecting the potential for take-up of the Domestic Violence Incentive

1. A number of factors limited the potential for take-up of the Domestic Violence Incentive, which was subsequently realised:
 - concerns about the appropriateness and safety of practice nurses acting as referral points for domestic violence. This issue was initially raised by stakeholders in consultations undertaken in 2006;
 - the timelines in FaHCSIA's plan for project activities leading to training delivery slipped. While initially training was scheduled for the period 1 August 2007 to 30 November 2008, this was delayed seven months;
 - accessibility to training, including the location of training sessions, cost (particularly for remote practices) to send staff to training and to replace staff while undertaking training, and access to online training;
 - limited information on training sessions; and
 - a perception that the level of funding provided to practices from this incentive is inadequate, with practices, on average, receiving around \$2000 per annum.
2. When DoHA became aware of FaHCSIA timelines for training delivery, in late 2005, it identified the need for an alternative approach to ensuring the timely delivery of the incentive, but this was not followed up. Nevertheless, DoHA undertook activities to address these factors, but each of these had limitations in terms of effectiveness. Activities included:
 - engagement with FaHCSIA, through a steering committee and an operational group which also included Lifeline and the Australian General Practice Network representatives, as well as ongoing communication outside these forums. An independent evaluation of the training commissioned by FaHCSIA identified that the operational group did not focus on strategies to increase participation from the target population (that is, practice nurses and Aboriginal health workers from PIP rural and remote practices);

- progressive access to funding from May 2008 to practices whose personnel had completed the training—at that stage 24 practices were eligible. This approach was adopted as an alternative to waiting for all potentially eligible practices to have access to training (estimated by DoHA in 2005 to be February 2009);
- promotion of workshops by divisions of general practice and support payments for practice nurses and Aboriginal health workers to attend face-to-face training through funding to the Australian General Practice Network. Difficulties in the working relationship between Lifeline and the divisions of general practice resulted in some divisions not actively promote the training. These difficulties were caused by: late information from Lifeline to the divisions on face-to-face training dates for particular locations; and lack of available funding from FaHCSIA to Lifeline for weekend delivery of face-to-face training, preferred by practices unable to release staff on work days; and
- advocating online training to improve access. While online training was delivered by Lifeline from mid-2008, demand for online places from PIP practices was high relative to capacity, with waiting lists of up to 55 people and consequently, delays in accessing training, including one case of a 12-month delay. To the end of the Lifeline contract as at June 2009,¹⁶⁰ 148 people had been enrolled in the online training, but as with the face-to-face training, Lifeline did not (and was not required to) report on the number of these that were from the target group.

¹⁶⁰ FaHCSIA subsequently contracted Lifeline to extend the training to December 2009.

Appendix 7: Analysis of contribution of individual incentives to improved services for patients

Contribution to improved quality of care for patients

Contribution of improved Information Management/Information Technology (IM/IT) Incentive to quality care for patients

1. Since its introduction in July 1998 to ceasing in May 2009, the IM/IT Incentives provided practices with payments for:
 - moving patient records from paper-based to electronic formats;
 - writing scripts electronically;
 - transmitting clinically relevant documentation electronically; and
 - ensuring security in the storage and transmission of electronic patient information.
2. Each of these payments provide the building blocks for the National eHealth Strategy, which aims at enabling:

a safer, high quality, more equitable and sustainable health system for all Australians by transforming the way information is used to plan, manage and deliver health care systems.¹⁶¹
3. There are some obvious benefits to quality patient care from the IM/IT Incentive payments; for example, more accurate management of patient recalls, and faster communication on critical pathology results. However, there is no evidence that the benefit to quality patient care of this Incentive had been quantified and was significant other through high levels of participation.¹⁶²

¹⁶¹ Australian Health Ministers' Conference (2008), *National E-Health Strategy: Summary*, December 2008. <[http://www.health.gov.au/internet/main/publishing.nsf/Content/604CF066BE48789DCA25751D000C15C7/\\$File/Summary%20of%20National%20E-Health%20Strategy-final051208.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/604CF066BE48789DCA25751D000C15C7/$File/Summary%20of%20National%20E-Health%20Strategy-final051208.pdf)> [accessed 19 October 2009].

