Response to Red Tape Taskforce Discussion Paper:

Review of PIP and EPC- Preliminary report on stages 3,4,5

October 2003

Introduction

As the statewide peak body for divisions of general practice in Victoria, GPDV supports divisions in their endeavours to develop a skilled, viable and effective general practice workforce, to improve the health and well-being of the people of Victoria.

GPDV supports the aim of the Commonwealth GP Red Tape Taskforce, as we believe that streamlining general practice administrative and compliance costs will:

- Improve the viability and efficiency of general practice, which in turn will enhance the capacity of general practice to improve the health care of Victorians; and
- Make it easier for divisions of general practice to help practices implement Commonwealth, state and local health initiatives.

This response is based on feedback gathered through consultations with GP chairs and staff of Victorian divisions, and from other written feedback from Victorian divisions. The paper firstly comments generally on the PIP and EPC programs, and then specifically considers the options canvassed in the Taskforce's discussion paper.

The Practice Incentive Program (PIP) and Enhanced Primary Care (EPC) Program

In the absence of an overall change management strategy for general practice systems and ongoing GP shortages, it has been extremely difficult for practices to participate effectively in these Commonwealth initiatives. Despite this, Victorian divisions remain largely supportive of initiatives that reward quality, evidence-based care rather than high patient throughput. Therefore, though the PIP and EPC were not well implemented by the Department of Health and Ageing, their aims should not be abandoned. The programs can be streamlined now, and we can learn from the successful rollouts of other programs when planning future initiatives. GPDV has undertaken statewide evaluations of both the GPII and EPC programs to understand how divisions have approached rolling them out to practices successfully. It was apparent that extensive support was required at a practice systems level to achieve change.

The GPII program in particular was an excellent example of how a strategic approach works to achieve change. Immunisation rates have increased from 54% to 90% over a 5-year period. Key features of GPII which were absent from both the EPC and PIP incentives, which are relevant to cutting red tape, were:

- Sustained and timely division program funding;
- A sufficiently funded practice support approach through divisions of general practice, with the aim of supporting practice capacity to implement best practice chronic disease management (for example efficient billing systems, IM expertise, and teamwork approaches);
- A dedicated hotline with well trained operators providing consistent advice;
- The timely availability of data at the practice level provided to divisions for analysis;
- A population health data base; and

- A national advisory committee with divisional and GP representation providing feedback to the Commonwealth on implementation issues.

GPDV strongly supports these features and suggests they be considered as key elements of refined current programs, and the planning for future program rollouts. We believe they would decrease both red tape and frustration at all levels of program implementation.

Response to Options Canvassed in Taskforce's Discussion Paper

Response to Stage 5 – Developed Options for Simplification and Redesign of Existing Programs

(a) Practice Based Payments – possible options

(i) *Reallocate funding to rebates* – GPDV opposes this option, as it would remove incentives toward accreditation, and reward higher patient throughput.

- A literature review of practice capacity research conducted by the Centre for GP Integration Studies at the University of New South Wales suggests that IM/IT capability, business capacity and an teamwork approach all contribute to the provision of quality chronic disease care[1].
- Scrapping the rural loading would exacerbate disadvantages in rural areas.
- Incentives to employ nurses should be continued as a stand-alone measure as it helps to augment the currently depleted GP workforce. Support for nurses also promotes a "team approach" to CDM care with the GP as the coordinator.

(ii) *Combine to a Single Practice Infrastructure Grant*
and
(iii) *Minor adjustment and refinement of current arrangements*

These are not mutually exclusive options. GPDV supports both the combination of items into a Single Practice Infrastructure Grant, and the refinement of individual components that would form parts of that Grant.

- Individual components should remain separated as a part of the single infrastructure grant, so that take-up of the components being funded can continue to be measured. GPDV agrees that higher monetary payments should be provided to practices fulfilling more of the components.
- Practice accreditation standards should be extended to be quality indicators for IM/IT connectivity, use of electronic health records, and provision of after hours care.
- Additional payments under the single grant should be offered for standards above those accreditation standards – GPDV supports the mooted "raising of the bar" for IM/IT standards, for example.
- Consideration should be given to extending the practice nurse incentives for the employment of new nurses in outer urban practices, if it can be shown that they help to relieve workforce pressure.
- GPDV opposes changes to the RRMA classification system as a measure of rurality, as changes such as a move to ARIA would disadvantage Victorian divisions and create unnecessary antagonism.

[1] *Building Practice Capacity for Chronic Disease Management in General Practice*. Paper written for the General Practice Partnership Advisory Council (GPPAC), May 2003, prepared by the Department of General Practice, the University of Adelaide, and the Centre for GP Integration Studies, University of New South Wales.

