Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Congress submission to the Redesigning the Practice Incentive Program consultation

Summary

This response to the Commonwealth Department of Health's Redesigning the Practice Incentive Program (PIP) consultation paper has been prepared by the Central Australian Aboriginal Congress (Congress).

Congress is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people living in and nearby Alice Springs, including six remote communities.

In principle, Congress is supportive of a redesigned PIP that supports quality improvement practices in primary health care. As an ACCHS, Congress already has a well-designed Continuous Quality Improvement (CQI) program which is likely to be enhanced by the outcomes of the redesign.

Congress fully supports the intention to retain the rural loading incentive; the afterhours incentive; the teaching payment; and eHealth incentive. These are important payments to sustain quality services for our population.

Overall the PIP is a vital funding source for Congress. PIP revenue is reinvested back into the comprehensive primary health care services provided by Congress which aim to close the gap in health outcomes between Aboriginal and non-Aboriginal people in Central Australia. Any redesign of the PIP should not compromise this revenue.

There are a number of principles to consider in the redesign process. These include:

1) Maintaining recognition of Indigenous disadvantage by keeping the existing Indigenous Health PIP or weighting the cost of Indigenous disadvantage within a streamlined Quality Improvement PIP
2) Administrative processes including data collection and reporting that is less onerous than existing processes
3) Maintaining a focus on managing chronic disease as this accounts for 80% of the Life Expectancy gap here in the NT between Aboriginal and non-Aboriginal people.
4) Transparent use of data for benchmarking against peers and public accountability
5) Maintain the Closing the Gap Indigenous Chronic Disease Co-Payment
6) Continue to allow for flexibility in how practices use their PIP revenue
7) Ensure there is ongoing consultation with ACCHSs in the PIP redesign and modelling

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Aboriginal health in Aboriginal hands.

1. Introduction

This response to the Redesigning the Practice Incentive Scheme (PIP) consultation paper has been prepared by Central Australian Aboriginal Congress (Congress).

Congress is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people living in and nearby Alice Springs, including six remote communities; Amoonguna, Ntaria and Wallace Rockhole, Ltentye Apurte (Santa Teresa), Utju (Areyonga) and Mutitjulu.

2. Context for response

While the gap in some health outcomes has decreased in recent years, Aboriginal people still experience a disease burden that is 2.3 times higher than non-Aboriginal people. In the Northern Territory the conditions that contribute most to the higher burden of disease for Aboriginal people include: cardiovascular diseases, mental and substance use disorders, injuries, kidney & urinary diseases, infectious diseases and endocrine disorders (which includes diabetes).[1] Chronic diseases are responsible for more than 80% of the gap in disease burden, which is worse in remote and very remote areas.

ACCHSs, such as Congress, function within the framework of a comprehensive primary health care (CPHC) service, which aims to address health inequities and close the health gap between Aboriginal and non-Aboriginal people through providing high quality, accessible, multidisciplinary clinical care as well as taking action to address the broader underlying, social determinants of health.. ACCHSs' service populations that have significantly more complex health needs, and frequently live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge. ACCHSs provide a comprehensive model of care that goes beyond the treatment of individual clients for discrete medical conditions to include[2]:

- a focus on cultural security;
- assistance with access to health care (e.g. patient transport to the ACCHS and support and advocacy to access care elsewhere in the health system);
- population health programs including health promotion and prevention;
- public health advocacy and intersectorial collaboration;
- participation in local, regional and system-wide health planning processes;
- structures for community engagement and control; and
- significant employment of Aboriginal and Torres Strait Islander people.

The evidence points to ACCHS as a highly effective model for addressing Aboriginal and Torres Strait Islander health and they are therefore recognised as the best practice model for primary health care services for Aboriginal people in all the key national strategy documents including the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP). A key recent study concluded:

... some studies showing that ACCHS are improving outcomes for Aboriginal people, and some showing that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload[3].

In particular, ACCHSs contribute significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birth weight[4].

The key role of ACCHSs is supported by the fact that Aboriginal people show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes[5].

The role of ACCHSs is particularly clear in the Northern Territory, where their comprehensive model of service delivery and advocacy for public health and system reform has been the foundation for much of the relative success of that jurisdiction in reducing mortality rates.[6]

Further detail of the CPHC framework and core services is at **Appendix A**.