¹⁶² Table 3.5 shows that at May 2009, 90 per cent and 88 per cent of PIP practices participated in the 'basic' and 'enhanced' IM/IT Incentive payments respectively, over 4200 practices in each case.

Contribution of Quality Prescribing Incentive to quality care for patients

4. This incentive involves activities recognised or provided by the National Prescribing Service. The National Prescribing Service undertakes regular evaluation of its recommendations/activities often in collaboration with university based researcher to test that they have intended positive outcomes on patients.¹⁶³ Based on the National Prescribing Service's own reports, there is evidence that this incentive contributes to improved patient outcomes.
5. Nonetheless, the effectiveness of this incentive payment is still reliant on the take-up by practices. In 2002–03 participation in Quality Prescribing Incentive reached a maximum of 1422 practices, currently decreasing to 840 (or by 41 per cent) in 2008–09. DoHA informed the ANAO that low take up, could be attributed to the relatively small payment involved. The ANAO estimates that in 2008–09, participating practices were eligible for an average payment of \$2860 from this incentive, compared with an average total PIP payment of \$61 600, consistent with this view.

Contribution of Diabetes Management Incentive to quality care for patients

6. DoHA advised that the diabetes cycle of care was initially developed in close consultation with the medical profession, and that its requirements are generally consistent with current best practice guidelines, such as those issued by the NHMRC.¹⁶⁴ Further, the minimum requirements for care align with those recommended by the RACGP.¹⁶⁵
7. In 2005, an evaluation was completed on the National Integrated Diabetes Program, of which the PIP incentive was the major

¹⁶³ The latest report in the evaluation series is: National Prescribing Service (2009), *Evaluation Report 11: 2007-08 – Progress, achievements and future directions*.
<http://www.nps.org.au/data/assets/pdf_file/0005/69566/NPS_Eval_Report_No.11_v1.2.pdf> [accessed 19 October 2009].

¹⁶⁴ National Health and Medical Research Council (2001, updated 2005), *National Evidence Based Guidelines for the Management of Type 2 Diabetes Mellitus*.
<<http://www.nhmrc.gov.au/publications/synopses/di7todi13syn.htm>> [accessed 18 February 2009].

¹⁶⁵ RACGP (2009/10) *Diabetes Management in General Practice*, (15th edition), pp. 34–35.
<<http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/Diabetesmanagement/200910diabetesmanagementingeneralpractice.pdf>> [accessed 19 February 2010].

component.¹⁶⁶ Almost half of the GP respondents to a survey conducted as part of this evaluation, said that the PIP incentive does not encourage them to diagnose new diabetes cases. Furthermore, while there was some suggestion that 'more patients were undergoing annual cycle of care and hence better managed', there was no comparative data prior to the introduction of the PIP incentive.

8. Since the time of the evaluation, there has been another study published that suggests that the Diabetes Management Incentive has increased the probability of diabetes testing by 20 per cent.¹⁶⁷ In addition, since it began in 2001, the number of completed diabetes cycles of care, as measured through the number of SIPs, has increased three-fold, from 52 657 in 2001–02 to 166 554 in 2008–09.
9. On this basis, there is evidence that this PIP incentive has improved quality patient care.

Contribution of the Asthma Management Incentive to quality care for patients

10. In 2004, an evaluation was completed on the Asthma Management Program, of which the PIP incentive was the major component.¹⁶⁸ While stakeholders regarded the incentive as significant and valuable in asthma management, only half of the GP respondents to a survey conducted as part of this evaluation, said that the PIP incentive was a useful concept in providing care to asthma patients in general practice.
11. Since that evaluation, the Asthma Incentive replaced its requirements for an asthma 3+ visit plan for patients with asthma with an asthma cycle of care plan. The AIHW has cited research that suggests the approach is best practice, and that rates of claims for completing cycles of care for patients with moderate or severe asthma have increased.¹⁶⁹ This increase is consistent with the number of SIPs, which has increased by 60 per cent since its introduction, from 15 392 in 2001–02 to 24 862 in

¹⁶⁶ Healthcare Management Advisors (2005), *Evaluation of the National Integrated Diabetes Program* (Funded by the Australian Government, DoHA, unpublished).

