

practice incentives program indigenous health incentive   
(PIP IHI)

Consultation paper

04 April 2019

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introduction

The Practice Incentives Program (PIP) commenced in 1998 and is a key driver of quality care in the primary care sector. There are approximately 5,700 PIP practices currently receiving PIP incentives in Australia[[1]](#endnote-1). The PIP aims to encourage general practices through financial incentives that support quality care and improve access and health outcomes for patients. The Indigenous Health Incentive (IHI) is one of 11 PIP incentives[[2]](#footnote-1).

The PIP IHI was introduced in March 2010 as part of a $805.5 million Indigenous Chronic Disease Package (contributed over four years from 2009 to 2013). The PIP IHI encourages general practices and Aboriginal Community Controlled Health Services to appropriately and effectively meet the health care needs of Aboriginal and Torres Strait Islander people[[3]](#endnote-2) with chronic disease[[4]](#footnote-2).

Following a review of the PIP in 2016, the Australian Government confirmed that the PIP IHI will remain but will be reviewed.

The PIP IHI aims to support general practices and Aboriginal Community Controlled Health Services to provide better health care for Aboriginal and/or Torres Strait Islander patients, including best practice management of chronic disease.

The leading cause of Indigenous mortality is chronic disease, with nearly three in four Indigenous deaths caused by circulatory disease, cancer diabetes and respiratory disease. There is evidence to show that management of chronic disease is contributing to reductions in circulatory disease[[5]](#endnote-3).

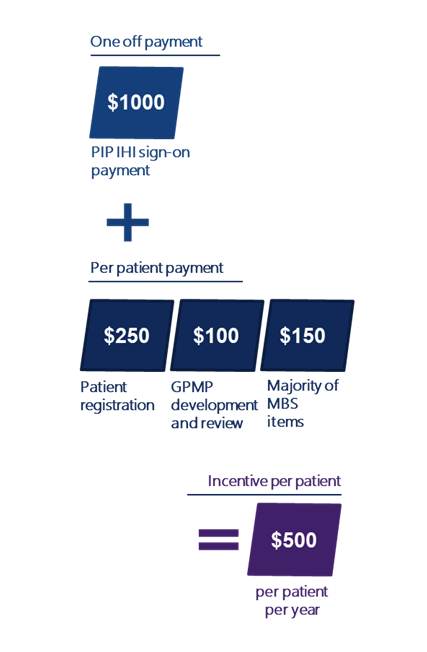
This Consultation Paper provides an overview of how the PIP IHI works and invites your views on the PIP IHI *opportunities for improvement*. Several questions are posed throughout the paper to help generate ideas and stimulate discussion.

Details on how stakeholders can participate can be found at Invitation to collaborate on page 8.

This consultation builds on an initial round of targeted stakeholder consultation that the Department undertook with the National Aboriginal Community Controlled Health Organisation, specific Aboriginal Community Controlled Health Services and mainstream peak bodies.

The current pip ihi payment structure

The design of the PIP IHI is intended to provide an incentive to mainstream and Aboriginal Community Controlled Health Services to deliver quality primary health care to Aboriginal and Torres Strait Islander people with chronic disease.

To be eligible for the PIP IHI, a practice must first be eligible for and participate in the PIP – i.e. it must meet the Royal Australian College of General Practitioners (RACGP) definition of a practice, meet the PIP definition of an open practice, be accredited under the National General Practice Accreditation Scheme (currently against the RACGP Standards for General Practice), maintain public liability insurance, and have professional indemnity cover.

There are four specific components to the PIP IHI[[6]](#footnote-3). The four components are:

**One-off practice sign-on of $1000**: This sign-on payment is made when the practice registers for PIP IHI and agrees to undertake specified activities to improve the provision of care to Aboriginal and Torres Strait Islander people with chronic disease.

**Annual patient registration of $250 per year per registered patient**: An annual payment to practices for each eligible Aboriginal and Torres Strait Islander patient 15 years and over, registered with the practice for chronic disease management in a calendar year. During the registration, patients must be offered, or be given, a Health Check for Aboriginal and/or Torres Strait Islander people (MBS item 715).

**Tier 1 outcomes payment of $100 per year per registered patient**: An outcomes payment is automatically triggered for each patient where the practice provides the target level of at least two services in a calendar year.

**Tier 2 outcomes payment of $150 per year per registered patient**: An outcomes payment is automatically triggered if a practice provides ‘the majority of eligible MBS services for the patient’ during the calendar year.

improving management of chronic disease

Each component of the PIP IHI is intended to contribute to best practice management of chronic disease for Aboriginal and Torres Strait Islander people. In the following pages we seek your views on the extent to which the components of the payment make a difference to the way health services support Aboriginal and Torres Strait Islander people with chronic disease.