(b) Clinical care incentives / payments - provider based – possible options

(i) *Reallocate funding to rebates* – GPDV opposes this option, as it would penalise practices that have been systemising care around these quality/preventative incentives. It would also provide financial benefits for higher patient throughput.

(ii) *Combine with other basic PIP components to a Single Practice Infrastructure Grant*

and

(iii) *Rationalise to a simple set of generic MBS chronic disease management and prevention items*

Speaking generally, there are three levels on which the Commonwealth can reward GPs for their work – reward for having the appropriate practice *structures*; reward for types of *procedures*; and reward for patient health *outcomes*. One vision for general practice is an environment in which the Commonwealth provides remuneration for:

- appropriate practice structures (eg: the existence of recall/reminder systems, age-sex disease registers, reflection through peer review activities); and
- % of the population that have received best practice care, measured either at the national level (like ACIR) or at the divisional level (like Illawarra Division's TAADIS), with customised statistics fed back to individual GPs/practices for facilitated reflection and peer group learning.

In this environment, GPs would retain clinical autonomy, with the profession (particularly the RACGP and Divisions) advising on evidence-based procedures. GPs would not be rewarded for specific prescribed best practice procedures, but would continue to be remunerated for time spent with patients through the MBS.

However, in the absence of structures that are adequately able to measure population health outcomes systematically, GPDV continues to support payments for evidence-based procedures such as completing asthma 3+ plans and diabetes cycles of care. Additional support for practices to use these items (such as providing remuneration for the work of practice nurses, ongoing CDM funding for divisions, and funding for IM/IT training at the practice level) is a better approach than tinkering with the items, which would cause confusion and further frustration.

Rationalising all of these items into a simple set of generic MBS CDM and prevention items would diminish the capacity to measure progress in disease-specific areas since there are no organisations that are resourced to measure health outcomes systematically.

(iv) *Adjustment and refinement of current arrangements* – GPDV opposes this approach. It would cause confusion and frustration, and would penalise the practices that have been systemising care around these quality/preventative incentives.

(c) Clinical care incentives / outcome payments – practice based – possible options

We are not convinced that there is a particular 'red tape' issue here for practices. Outcome payments reward practices for better population health outcomes, and GPDV is strongly supportive of this concept. The main problem with the current set of outcomes payments is that HIC feedback to practices is unhelpful in assisting them to better plan and improve population health outcomes.

(i) *Reallocate Funding to Rebates* –GPDV opposes this option, as it would penalise practices that have been working hard to achieve Commonwealth outcome targets and would provide financial benefits for higher patient throughput.

(ii) *Combine to a Single Practice Clinical Outcomes Payment* – There is no rationale for such an approach and therefore we are opposed to it.

(iii) *Adjustment and Refinement of Current Arrangements* – The mooted change is to dispense with the practice requirement to 'sign on' for the cervical screening outcome payment. We do not believe that this is a 'red tape' issue for practices. Such adjustment would create further confusion and frustration.

Conclusion – the Major Issues

Complexity of current blended payment arrangements

GPDV supports the work of the GP Red Tape Taskforce. Some streamlining, without unnecessary 'tinkering' with individual items, would certainly help practices. We ask that the original aims of blended payments systems (to reward comprehensive quality care due to the 'market failure' associated with stand-alone MBS arrangements) not be discarded. Quality items should also be adequately priced, in order to reward commitment to quality processes.

Workforce shortages

Workforce shortages are one of the major barriers to more planned and preventative care in practice. Many practices do not have the capacity to participate in PIP or EPC items or to undertake longer consultations due to unrelenting and immediate patient demand for services. In short, they are forced (whether willing or not) to be reactive. This problem is particularly acute in rural and outer urban areas. The work of the Victorian Rural Workforce Agency, divisions and some government initiatives have made a difference, but clearly more needs to be done.

More support for an expanded practice nurse and Aboriginal Health Worker workforce has the potential to further augment the primary care workforce in general practice. Though more research in this area is sorely needed, there is widespread support for the further development of the role of general practice nurses in Victoria.

Restrictions on team-based approaches to care

Presently, the MBS and advice from the Commonwealth limits the potential role of the practice nurse in the implementation of best practice quality care. For example, the administration of immunisations and the fulfilment of the diabetes and asthma PIPs are classified as attendance items in the MBS which means that the practice is only remunerated for the time the GP spends with the patient. Practices should be rewarded for providing quality care regardless of whether that is provided by the GP or the nurse.

Program implementation

Poor program planning, in some instances, has been a barrier to successful implementation. The Commonwealth needs to recognise the expert opinion and valuable experience of those facilitating the implementation of programs "on the ground" (SBOs, divisions and practices), and seek to involve them at all stages of program planning and refinement. GPDV supports the development of program implementation standards at the Commonwealth.