Major Developments in Results-Based Financing (RBF)
in OECD Countries:

Country Summaries and Mapping of RBF Programs

Australia: The Practice Incentives Program (PIP)

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Introduction

Australia's health care system is considered to be one of the best performing health systems overall, demonstrating success in controlling costs, while at the same time achieving high levels of health outcomes. Australia spends a little above the OECD average on health (USD PPP $3,137 per capita compared to the OECD average of USD PPP $2,984 per capita) and has managed to contain the growth in health expenditure, unlike in other OECD countries where spending has increased steadily over the last ten years (OECD, 2009). Australia has achieved one of the highest life expectancies among OECD countries, ranking third after Japan and Switzerland in 2007 (OECD Health Data, 2009).

In spite of these achievements, however, concerns have emerged in recent years about the quality and coordination of care and prevention. Chronic conditions such as diabetes are reaching epidemic proportions, and incidents involving quality and safety of hospital care have received attention. The fee structure of the Medicare Benefits Schedule (MBS) under Australia's national health insurance scheme (Medicare) encourages a large number of short consultations and provides minimal incentives for quality or preventive activities (Australian Government Department of Health and Ageing, 2010). The rural general practice (GP) work force was decreasing, and many practitioners were withdrawing from hospital and obstetric care (Department of Health and Family Services, 1996).

Australia has experience in using pay-for-performance for solutions to some problems in health care delivery (Boxall, 2009). Two large ongoing P4P schemes date back to the 1990s: the General Practice Immunisation Incentive (GPII) Scheme to increase vaccination coverage among children, and the Practice Incentives Program (PIP) to encourage continuous improvements in primary health care. More recent P4P initiatives reward hospital quality achievement, including a scheme run by the Australian Government Department of Veteran's Affairs introduced in 2006, and the Clinical Practice Improvement Payment system in the Australian state of Queensland, which was introduced in 2007. As part of the Pharmaceutical Benefits Scheme reform initiated in 2008, community pharmacies receive a small incentive payment for dispensing substitutable, premium-free brands, as well as an increase in pharmacy mark-ups and dispensing fees (Australian Government Department of Health and Ageing, 2009).

Faced with serious challenges in fragmented primary health care, brought about partially by Medicare Australia's fee-for-service rebates system, the Australian Government Department of Health and Ageing (DoHA) introduced the PIP in 1998 as one part of a broader strategy to reform primary health care (Russell & Mitchell, 2002). These "practice incentive payments" reward a number of areas of primary health care including comprehensive after-hours care, rural practices, teaching medical students, and use of electronic health records (eHealth). The PIP allows GP practices to participate once they have been accredited against the Royal Australian College of General Practitioners' (RACGP's) *Standards for general practices*. Practices can choose among 13 incentive areas to participate. Incentive payments reached A$61,600[1] on average per practice in 2008-09, or A$19,700 per FTE GP (Australian National

[1] 1 A$ = 0.994 US$ in January 2011.

Audit Office, 2010). The program is among the largest in the world, with some A$2.7 billion spent since its inception.

Health Policy Context

What were the issues that the program was designed to address?

Australia's primary health care is delivered in large part by a network of private GP practices that are permitted to set their own fees. Patients receive a rebate from Medicare Australia for eligible services as determined by the Medicare Benefits Schedule (MBS). A large share of practices choose to direct bill Medicare (known as "bulk billing"), which holds them to the MBS rebate levels without being able to charge additional fees to patients (Russell & Mitchell, 2002). This fee-for-service payment system was considered to be at least partially responsible for increasingly fragmented primary health care and the shift away from prevention, and has contributed to the poor management of chronic diseases.

Reform efforts began in 1991, resulting in the "General Practice Reform Strategy," which was designed to improve the integration, quality, and comprehensiveness of GP care (Australian Government Department of Health and Ageing, 2010). A key reform was about twenty years ago when around 120 "Divisions of General Practice," were formed which were geographically based organizations that represent networks of approximately 150 GPs (ranging from 12 to 800). The Australian Government provides infrastructure funding to enable Divisions to engage in cooperative activities to address health needs at the local level (National Health Strategy, 1992).

The Practice Incentives Program started in 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 would move toward a "blended payment" model, providing a portion of funding to general practices that was unrelated to the volume of fee-for-service payments (Australian National Audit Office, 2010). The scheme aimed to create incentives for practices to provide longer visits and discourage a high volume of brief consultations.