¹⁶⁷ Anthony Scott, *et al.* (2009), 'The effects of an incentive program on quality of care in diabetes management', *Health Economics*, Vol 18, Issue 9, pp. 1091–1108.
<<http://www3.interscience.wiley.com/journal/122525707/abstract>> [accessed 18 February 2009].

¹⁶⁸ Urbis Keys Young (2004), *Evaluation of the Asthma Management Program* (Funded by the Australian Government, DoHA, unpublished).

¹⁶⁹ Australian Institute of Health and Welfare (2008), *Asthma in Australia 2008*.

2008–09. On this basis, there is evidence that this PIP incentive has improved quality patient care.

Contribution of Practice Nurse Incentive to quality care for patients

12. The Practice Nurse Incentive was part of a broader program introduced in 2001, Nursing in General Practice initiative. An evaluation of this initiative in 2005, concluded that:
- practices with practice nurses have found that practice nurses allow greater throughput of patients, reduced waiting times, and to a lesser extent, increased GP time;
 - it improved the quality of the practice through accreditation, sterilisation techniques and improved recall systems for chronic conditions;
 - it had a positive impact on the management of chronic disease through recall systems and education; (and)
 - it provided opportunities for rural GPs to link more effectively with the range of health professionals required to support the care of their patients.¹⁷⁰
13. The report indicated that the PIP incentive had contributed to these achievements through increasing the uptake of practice nurses employed in the three years since February 2002, by 30 per cent. In addition, in the four years to November 2009, the percentage of PIP practices potentially eligible for this incentive increased as did the participation rates among such practices by a further eight per cent. This suggests that the Practice Nurse Incentive has positively contributed to quality patient care.

Contribution to improved access for patients

Contribution of the Practice Nurse Incentive to general practice access

14. In the five years from May 2004, the percentage of eligible practices in urban areas of workforce shortage, increased from 43 to 70 per cent (an increase of 645 practices), and in rural/remote areas, from 74 to 89 per cent. This indicates that the incentive has been successful in

¹⁷⁰ Healthcare Management Advisors (2005), *Evaluation of the 2001 Nursing in General Practice Initiative*, p. 3 (funded by the Australian Government, DoHA, unpublished).

improving access to those primary health care services delivered by practice nurses and Aboriginal health workers.

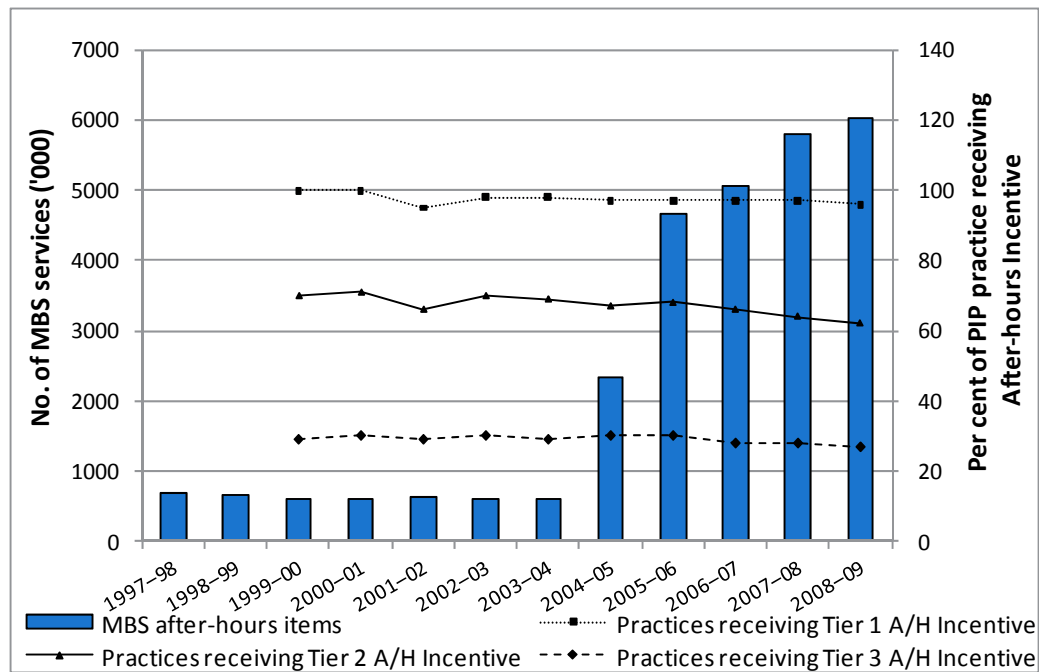
Contribution of the After-hours Incentive to general practice access