The four *opportunities for improvement* shown to the right have been informed by feedback to date from stakeholders.

#### 

Building cultural SAFETY

The PIP IHI guidelines state that PIP IHI registered practices are required to undertake cultural awareness training within 12 months of sign-on to the incentive[[7]](#footnote-4). To meet the requirement, at least two staff members from the general practice (one must be a GP) must complete appropriate cultural awareness training within that time. For the purpose of the PIP IHI appropriate training is any endorsed by a professional medical college, including:

* those offering Continuing Professional Development points, or
* those endorsed by the National Aboriginal Community Controlled Health Organisation or one of its state or territory Sector Support Organisations.

The 2017 Aboriginal and Torres Strait Islander Health Performance Framework states that while most Indigenous Australians had positive interactions with doctors, ‘Indigenous Australians in non-remote areas reported that their GP, rarely or never: showed respect for what was said (15 per cent), listened to them (20 per cent) or spent enough time with them (21 per cent)[[8]](#endnote-4).’

Health services and the health system should be responsive to cultural differences. Aboriginal and Torres Strait Islander people are more likely to access services that are respectful and culturally safe places[[9]](#endnote-5).

Feedback from stakeholders to date supports improving the level and quality of culturally appropriate care across the broader health system. Cultural awareness training can be the first step, however developing mutually respectful relationships with Aboriginal and Torres Strait Islander patients and understanding the local Indigenous community takes effort and is essential for practices to deliver culturally appropriate care.

Do the current PIP IHI guidelines facilitate culturally appropriate care for Aboriginal and Torres Strait Islander patients?

Is a requirement that cultural awareness training be undertaken appropriate for health practices?

How can we monitor the cultural competence of registered PIP IHI practices?

Streamlining administration

Indigenous patients are required to sign a PIP IHI consent form which requires them to:

* confirm they have a chronic disease
* confirm their understanding that their personal details will be shared between the practice and the Australian Government, and
* self-identify as being of Aboriginal and/or Torres Strait Islander origin[[10]](#footnote-5).

A patient’s initial PIP IHI registration is also the trigger for that patient’s record to be annotated (in the general practice’s system) as eligible to receive the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment Measure. The CTG PBS Co-payment Measure allows PBS medicines to be purchased at a cheaper price or free of charge.

At the end of each calendar year, practices need to re-register their patients for the following calendar year[[11]](#footnote-6). This requires the patient to provide their consent each year.

The registration can be completed via a paper form (which must be posted or faxed to the Department of Human Services) or by using the Health Professional Online Services (HPOS) system.

If practices use HPOS, they don’t need to provide a copy of the form to the Department of Human Services, but they must keep the form on file for six years for audit purposes.

Feedback to date indicates the annual registration process is administratively burdensome and onerous for health practices.

There is also evidence that the patient registration process can be competitive among health services.

How does the patient registration process improve or impede chronic disease management and care?

Is the current financial incentive for patient registration contributing to better management of chronic disease?

Is the current registration processes burdensome and how can it be streamlined?

Should the payment be linked to the provision of care rather than an administrative process?

Best practice management of chronic disease

There are two tiers of outcomes payments available to the health service each calendar year for each registered patient: Tier 1 and Tier 2 outcomes payments. Outcomes payments are based on MBS services provided from   
1 January to 31 December of each year the patient is registered.

A **Tier 1 outcomes payment** of $100 per patient is made to practices that:

* prepare a General Practitioner Management Plan (GPMP) or coordinate the development of Team Care Arrangement (TCA) for the patient in a calendar year, and
* do at least one review of the GPMP or the TCA during the calendar year, or
* do 2 reviews of the patient’s GPMP or TCA during the calendar year, or
* contribute to a review of a multidisciplinary care plan for a patient in a Residential Aged Care Facility, twice during the calendar year.

A **Tier 2 outcomes payment** of $150 per patient is made to the practice that provides the majority of eligible MBS services for the patient (with a minimum of any five eligible MBS services) during the calendar year[[12]](#footnote-7).

Feedback from health practices indicates that:

* the calendar year timing for Tier 1 outcomes payments can be problematic. It can be challenging to develop a care management plan and review it within a calendar year, particularly if patient registration and development of a care management plan occurs in November and December of each year; and,
* continuity of care and a longitudinal relationship are important components of good chronic disease management. Feedback indicates there may be potential for other MBS items to be considered part of best practice management of chronic disease for Aboriginal and Torres Strait Islander patients.

What does good chronic disease management and care look like in a primary health care setting?

Should all Indigenous patients with a chronic disease have a GPMP?

How important are reviews of GPMPs in the management of chronic disease?