The main objective of the PIP is to encourage continuing improvements in general practice through financial incentives to support quality care, and improve access and health outcomes for patients. Practices are required to be accredited or registered for accreditation to participate in the PIP. PIP practices may be eligible for a number of incentive payments, providing a more flexible payment model that can influence both short- and long-term changes in service delivery. Improving accountability, reporting and data collection on selected health issues were implicit, if not explicit, objectives, as shown by the introduction of the Information Management /Information Technology (later evolved to eHealth) Incentive, one of the largest payment components of the program. The program is under the umbrella of wider incentive initiatives in health carried on by the DoHA, which also comprise the rural incentive program, mental health nurse incentive program, and the GPII Scheme.

Stakeholder involvement

PIP is administered by Medicare Australia on behalf of DoHA. DoHA has overall policy responsibility for PIP, while Medicare Australia is responsible for the day-to-day administration of the program, including verifying compliance with program and payment eligibility criteria, and calculating and making payments. Other stakeholders have participated in the design and governance of the program. For example, the basis for the PIP payment formula was developed in consultation with the General Practice Financing Group (GPFG), which was a negotiating body comprising the Royal Australian College of General Practitioners, Australian Medical Association, Rural Doctors Association of Australia, Australian Divisions of General Practice, and the Australian Government.(Medicare Australia, 2010).

Technical Design

How does the program work?

Performance Domains and Indicators

The program is designed around 13 incentive areas organized in three main streams--quality of care, capacity, rural support (Table 1). Not all of the incentives are strictly related to performance, and some of them could be considered to be conditional cash transfers to practices upon implementation of certain services.

The Quality Stream incentives pay for coverage of services that comply with evidence-based guidelines, which the Program treats as a proxy for outcomes. The Capacity Stream incentives give additional resources to GP practices that invest in infrastructure, such as computerization, or to expand services, such as providing after hours care or providing care in Residential Aged Care Facilities. The incentive related to Information Management /Information Technology (IMIT) has been particularly important in PIP. This stream has evolved over time as the IT capacity and needs of practices has changed and available technology has become more sophisticated. The original IMIT incentive was instrumental in driving computerization of GP practices. The latest incentive, the eHealth Incentive, was introduced in 2009 and aims to encourage general practices to keep up-to-date with the latest developments in eHealth.

The Rural Support stream incentives provide additional resources to GP practices in more rural and remote settings and compensate them for bringing services to these areas that otherwise would be difficult to access for these populations, such as some more specialized surgical and obstetric procedures.

Incentive Payments

The way incentive payments are calculated and made in the PIP is complex. The recipient (whether the general practice or GPs working in PIP practices), basis for payment amount, payment determination (prospective or retrospective), and frequency of payment vary across incentives, and they can vary further for components or tiers within incentives. Payments for most of the indicators are made to the

practices, but some of the quality incentives are paid directly to individual GPs for each priority service they deliver.

Table 1. Incentives in the Australia PIP

Incentive	Activity	Payment Amount
Quality Stream		
Quality Prescribing	Practice participation in quality use of medicines programs endorsed by the National Prescribing Service. Paid annually in May.	A$1 per SWPE[2]
Diabetes Incentive	*Sign-On Payment*: one-off payment to practices using a diabetes register and recall/reminder system.	A$1 per SWPE
	Outcomes Payment: payment to practices where at least 2% of practice patients are diagnosed with diabetes and GPs have completed a cycle of care for at least 20% of them.	A$20 per diabetic SWPE/year
	Service Incentive Payment: payment to GPs for each patient completing an annual cycle of care	A$40 per patient/year
Cervical Screening Incentive	*Sign-on Payment*: one-off payment to practices for engaging with the state/territory cervical screening registers.	A$0.25 per SWPE
	Outcomes Payment: payment to practices if at least 50% of women aged 20 -69 screened have been screened in the 30-month reference period.	A$3 per female SWPE aged 20-69.
	Service Incentive Payment: payment to GPs for screening women aged 20 -69 years who have not had a cervical smear within the last 4 years.	A$35 per patient/year
Asthma Incentive	*Sign-on Payment*: one-off payment to practices that: • use a patient register, and a recall and reminder system; • agree to use the asthma cycle of care; and • agree to have their details forwarded to appropriate bodies.	A$0.25 per SWPE.
	Service Incentive Payment: payment to GPs for each cycle of care completed for patients with moderate to severe asthma.	A$100 per patient/year
Indigenous Health Incentive	*Sign-on Payment:* one-off payment to practices that agree to undertake specified activities to improve the provision of care to their Aboriginal and/or Torres Strait Islander patients with a chronic disease.	A$1000 per practice
	Patient Registration Payment: Payment to practices for each Aboriginal and/or Torres Strait Islander patient aged 15 years and over, registered with the practice for chronic disease management.	A$250 per eligible patient/year
	Outcomes Payment Tier 1: Payment to practices for each registered patient for whom a target level of care is provided in a calendar year. *Outcomes Payment Tier 2:* Payment to practices for providing the majority of care for a registered patient in a calendar year.	Tier 1: A$100 per patient/year Tier 2: A$150 per patient/year
Capacity stream		
eHealth Incentive	The PIP eHealth Incentive has three eligibility requirements. Practices must meet each of the eligibility requirements to qualify for payments.	A$6.50 per SWPE capped at A$12, 500 per practice, per quarter.
Practice Nurse Incentive	**Practices in urban areas of workforce shortage (RRMAs 1-2):** Payment to PIP practices that employ a practice nurse, Aboriginal health worker and/or allied health worker, for the minimum number of sessions per week over the payment quarter.	A$8 (RRMA 1-2) capped at A$40,000/year.
	Practices in rural and remote areas (RRMAs) 3-7: Payment to	A$7 (RRMA 3-7) capped at