15. Overall, 96 per cent of PIP practice participated in this incentive in 2008–09. There has been a slight downward trend of practices participating in each of the three tiers of the After-hours Incentive, since 2000–01. In contrast, since 2003–04 there has been a significant increase in the number of after-hours services delivered by GPs; this increase coincided with the expansion of MBS after-hours items in early 2004,¹⁷¹ suggesting that this expansion led to improved supply of after-hours care, and subsequent take-up by patients. These trends are shown in Figure A 1.
16. While recognising that the After-hours Incentive ensures practice patients have access to after hours services by accredited practices (either within, or outsourced by, the PIP practice), in terms of access, the data suggests that it has been a relatively limited in its effectiveness to increase access to general practice services after hours, when compared with the effect from the expansion of MBS after-hours items.

¹⁷¹ Department of Health and Ageing, *2004-05 Annual Report*, p. 75.

Figure A 1

Number of A/H MBS services & A/H Incentive participation, 1997–98 to 2008–09



Source: ANAO analysis of Medicare Australia data. Number of after-hours items based on MBS items 1, 2, 97, 98, and groups A11, A22 and A23.

Contribution of the Teaching Incentive to general practice access

17. Since 2001–02, the number of teaching sessions has grown significantly, averaging an increase of 18.4 per cent per annum, with 101 255 teaching sessions undertaken in 2008–09. Provided there is a proven link between teaching sessions and improved general practice workforce capacity, this result suggests that the Teaching Incentive is effective in increasing access to general practice services.

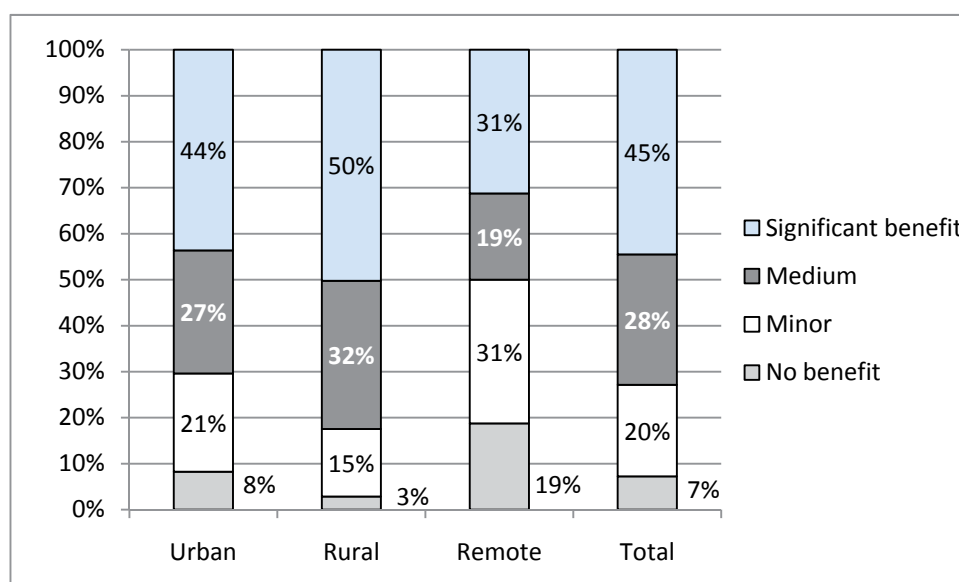
Contribution of PIP rural and remote payments to general practice access

Contribution through supporting financial viability of rural and remote practices

18. For the May 2009 payment, of the PIP payments to general practices, \$15.4 million (or 22 per cent) was paid on the basis of practices being located in rural and remote areas (RRMAs 3–7).¹⁷²
19. A key professional stakeholder group advised the ANAO that PIP is important to the financial viability of rural and remote practices. Based on the survey of general practice undertaken by the ANAO, this view is supported more by rural rather than remote practices, as shown in Figure A 2.