3. Contribution of the PIP to ACCHS and the delivery of comprehensive primary health care services.

PIP payments are a vital contribution to Congress' income and annual budget. Congress is accredited under the RACGP's Standards for General Practice, and is therefore eligible for PIP incentives. As grant funding has largely been capped, PIP incentives, along with the Medicare Benefits Schedule (MBS), are the major source of growth funding. This growth funding enables Congress to meet increased need and review and develop services in a dynamic way, without having to go through a cumbersome, budget appropriation process. This helps to improve access to services for Aboriginal people in remote areas as well as encourage best practice in areas such as screening and chronic disease management. It is a vital way of funding the care provided to the 3000 Aboriginal people who utilise Congress services each year who do not live in our health service area and are therefore not included in our grant funding.

Congress' services and client profile means the service is eligible for a number of PIP incentives, in particular Indigenous Health, Diabetes, Cervical Screening, Asthma, eHealth, Rural loading, After Hours and Teaching. For instance, Congress sees approximately 2400 patients each year in Alice Springs who are eligible for the Indigenous incentive. Over 30 per cent of Congress resident clients have at least one chronic disease and over 44 per cent have comorbidities. Around 1500 patients are eligible for the Diabetes incentive. Congress also runs the only after-hours clinic in Alice Springs which is open on weekends and public holidays, in addition to providing a major general practice teaching program in partnership with Northern Territory General Practice Education (NTGPE).

Although the income is vital, administrative processes are a burden for both staff and patients. This means that even if the work is done, the incentives are not always accessed and revenue received does not necessarily reflect overall activity. However, with improved processes and a systematic drive to increase its use of the PIP, Congress is on track to receive a projected PIP income of $1.45 million in 2016/17. It is expected that $1.2 million will come from full use of the Indigenous Health PIP.

As with all income received by Congress, the PIP payments are reinvested back into the existing services and activities in prevention, clinical and social support services, continuous quality improvement, workforce, education and training, all of which contribute to Closing the Gap. The combination of PIP and MBS payments, alongside primary health care grant funding, provides a level of funding that is closer to meeting the need for primary health care services as determined by the Northern Territory Aboriginal Health Forums Core Functions of Primary Health Care (**see Appendix A**). There is still a need for additional primary health care funding in some areas.

It is essential then that there is no reduction in this income stream as a result of a redesigned PIP scheme. Congress' participation in a national scheme would be contingent on further understanding of potential revenue compared with current revenue.

4. ACCHS quality framework

As an ACCHS, Congress uses accreditation (general practice standards and ISO 9001), CQI, and performance reporting to drive improvements in the quality and safety of its services and outcomes for its patients. Congress has a well-developed CQI program and dedicated CQI section which assists managers and the executive leadership by providing reliable data for decision making. Quantitative data is also used to report on NT Aboriginal Health Key Performance Indicators (NTAHKPIs) and national KPIs (nKPIs). The submission of these data is compulsory and results are publically reported.

Congress' CQI team supports ongoing service improvement and supports evidenced-informed decisions across all Congress programs. The CQI team presents bi-annual nKPI and NTAHKPI reports to Congress clinic teams. These reports are used by program managers to develop new operational plans and to identify areas requiring improvement. The fundamental aims of the CQI framework include: developing CQI capacity; a Plan-Do-Study-Act (PDSA) improvement cycle that provides a structure for testing changes to improve the quality of services; and teamwork.

For example, in one year the anaemia in children less than 5 years PSDA cycle has reduced anaemia rates from 18 to 13 per cent in urban clinics, and from 13 to 2 per cent in a remote clinic. Improvements have been due to a collaborative effort by clinic staff including goal setting, outcome measures, evidenced-based clinical interventions, innovative organisational and practice change, and reviewing outcomes to see how they have worked (see Attachment A).