[2] Standardized Whole Patient Equivalent (SWPE) is a measure of a practice's patient load independent of the number of services provided. It is based on an estimate of the share of total care provided for a patient by the GP practice and is estimated from Medicare Australia claims data and weighted by age and sex.

	practices in rural and remote areas that employ a practice nurse and/or Aboriginal health worker for the minimum number of sessions per week over the payment quarter.	A$35,000/ year.
After Hours Incentive	Tier 1—Practice patients have access to 24 hour care, seven days a week through formal external arrangements.	A$2 per SWPE annually.
	Tier 2—Practice GPs must provide at least 10 or 15 hours per week of after hours cover depending on practice size. At all other times practice patients have access to after hours care through formal external arrangements.	A$2 per SWPE annually (+ payment for Tier 1)
	Tier 3— Practice GPs provide their practice patients with 24 hour care, seven days a week.	A$2 per SWPE annually (+ Tiers 1&2)
Teaching Incentive	Teaching of undergraduate medical students. Maximum of two 3-hour teaching sessions per GP, per day.	A$100 per session.
Aged Care Access Incentive	Tier 1—GPs must provide at least 60 eligible services in Residential Aged Care Facilities (RACF) in the financial year.	A$1500 per year.
	Tier 2—GPs must reach the QSL 2 by providing at least 140 eligible services in RACF in the financial year.	A$3500 per year
Rural support stream		
Rural Loading	The practice's main location is outside metropolitan areas (increases with extent of remoteness) based on the RRMA 3–7 Classification. Rural loading is applied to the practice's total PIP payment.	0-50% loading
Procedural GP Payment	Tier 1— A GP in a rural or remote practice provides at least one procedural service (services typically provided in hospital setting), in the six month reference period.	A$1000 per six month reference period.
	Tier 2— A GP in a rural or remote practice meets the Tier 1 requirement and provides after hours procedural services.	A$2000 per six month reference period.
	Tier 3— A GP in a rural or remote practice meets the Tier 2 requirements and provides 25 or more eligible surgical and/or anaesthetic and/or obstetric services in the six month reference period.	A$5000 per six month reference period.
	Tier 4— A GP in a rural or remote practice meets the Tier 2 requirements and delivers 10 or more babies in the six month reference period or meets the obstetric needs of the community.	A$8500 per six month reference period.
Domestic Violence Incentive	Payment to encourage practices in RRMA 3–7 to employ a qualified practice nurse or Aboriginal health worker that is available to act as a referral point for women experiencing domestic violence for the minimum number of sessions per week.	A$1 per SWPE capped at A$4000 per practice/year.