Figure A 2

Benefits from participation in PIP to financial viability of practices



Source: ANAO survey of general practice. Number of respondents—489.

20. While 82 per cent of responses from rural practices considered there to be at least a medium benefit to their financial viability from PIP, only 50

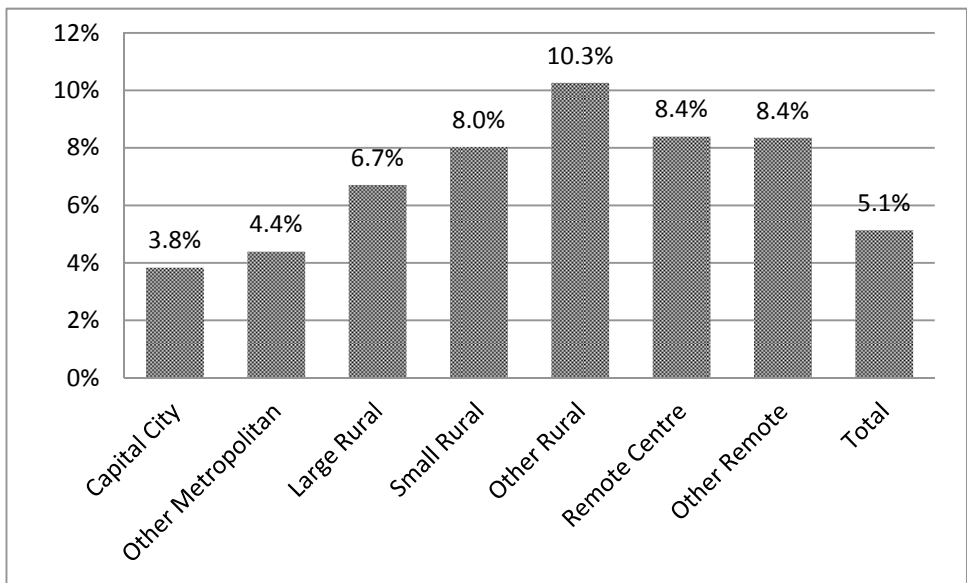
¹⁷² This amount comprises of the following payment types: Rural and Remote Loading—\$7.0 million; Practice Nurse Incentive—\$6.0 million; Procedural Payment—\$2.3 million; and Domestic Violence Incentive—\$0.1 million.

per cent of remote practices shared this view—this difference may not be significant once the statistical error is taken into account.¹⁷³

21. For both rural and remote practices, PIP contributes a significantly greater proportion to the practice income than for practices in urban areas. Figure A 3 shows, for 2008–09, PIP’s (practice related) contribution as a percentage of government GP-related expenditure for each of the rural and remote categories.

Figure A 3

PIP payments to practices as percentage of GP-related expenditure by RRMA, 2008–09



Source: ANAO analysis of Medicare Australia data. Included in GP-related expenditure is PIP expenditure to practices (PIP payments to general practitioners excluded) and GP and general practice MBS item expenditure (currently Groups A1, A2, A5, A6, A7, A11, A14, items 721 to 779 from Group A15, Groups A17, A18, A19, A20, A22, A23, M1, M2 and M5).

22. On balance, there is sufficient evidence to conclude that PIP payments provide the potential for greater financial viability for practices in rural and remote locations, and as such increase the potential for accessibility to general practice services.

¹⁷³ Approximately 10 per cent of practices responded to the survey. While overall results are subject to a 95 per cent confidence interval of ± 4 per cent, the confidence interval for the remote results is ± 23 per cent.

Contribution through ensuring Rural loadings provide support commensurate with accessibility need

23. For each of the RRMA categories, the ANAO assessed the number of full-time work-equivalent (FWE) GPs per 100 000 population. The ANAO also determined for each RRMA category the Rural loading payments per full-time equivalent (FTE) GP working in practices receiving PIP.¹⁷⁴ The results are shown in Table A 5 below.

