AUSTRALIAN PRIMARY HEALTH CARE
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# USING FINANCIAL INCENTIVES TO IMPROVE THE QUALITY OF PRIMARY CARE IN AUSTRALIA

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## POLICY CONTEXT

There is a broad consensus that financial incentives to improve quality of primary care should be introduced in Australia. Although there is little rigorous evidence from other countries, a carefully designed incentive scheme that builds on what exists and uses lessons from other countries, has strong potential to re-orient the system towards quality of care and health outcomes.

## KEY FINDINGS

The Cochrane systematic review found six rigorous empirical studies of effects of the use of financial incentives on quality in primary care. All showed relatively weak effects of financial incentives on quality of care. However, the narrative review and synthesis revealed a number of weaknesses in the design of currently used incentive schemes. Key design features of any future scheme should be:

- *Build on what exists already.* The schemes evolve over time and usually involve a series of complex interventions that include accreditation, education, existence of quality improvement programs, investment in IT and data collection systems, and professional support. These are all necessary interventions that create the conditions for linking financial incentives to quality of care.
- *Reward for improvements in quality as well as achievement of levels of quality.* Rewarding for the achievement of a specified level of quality is most common, but may not be as effective at improving quality compared to rewarding for improvements in quality. Rewards for the maintenance of a given level of quality should not be ignored, but should not be the main element of the incentive scheme.
- *Financial incentives linked to quality should comprise at least 10 per cent of physician's total revenue.* In the US, many schemes represented less than 10 per cent of revenue and were funded from efficiency savings, so no new resources were invested. In the UK, rewards comprised about 30 per cent of revenue and were associated with large increase in overall incomes, although there are doubts as to how cost-effective this investment has been.
- *Financial incentives are more likely to have an effect where there is one single funder of primary care services.* With multiple funders, the effects of incentives introduced by one funder will be less effective.

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- *A stable and enrolled population will strengthen the role of financial incentives.* It is easier to attribute changes in quality and performance to a specific provider/medical group who has been responsible for coordinating the health care of their patients. The incentives may be weaker if a patient visits multiple providers, since providers don't feel 'responsible' or do not feel they have control over their performance, and so may be less likely to change their behaviour.
- *Incentives should be paid at the practice level, and payments to health professionals involved in improving quality of care should be equitable with respect to their skill and effort.* Incentives for quality should be paid to practices. If practice chooses to use this payment to reward health professionals, then it should be used for all health professionals involved in the provision of health care to patients. Payments to team members should be equitable with respect to their skill and effort.
- *Keep payments simple to administer for primary care practices.* This is a particular issue for Australia, where several 'red tape' reviews have taken place with respect to GP payments.
- *Consider potential unintended consequences.* There is a possibility of unintended consequences of these schemes, such as a focus on the remunerated areas at the cost of unremunerated areas, and these need to be thought through and managed carefully.
- *Conduct rigorous evaluation of the effects of any new scheme.* Only six empirical studies of reasonable quality were included in the Cochrane review. The need for rigorous and controlled evaluations of any changes, although presenting challenges, should be seriously considered before a scheme is fully implemented.

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# POLICY OPTIONS

Building on what already exists in Australia and international evidence, the use of financial incentives should be further explored. Three phases of development are recommended, with rigorous evaluation before and after each stage.

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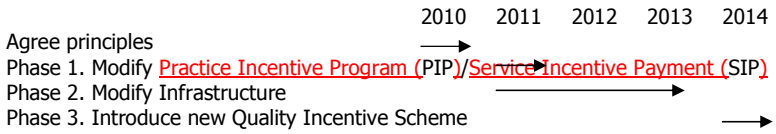
### Figure 1. Timeline for development of new Quality Incentive Scheme




### Phase 1. Modify current incentive schemes (2011)

- Reduce the value of SIP payments and reinvest the money into modified outcome payments to reward quality *improvements* for diabetes, asthma, cervical screening, and childhood immunization.
- New outcome payments should pay a fixed payment per patient, and paid for every 5 per cent increase in the proportion of patients receiving quality of care. The fixed payments should increase as higher proportions of patients are treated to reflect the higher costs of additional patients.
- To reward practices already providing a high level of quality care, a practice which maintains coverage at a given percentage for a minimum time period (e.g. a year) across all disease areas, would receive a percentage 'quality supplement' to their total PIP payments.

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### Phase 2. Develop infrastructure for a new *Quality Incentive Scheme* for chronic disease and complex care (2011-2013)

- In addition to the modified PIP, further infrastructure for data collection is necessary if incentives are to be expanded to other priority disease areas. This should be based around the methods being used by the Australian Primary Care Collaboratives.

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Regional Primary Health Care Organisations (PHCOs) could be more heavily involved in supporting practices to undergo quality improvement cycles and with IT infrastructure.

### Phase 3. Introduce a new *Quality Incentive Scheme* (2014-2016)

- The scheme should be phased in by groups of Regional PHCOs. Wave one would comprise one-third of PHCOs in 2014, Wave two one-third in 2015, and the final third in 2016.
- All SIP and new outcome payments (see Phase one) to be rolled into new Quality Incentive Scheme (QIS) with additional funding.
- Roll all other PIP capitation payments (eg after hours, teaching, IT etc) into a single infrastructure grant based on the number of enrolled patients, with a loading for rurality and the maintenance of quality. Minimum levels of infrastructure would need to be in place to receive these grants, with some elements of infrastructure incorporated into accreditation.
- Link outcome payments to patients who are enrolled. This would form the denominator for the incentive payments, so practices would be asked to report disease prevalence for their enrolled population. It would enable the scheme to be expanded to other disease areas.
- The APCC quality improvement scheme would be the basis for the new incentive scheme, and it would be rolled out across Australia and managed by PHCOs and APCC. It would be conducted on patients who are enrolled with practices, providing a new avenue of data reporting and data collection, and linked to disease areas included in the QIS.
- Whether new disease areas should be included and types of metrics used should be considered by an independent body which can periodically review and synthesise evidence along similar lines to MSAC and PBAC.
- The total payments offered would need to be higher than those made in the current PIP scheme, to enhance the attractiveness of the scheme and encourage higher participation.

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### Evaluation.

A controlled before and after study should be carefully designed in 2011 using the phased introduction of the scheme across Regional PHCOs from 2014-2016. Baseline data on quality would be collected in 2013. PHCOs should be chosen randomly in each year. BEACH data and Medicare data should also be used for evaluation.

## METHODS

A Cochrane systematic review and narrative review and synthesis of linking financial incentives to improvements in the quality of primary care was conducted. Experience from the US, UK, and Australia were examined in detail. Key Australian informants were interviewed to examine the current context in Australia, and were invited to comment on the draft policy options.

For more details, please go to the full report

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