Source: (Medicare Australia, 2010)

Most of the incentive payments are flat-rate rewards per Standardised Whole Patient Equivalent (SWPE), which is a measure of a practice's patient load independent of the number of services provided, or per service provided. The exception is rural loading, which is paid as a percentage of the total incentive payments made to the practice. The Quality Stream incentives, with exception of the Quality Prescribing Incentive, give one-off payments to practices that participate and meet specific criteria, such as participating in the cervical cancer screening register. Practices are then paid a per-patient bonus for achieving specified coverage rates for priority services, such as achieving a 50 percent rate of cervical cancer screening for the target group, or 20 percent of diabetic patients with a completed cycle of care. Some incentives in the quality stream include a third element of payment, which is made directly to individual GPs for each priority service they provide. For example, individual GPs receive a payment for each of their patients with diabetes completing an annual cycle of care.

The payment can be made prospectively (for practice nurse or domestic violence) or retrospectively, although all payments will be paid retrospectively after November 2012 Payments are made quarterly for diabetes, asthma and cervical screening after a one-off payment for signing on to the incentive. To qualify for payments, practices must be participating in the PIP and meet the eligibility requirements of the incentives at the 'point in time' that corresponds to the last day of the month prior to the next quarterly payment month.

There are no restrictions on how the practices can allocate their incentive payments. The guidelines established by the DoHA stipulate that "payments are intended to support the practice to purchase new equipment, upgrade facilities, or increase remuneration for doctors working at the practice" (Australian Government Department of Health and Ageing, 2009). There are no reporting requirements for how the incentive payments are used.

Data Sources and Flows

Information on service indicators is collected through the Medicare claims processing system and other routine reporting, such as from the National Prescribing Service for the Quality Prescribing Incentive payment. For other incentive streams, information is submitted to the PIP database that documents the activity of the practitioner. An annual Confirmation Statement process was introduced in May 2010. Practices are required to check, complete and confirm whether the practice is continuing to meet the eligibility requirements of the incentives the practice has applied for. A new online administrative system was introduced in October 2010 to allow practices to apply for new PIP incentives and review payment levels, and is aimed at reducing the administrative burden of practices (Medicare Australia, 2010).

Data are collected by Medicare Australia, which has the responsibility to assess the performance of the practice on some selected indicators, calculate the practices SWPEs, and decides on the total payment to practices and individual GPs. The Continuous Data Quality Improvement Program controls the quality of payments on a sampled basis, recording all sources and types of errors commonly found in the reporting of results. Medicare Australia is also conducting random and targeted Audits to ensure that practices meet the eligibility requirements.

Reach of the Program

Which providers participate and how many people are covered?

Participation in the PIP is voluntary and conditional on the GP practice being accredited or registered for accreditation against the Royal Australian College of General Practitioners *Standards for general practices*. To date, around 5,000 GP practices throughout the country participate in PIP, which represents about two-thirds of all practices and about 21,000 Full-time Equivalent General Practitioners. It is estimated that 82 percent of GP patient care was delivered through PIP practices in 2009 (Australian Government Department of Health and Ageing, 2009). After meeting the requirements to participate in the PIP, practices decide on enrolment in individual incentive areas within the general PIP framework, according to their eligibility for the different initiatives. This allows for flexibility and provides tailored

incentives to each practice. Some practices also participate in other programs, such as the General Practice Immunisation Incentive Scheme and the Mental Health Nurse Incentive Program.

Practices receive quarterly payments following enrolment in the program. The average payment to a practice in 2009-2010 amounted to around A$57,800, which is typically between 4 and 7 percent of total practice income. There have been great disparities in payment, however. One practice alone received A$576,000, with FTE GPs receiving individually A$36,000, or 90 percent more than the average.

Improvement Process

How is the program leveraged to achieve improvements in service delivery and outcomes?

Whether and how the PIP is driving performance improvement in Australia's GP practices is difficult to ascertain. There is very little information about how the incentive payments are used by the practices, or whether improvement processes have been put in place or strengthened. There is no apparent dialogue between the program administrators (DoHA and Medicare Australia) and the practices on the performance measures, and there is no systematic feedback of performance information to providers for their internal management purposes. There also is no formal feedback from practices back to the DoHA or Medicare Australia on the different types of problems encountered by individual providers in achieving targets and improving performance. However, the DoHA regularly consults with GP professional organizations through an advisory group, where feedback from organizational members may be provided to the DoHA. Data on the performance of individual practices are not made publicly available because of privacy issues, which represents a major limitation to the accountability mechanisms of the incentive. Several of these weaknesses were highlighted by a recent review of the Australia National Audit Office (ANAO) released in 2010.