The CQI program also sits within the broader system of clinical governance y which includes:

- The CQI Clinical governance committee which undertakes a root cause analysis of incidents and complaints, leads CQI priority areas and oversees the development and review of clinical policies and procedures essential for CQI .
- Staff credentialing and registration
- Complaints, incidents and suggestions and CQI registers
- Clinical audits
- Development and review of the clinical information system (Communicare)
- Development of operational plans with appropriate KPIs for all programs and services

5. Overall comments on redesign proposal and options

5.1. Quality Practice Improvement Incentive Payment

In principle, the concept of a Quality Practice Improvement Incentive Payment by consolidating mainstream PIP items is supported. Congress has a well-developed CQI program which, under the suggested changes, will be rewarded and encouraged. There is good evidence that this will lead to a better quality primary health care system overall.[7]

The changes suggested in the consultation paper will enhance the aims and principles of the existing CQI framework. The proposed redesign supports a data-driven, innovation-focused quality improvement model. This is part of a worldwide shift from volume-based health-care to a focus on value-based health care with incentives driving quality and innovation, rather than quantity.[8] Congress has been practising this approach for many years now and supports the move to incentivise this type of systems approach to CQI rather than individual disease management.

Given that ACCHSs undertake their own rigorous CQI programs, Congress is supportive of design Option 1- the administration of the PIP Quality Improvement Incentive by building on existing activities. Option 2, PIP administered through a third party provider would not be supported. The experience of a third party provider in the national KPI system for Aboriginal health has not been good and it is almost certain that the redesigned system will only make use of appropriate specialist public institutions such as the AIHW to overcome these difficulties.

5.2. Retaining four existing incentive payments

Congress fully supports the intention to retain the rural loading incentive; the afterhours incentive; the teaching payment; and eHealth incentive. These are vitally important payments to sustain quality services for our population and need to be retained at the same rate, for example remote loading is currently 25 per cent for Alice Springs and 50 per cent for remote communities.

5.3. Key concerns and recommendations

There are a number of concerns that will also need to be addressed in the further development of the redesigned PIP. These include:

1) *Maintaining recognition of Indigenous disadvantage*.

The redesign of the PIP will need to take into account the complexity of Aboriginal disadvantage and health outcomes. A payment mechanism should continue to be in place so that there is still a focus on closing the health gap between Aboriginal and non-Aboriginal people and that there is no further disadvantage through loss of services. Options include:

- Keep the existing IHPIP, at the current payment of $500 per person per year.
- Alternatively, weighting the cost of Aboriginal disadvantage within a streamlined PIP incentive by at least $500 per eligible person per year so that no revenue is lost

Additionally, as the Health Care Homes (HCH) trial evolves, identification, selection, enrolment and subsequent tiered payments will need to account and cost for Aboriginal disadvantage. At this stage

in the development and testing of risk stratification tools, measuring the additional impact of disadvantage of Aboriginal people on health risks r can be estimated. For example, it is known that risk calculators, such as the Framingham Cardiovascular Risk Calculator, underestimate the cardiovascular risks for Aboriginal people, so in the Central Australian Rural Practitioner's Association (CARPA) Manual an additional 5 per cent loading is added on to create an Aboriginal specific cardiovascular risk calculator. This has also been done to get an appropriate cardiovascular risk assessment for Maori people in New Zealand. It has not been possible to identify exactly the reasons for the increased risk other than to give a loading for Aboriginal people as the reasons such as "lack of control" are too hard to measure any other way.

The HCH trial risk stratification tool should therefore initially include Aboriginality as a criteria to account for socioeconomic disadvantage and higher service needs of Aboriginal people with one or more chronic diseases, to at least the level of the current PIP (i.e. plus $500 per patient).

This should ensure there is no loss of revenue and related service and should continue until:

- The risk stratification tool can more accurately assess the complexity of Aboriginal health disadvantage and individual need; or

- the health gap closes.

2) *Administrative processes including data collection and reporting that is less onerous than existing processes*

The data collection process for a redesigned PIP incentive should be less onerous than the administrative burden of the current PIP. It should also be useful for local decision-making. The current AHNTKPI reports and nKPI reports that Congress already produces should be sufficient to meet the data requirement of the revised CQI PIP program and such systems of reporting on key health service performance data should be extended to mainstream general practice. Currently the purpose of AHNTKPI and nKPI data is to 'improve the delivery of primary healthcare services by supporting continuous quality improvement (CQI) activity among service providers'[9]. However, it is important that data collected also supports local CQI activities and that services can independently access their own trend information as well as compare their data with peers[10].