Table A 5

General practitioners per 100 000 population, 2008–09 Rural loading payments per general practitioner by RRMA (3–7) category

RRMA category	Rural loading		2008–09 Rural loading per FTE GP in PIP practices ^a		FWE GPs per 100 000k population ^b	
	Per cent	Ranking ↑	\$	Ranking ↑	Number	Ranking ↓
Large rural centre 3	15	1	2 891	1	82	3
Small rural centre 4	20	2	4 483	2	87	2
Other rural area 5	40	4	9 905	4	88	1
Remote centre 6	25	3	5 767	3	60	5
Other remote 7	60	5	10 354	5	71	4
Across all RRMA categories			1 834		91	

Source: a)—ANAO analysis of Medicare Australia data. FTE GPs are based on the May 2009 payment.

b)—ANAO analysis from

<<http://www.phcris.org.au/products/asd/keycharacteristic/index.php?2007-08>> survey data.

24. Table A 5 shows that directly reflecting the loadings themselves, the PIP payments per FTE GP increase from RRMA 3 to RRMA 7, except for RRMA 6 which, with a 25 per cent loading, payment amount is between that of RRMA 4 and RRMA 5.
25. If the Rural loading payments were to influence accessibility to general practitioners, the loading should be related inversely to general practitioners per capita with the RRMA. That would suggest that the number of GPs would decrease from RRMA 3 to RRMA 7, except for

¹⁷⁴ FTE GP measure takes account of partial contribution by part-time doctors, but does not recognise the extra contributions of doctors whose billing practice exceed the average full-time doctor for the year (that is, no individual can exceed a contribution of 100 per cent. FWE GP measure does not include such a restriction. <<http://www.healthactive.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-gpstats-explan.htm>> [accessed 21 September 2009].

RRMA 6 whose rate should fall between those of RRMA 4 and 5. However, Table A 5 shows that this is not the case. RRMA 5, with a 40 per cent loading, has the highest number of FWE GPs per 100 000 in any of the rural and remote categories, while RRMA 6, with a 25 per cent loading, has the lowest relative number of GPs.

26. Currently, the Rural loading payments to practices do not proportionately reflect areas of general practice workforce shortages and therefore, do not proportionately contribute to access to general practitioner services. This is particularly so for RRMA 6.
27. In early 2009, advice was provided to government on the relative Rural loadings for RRMA 5 and RRMA 6. No decision has been taken on this matter, given the Government's intention to move PIP from RRMA to the Australian Standard Geographical Classification – Remoteness Areas system.¹⁷⁵

Contribution of the Procedural GP Incentive to general practice access

28. The Procedural GP Incentive rewards practices whose GPs provide surgical, anaesthetic and obstetric services in rural and remote areas. On average, over one in five of such practices actively participates in this incentive, with the greatest participation in practices in RRMAs 5–7, as shown in Table A 6.

Table A 6

Participation in the Procedural GP Incentive, May 2009

RRMA category	Procedural GP Incentive practices	Per cent of PIP practices
Large rural centre 3	20	6.4%
Small rural centre 4	76	5.3%
Other rural area 5	202	29.7%
Remote centre 6	16	29.6%
Other remote 7	19	18.1%
TOTAL (3–7)	333	22.5%

Source: ANAO analysis of Medicare Australia data.

¹⁷⁵ See paragraph 2.28.

Contribution of the Domestic Violence Incentive to service access

29. With its aim of encouraging GPs in rural and remote areas to act as referral point for people experiencing domestic violence, the Domestic Violence Incentive has potential to improve access to relevant services, albeit that these are not general practice services.
30. There is a low take-up of this incentive, and no key performance indicators in place to measure, for example, the number of referrals in participating practices. Until the time that DoHA undertakes an evaluation of this incentive, its effectiveness in improving access to care is not known.