The link between the incentives in the PIP, performance improvement, and better outcomes has never been clearly established, and the overall program is not monitored against any outcome indicators. GP practices receive incentive payments for becoming accredited and providing certain priority services according to established guidelines. Whether that in fact leads to improved quality of care and better outcomes has not been verified. Furthermore, the uptake and payment across incentive areas is highly skewed. Whereas eHealth accounts for 33 percent of all incentive payments (reflecting both higher uptake and relatively higher reward), all three priority service areas combined only account for 11 percent of the total pay-out in 2008-09 (Figure 1). Only 17 percent of practices eligible to participate in the Domestic Violence Incentive participate (Australian National Audit Office, 2010).

Both the choice of GP practices about which incentive streams to participate in and the way they use their incentive payments show that IT is the part of GP practice development and quality improvement that is supported most by PIP. Although GP practices can apply for as many of the incentives as they are eligible for, by far the largest pay-out is for the eHealth Incentive. Furthermore, although there is no good information on how GP practices use PIP incentive payments, it is generally believed that most practices distribute at least a portion of the funding to staff GPs and the rest into practice infrastructure, with most of the money going to IT (Ferguson, 2006). Whether and how upgraded IT supported by PIP

is being used to improve service delivery and whether improved IT can be linked to improved quality of care and better outcomes are unknown.

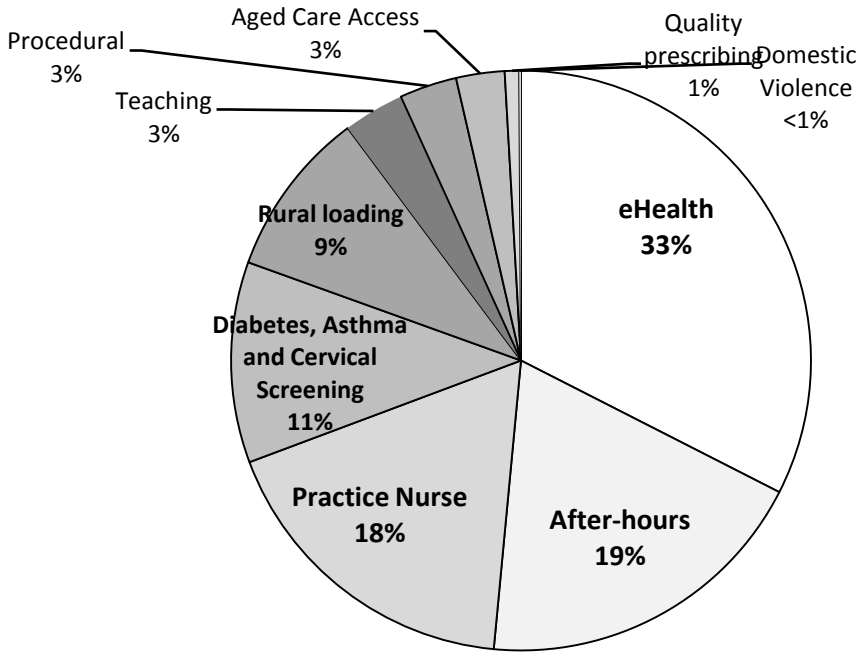
Results of the Program

Has the program had an impact on performance, and have there been any unintended consequences?

Program Monitoring and Evaluation

In spite of the longevity of the program and billions of dollars that have been spent so far, there are no comprehensive, rigorous evaluations of PIP. The monitoring done by DoHA is superficial and related mainly to the uptake of the program. DoHA tracks and reports on several program coverage indicators: (1) number and share of practices participating in PIP; (2) the volume of payments made; (3) the percentage of care provided by practices participating in PIP; and (4) the proportion of Australian Government funding for general practice that is channeled through PIP. The lack of more in-depth monitoring and evaluation may be related to the main stated objective being to increase accreditation among primary care practices, which is easily observable and measurable. DoHA claims that the percentage of all primary care that is provided by PIP practices is a proxy for care provided in accredited practices, which reflects higher overall quality of care. This chain is based on assumptions that are not supported by empirical data.

Figure 1. Distribution of PIP Incentive Payments (2008-09)



Source: ANAO 2010.

The primary accountability mechanism for PIP is regular reviews by ANAO (with five reports since the creation of the scheme). Although these reviews are not impact evaluations, they do provide some assessment of the effectiveness of program implementation and the performance of PIP against some of its stated objectives. The latest report sought to address the question to which extent the program met the new policy objectives set up in 2006. It provides a mixed picture on the overall results of the program, especially on the lack of reliable data to estimate the impact of the scheme (Australian National Audit Office, 2010).