3) *Maintaining a focus on managing chronic disease*

Caution is needed in bundling data and payments so that a focus on key chronic diseases is not lost altogether, diverting attention from aspects of care not targeted by incentives e.g. eye checks on patients with diabetes. The focus on improved chronic disease management should continue, though assessed through output and outcome measures rather than just process measures, to encourage collaboration and team care.

4) *Transparent use of data for benchmarking against peers and public accountability*

Over time, practice CQI data should be transparent and public but this will need appropriate further consultation and not be rushed as part of the implementation of the reformed PIP. This will increase accountability and assist practices to improve by comparing data with other practices.[11] However, data comparisons will need to take into account population demographics that influence processes

and outcome indicators (e.g. social disadvantage, age, disease prevalence) where clients will have poorer health outcomes and service usage other populations.

5) *Maintain the Closing the Gap Indigenous Chronic Disease Co-Payment*

The Indigenous Health PIP is linked to the Closing the Gap Indigenous Chronic Disease Co-Payment (CTG) which allows Aboriginal people to have their Pharmaceutical Benefits Scheme co-payment reduced from the general co-payment rate to the concessional rate. Prescribers must either be from an accredited General Practice, or from a non-remote (i.e. non Section 100 approved) Aboriginal Health Services. The removal of the Indigenous Health PIP will impact on the GTP co-payment. One solution will be to delink to the CTG prescriptions from the Indigenous Health PIP.

6) *Continue to allow for flexibility in how practices use their PIP revenue*

Organisations should not have conditions or limitations on how PIP revenue is reinvested back into the primary care service. This should continue to be something that local health services can determine to best meet the local needs for improved and enhanced services.

7) *Ensure there is ongoing consultation with ACCHSs in the PIP redesign and modelling*

There should be a number of consultations as the options are further developed. Any modelling of incentives and potential revenue should be checked against the potential loss of incentives to ACCHS.

Appendix A

The importance of comprehensive primary health care

The term 'primary health care' (PHC) gained widespread currency following the Alma-Ata Conference held by the World Health Organisation in 1978[12]. The definition of PHC advanced by Alma Ata was comprehensive: as well as the provision of medical care, it also captures the ideal of 'wellness' as a goal, and prevention, health promotion, advocacy and community development as major methods to achieve it. It emphasises the need for maximum community and individual self-reliance and participation and involves collaboration with other sectors.

This comprehensive definition of primary health care is now broadly accepted in Australia especially when it comes to improving the health of disadvantaged populations such as that of Australia's Aboriginal and Torres Strait Islander peoples[13].

A well-resourced and robust comprehensive primary health care system is therefore a critically important platform from which to address the health of Aboriginal and Torres Strait Islander Australians.

Core primary health care services

Congress functions within the framework of a comprehensive primary health care (CPHC) service, addressing health inequities, and aiming to close the gap between Aboriginal and non-Aboriginal people. The effectiveness of this model is due to the wide and innovative range of strategies that provide equity of access to culturally appropriate services and programs that are affordable and acceptable to the community, and holistically care for health and wellbeing of Aboriginal people.

Another key part of the progressive realisation of the CPHC vision, which has been leading the health improvement that has occurred in the Northern Territory, has been increasing iterations of what has become known as "core primary health care services" which translate the PHC norms and principles into the core outputs of Aboriginal primary health care practice including a range of clinical services, support services, social and preventative programs and policy and advocacy functions. There have been three iterations of the core primary health care services model with the most recent and comprehensive version produced in 2011 in which there are five service domains[14]:

1. Clinical Services
2. Health Promotion
3. Corporate Services and Information
4. Advocacy, Knowledge, Research, Policy and Planning
5. Community Engagement, Control and Cultural Safety

Defining core services is part of defining the progressive realisation of the right to health as the obligation on governments to ensure access to evidence-based services and programs according to need is made more explicit. Australia has the resources to ensure all of the services and programs outlined in this core services model are accessible through ACCHSs. This includes services and programs in areas such as early childhood, family support, alcohol and other drug treatment and aged and disability care along with the more familiar clinical, maternal and child health, chronic disease and other services. Resourcing all of the core services will enable CPHC to make its maximum contribution to Closing the Gap. Along with the development of these core services has been the

corresponding development core primary health care indicators that enable each service to track its own progress in key areas and report this to their communities.

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