Contribution of the GP Aged Care Access Incentive to general practice access

31. The GP Aged Care Access Incentive (ACAI) provides payments for general practitioners working in PIP practices who achieve targets in services provided to residents of residential aged care facilities (RACFs). Qualifying services relate to specific RACF MBS items, delivered by GPs from 1 July 2008.
32. DoHA determined that in the seven months to 31 January 2009, ten per cent more qualifying services were delivered to residents of RACFs by eligible GPs than in the same period 12 months previously; this compares with an increase of five per cent by all other medical providers. Furthermore, during this period, the number of eligible providers delivering levels of services qualifying for a Tier 1 incentive payment, increased by six per cent over the number delivering this level of service in the equivalent period 12 month previously. There was also an increase of five per cent in patients seen by GPs eligible for a Tier 1 incentive, compared with the previous year. This last analysis did not indicate a comparative assessment for practitioners outside PIP practices.
33. DoHA's assessment suggests that the ACAI payments have been effective in increasing GP service delivery to residents of RACFs, noting that this is an assessment relatively soon after payment implementation.

Appendix 8: Analysis of the PIP Business Practice Agreement

Table A 7

ANAO analysis of the PIP BPA

Criteria The BPA defines/contains:	Criteria Met	ANAO comments/findings
The parties to the Agreement	Met	Stated in Section 3 of the BPA.
The objective of the Agreement	Met	Stated in Section 7 of the BPA under 'Scope'.
The legislation and/or policy basis of the Agreement	Largely met	Section 1 of the BPA identifies the legislation basis for the BPA and the appropriation from which PIP is drawn. Section 2 states the program objective, but reflects the original objective rather than the one current at the time of the Agreement.
Roles and responsibilities of each party to the Agreement	Met	Sections 8 and 9 of the BPA identify the requirements of, and obligations on, each agency.
Details of services to be provided	Met	Sub-section 8.1 of the BPA states the deliverables required of Medicare Australia.
Funding arrangements and the value of the services to be provided	Met	Section 11 of the BPA identifies the sources of departmental expenses for service delivery, through direct appropriation, and of administered expenditure, through the Primary Care Practice Incentives appropriation. Schedule 1 of the MOU addresses the Budget Consultation Protocol.
Principles applying to the Agreement	Met	Sub-section 10.4 of the BPA states the administrative principles in relation to the management and operation of the PIP, namely: customer focus; timely and accurate payments; data quality; electronic commerce; and performance monitoring.
The duration of the Agreement and process for reviewing and renegotiating the Agreement	Met	Section 5 of the BPA outlines the duration of the agreement (three years unless extended or terminated in line with the MOU), and the means for varying the BPA. This is supported by details at Sections 26 and 27 of the MOU.
Governance arrangements	Met	Section 9 of the MOU outlines the governance arrangement for the MOU and identifies that each BPA should have appropriate consultation, performance monitoring and reporting. Section 12 of the BPA states the functions of the PIP liaison meetings, the principal means for governance of the agreement.
Processes for resolving disputes by either agency	Met	Section 13 of the BPA refers to Section 18 of the MOU which outlines an escalating dispute resolution approach for BPAs and protocols.

Criteria The BPA defines/contains:	Criteria Met	ANAO comments/findings
Related key documents and their location	Largely met	The PIP BPA forms part of the MOU which also includes a range of protocols as part of the agreement. The BPA refers to business rules for each of the incentives. These business rules are formal documents signed by both agencies that outline the basis and payment arrangements for incentives. While these are not included as schedules to the BPA, both agencies are well acquainted with the business rules for each incentive.
Terminology and acronyms	Met	Stated in Section 4 of the BPA, under 'Interpretation'.
Key performance indicators (KPIs)	Met	Throughout the BPA, deliverables are identified that are related to particular targets (for example, response within 10 working days from the date of receipt of any written requests for advice from DoHA). The administrative principles identify that Medicare Australia's performance will be assessed against the performance indicators agreed between the agencies. This has been actioned through a scorecard that measures the provision of reporting in line with the BPA, timeliness and accuracy of payments, and timeliness of answering phone calls to the PIP enquiry line, and compliance audit and liaison requirements. Medicare Australia reports its achievements against targets, to DoHA on a quarterly basis.
Performance reporting and requirements for management information	Met	Sub-section 8.3 of the BPA identifies a range of management reports and their frequency, including compliance audit reports, and reports for the release of funds and payments to practices.
Agreement managers and contact officers in each agency	Met	Section 6 of the BPA identifies the officers responsible for the overall management of the BPA and for its day-to-day administration.
Protocols	Met	The MOU includes protocols for: Budget consultation, parliamentary and ministerial coordination; legislation consultation; policy and legislative interpretation; and program integrity and risk management.