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

Are multiple visits to the GP an indication of good management of chronic disease?

Are there other measurable approaches/health care activities that support chronic disease management for Indigenous patients?

Better responding to patient mobility

The PIP IHI acknowledges population mobility as a significant factor, allowing for a patient to be registered with more than one practice during the calendar year. However, only one practice can receive a $250 patient registration payment per calendar year[[13]](#footnote-8). As described on page 8, there is some anecdotal evidence that population mobility may contribute to the patient registration being a competitive process, with practices vying to sign up their ‘usual’ patients before another practice signs them up and receives/claims the $250 per patient.

Patient mobility may also affect the ability of health practices to achieve a Tier 1 outcomes payment. The development and review of chronic disease care management plans in a calendar year may still be accomplished, but by several different practices, so only one practice claims a Tier 1 outcomes payment.

How can PIP IHI best respond to Indigenous patients who need to move around for personal/family reasons?

Does the calendar year rule disadvantage practices and patients who are mobile?

How can practices maintain continuity and consistency of care in light of patient mobility?

Invitation to collaborate

Stakeholders are invited to provide input to the PIP IHI review and consider the *opportunities for improvement.* There are two ways that stakeholders can provide input:

1. Participate in the consultation process through a workshop or webinar. Details will be provided at later date.
2. Provide a written submission that comments on the *opportunities for improvement* detailed in this Consultation Paper.

Submissions should be no more than 10 pages and be received by the Department of Health by 10 June 2019 via email:

[indigenousphcpolicy@health.gov.au](mailto:indigenousphcpolicy@health.gov.au)

or post:

Primary Health, Data and Evidence Branch, Indigenous Health Division

Department of Health

MDP 750, GPO Box 9848

Canberra ACT 2601

**Opportunities for improvement**

Do the current PIP IHI guidelines facilitate culturally appropriate care for Aboriginal and Torres Strait Islander patients?

Is a requirement that cultural awareness training be undertaken appropriate for health practices?

How can we monitor the cultural competence of registered PIP IHI practices?

How does the patient registration activity improve or impede chronic disease management and care?

Is the current financial incentive for patient registration contributing to better management of chronic disease?

Is the current registration processes burdensome and can it be streamlined?

Should the payment be linked to the provision of care rather than an administrative process?

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How can PIP IHI best respond to Indigenous patients who need to move around for personal/family reasons?

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How can practices maintain continuity and consistency of care in light of patient mobility?

SOURCES

1. Department of Health, Practice Incentives Program Data, September 2018, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-PIP\_Data. [↑](#endnote-ref-1)
2. The are 11 PIP incentives including: Asthma, After Hours, Cervical Screening, Diabetes, eHealth, General Practitioner Aged Care Access, Indigenous Health, Procedural General Practitioner Payment, Quality Prescribing Incentive, Rural Loading, and Teaching Payment. [↑](#footnote-ref-1)
3. KPMG, National Monitoring and Evaluation of the Indigenous Chronic Disease Package, June 2014. [↑](#endnote-ref-2)
4. The PIP Indigenous Health Incentive uses the MBS definition of a chronic disease—a disease that has been, or is likely to be, present for at least six months. It includes but is not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. [↑](#footnote-ref-2)
5. Australian Government, Closing the Gap Prime Minister’s Report 2018, 2018. [↑](#endnote-ref-3)
6. A rural loading ranging from 15–50 per cent, depending on the remoteness of the practices, is applied to practices located in Rural Remote and Metropolitan Areas 3–7. The Department of Health currently uses the Rural, Remote and Metropolitan Areas model, not the Modified Monash Model. [↑](#footnote-ref-3)
7. Exemptions apply for practices who have undertaken appropriate training completed up to 12 months before the practice signs on for the incentive and/or for practices under the management of an Aboriginal Board of Directors or a committee made up mainly of Aboriginal community representatives. [↑](#footnote-ref-4)
8. Aboriginal and Torres Strait Islander Health Performance Framework, Australian Government, 2017. [↑](#endnote-ref-4)
9. Australian Indigenous Doctors’ Association, Cultural Safety Factsheet. [↑](#endnote-ref-5)
10. Patients do not need to provide evidence to support this. [↑](#footnote-ref-5)
11. Annual re-registration for the CTG PBS Co-payment Measure is not required. [↑](#footnote-ref-6)
12. If two or more practices provide the same number of eligible MBS services for a patient (with a minimum of any five eligible MBS services) in the calendar year, a Tier 2 outcomes payment will be made to each practice. [↑](#footnote-ref-7)
13. Practices may be eligible for either, or both, Tier 1 and Tier 2 outcomes payments even if the patient is currently registered for the PIP IHI at another PIP-registered practice. [↑](#footnote-ref-8)