Source: ANAO analysis. Criteria derived from ANAO Audit Report No.4, 2008–09, *The Business Practice Agreement between the Department of Education, Employment and Workplace Relations (DEEWR) and Centrelink*, Canberra.

Appendix 9: Medicare Australia steps for new incentive implementation

Table A 8

Steps typically undertaken in implementing new PIP incentives

Step	Responsibility of:	Purpose/process
Agreement on business rules	DoHA and Medicare Australia's National Office	The 'business rules' for an incentive is a document signed by both agencies that specifies: policy and funding basis, payment arrangements, eligibility, and key responsibilities of each agency in line with BPA.
Development of business requirements	Medicare Australia's National Office	Business requirements provide the details for Medicare Australia's IT area of system changes needed for the new incentive. The requirements identify timing of the first payment, required changes to data input screens, payment calculations, advice to recipients on provision of payments, reports for DoHA, and information, including reporting, for Medicare Australia's website. Under the business rules, a copy is required by DoHA.
Implementation of IT changes	Medicare Australia's IT area	Upon receiving the business requirements for a new incentive, the IT area develops an IT implementation plan that identifies costs, tasks, and timeframes in which to implement the necessary IT changes as specified in the business requirements. With agreement from the branch with overall responsibility for PIP, the IT implementation plan is used to inform and assist in managing the IT changes.
Development of guidelines, application forms and information letters for practices/GPs	DoHA	DoHA develops incentive guidelines and supporting application forms (as needed) and information letters as part of its program development responsibilities. Under the business rules these documents are required to be provided to Medicare Australia in a timely manner.
Letters, guidelines and application forms sent to practices/GPs	Medicare Australia's National Office sent through IT processing centre	Information to practices is approved through Medicare Australia's forms and letters approval process, and then printed. ¹⁷⁶ The IT system draws on the PIP database of details on practices and their providers to send information to potentially eligible practices/GPs.
Development of Q & As	DoHA	Q and As are used by the PIP enquiry line operating staff in answering enquiries from practices and their GPs.

¹⁷⁶ Pro-forma letters for the ACAI and eHealth Incentive were sent on DoHA letterhead, with the eHealth application form issued under the DoHA logo, given that there was an extended clearance period required by Medicare Australia for such items at the time. See paragraphs 5.13–5.14.

Step	Responsibility of:	Purpose/process
Development of user reference guide	Medicare Australia's National Office	The user reference guide is to ensure that operating staff understand: how to process applications to meet eligibility requirements; the changes to IT systems to accommodate the new incentive; and the payment advice format that practices will receive.
Training of operational staff to implement new incentive	Medicare Australia's SA office	Training is needed so that operational staff understand the requirements for the new incentive for handling enquiries and processing applications.
Handling enquiries from practices/GPs	Medicare Australia's SA office	Practices are advised in letters on the new incentive to contact the PIP enquiry line, operated from the Medicare Australia's SA office.
Processing application forms, including entering details into PIP IT database	Medicare Australia's SA office	Practices submit application forms to the Medicare Australia's SA office by mail or fax. They are assessed with details manually entered to the PIP IT system and an advice letter provided to practices on the outcome of the assessment.
Making initial and subsequent payments	Medicare Australia's National Office sent through IT processing centre and authorised by DoHA	DoHA authorises payments to practices, based on reports provided by Medicare Australia's National Office. Medicare Australia's SA office arranges manual payments for practices whose payments have been held and subsequently released, or if advised by practices of operator error in recording details. ¹⁷⁷

Source: ANAO assessment of DoHA and Medicare Australia documentation.

¹⁷⁷ Until November 2009, the SA office also undertook 3- and 6-monthly recalculations of PIP entitlements. Up to that time, practices could advise of changes, such as new providers, and have up to their previous two quarterly payments adjusted to reflect the changes.

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