The PIP has been successful at meeting the objective of adding a flexible component to the fee for service payment system. 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). The latest ANAO review also found that PIP has been successful at meeting its objective of increasing rates of accreditation among general practices. Accreditation has increased to 67 percent of practices as a result of PIP. In their survey of GPs, 43 percent of practices responded that the main reason they applied for accreditation is to have access to PIP (Australian National Audit Office, 2010). Nonetheless, the report fails to provide evidence on the actual ongoing efforts of participating practices in improving standards of care. This may be attributed to self-selection into the scheme, with 'better-off' practices applying for PIP. In fact, the review found that accreditation and PIP participation rates have leveled off, because not all practices find it worthwhile to incur the fixed costs to become accredited.

Overall, the latest ANAO report emphasizes the need to define adequate effectiveness measures to fully assess the overall impact of the program. So far, the data for evaluation have mainly relied on the Key Performance Indicators (KPI), which are also those used in the definition of payment levels for individual practices. The report noted that evaluation indicators should be defined based on the objectives of the program and should be different from the payment indicators used in the scheme. Evidence on the effectiveness of the scheme is thus limited, which has already been pointed out successively by the different audit reports. Data on the performance of practitioners outside the PIP scheme should also be collected and analyzed, for instance from MBS claims. Comparisons between the participating and non-participating schemes could provide conclusive evidence about PIP's effectiveness.

Finally, the original policy objective for PIP in 1998 was to compensate for the shortcomings of Medicare Australia's fee-for-service payment system. The reviews of the program that have been done have been pessimistic about the extent to which PIP encourages GPs to spend more time with their patients. The analysis provided in the most recent ANAO report using MBS claims shows that higher volume practices have been disproportionately rewarded by PIP, which suggests that the blended payment system under PIP has not drastically changed the incentives for GP practices.

Performance Related to Specific Indicators

Several independent studies of individual incentives also provide little evidence on the effectiveness of PIP in driving quality improvement and better outcomes. Two studies published in 2005 and 2009 on diabetes case detection show the ambiguity related to the effectiveness of the incentives. The 2005 study performed by the Healthcare Management Advisors (2005) found that PIP did not create

incentives for GPs to diagnose more cases of diabetes. In a later study, Scott et al. (2009) found that the incentive program increased the probability of an HbA1c test being ordered by 20 percentage points, and that participation in the program is facilitated by the support of Divisions of General Practice.

The ANOA report concluded that the after-hours incentive and the domestic violence incentive have not met their stated policy objectives, although DoHA disagreed with this conclusion (Australian National Audit Office, 2010). The benefits of the implementation of eHealth also could be better leveraged, as the evaluation showed that despite the high take-up of the incentive, major improvements in quality of care related to better electronic information have lagged. Electronic transmission of documents, electronic patient record transferred etc. would require a more coordinated system between the different practices, especially those using eHealth techniques and those not participating in the program (Australian National Audit Office, 2010).

Some incentives are showing more promising results, such as the Practice Nurse Incentive and Asthma Incentive. The Practice Nurse Incentive has led to improved management of chronic diseases, increased time spent with patients, and reduced waiting times. The evaluation of the Asthma incentive has provided evidence on an overall positive impact of PIP on the completion of treatment cycles and general quality of care provided to asthma patients.

Equity

The accreditation process can be a significant barrier to certain general practices including Aboriginal Medical Services (AMSs) and to smaller practices. As such, AMSs and small practices servicing remote locations and non-English speaking communities have been underrepresented in PIP. The PIP participation rate for solo practices (34 percent) is half the overall participation rate (67 percent)(Australian National Audit Office, 2010). This disparity in PIP participation across smaller practices and those serving more disadvantaged populations may contribute to inequity in the program. If there is a geographical or economic self-selection of practices into PIP, additional revenues for the participating schemes is likely to further exacerbate these gaps in quality of care.

On the other hand, PIP has a positive effect on access and provision of care in rural areas, contributing to the reduction of rural-urban inequalities. For some rural practices, PIP represents an important source of revenue, and the rural loading payment is an important component of the financial viability of rural practices. Furthermore, under the Closing the Gap Measure, however, the DoHA has provided additional funding to AMSs to assist them to become accredited. The net impact of the program on equity has not been adequately assessed or monitored. The equity dimension of the initiative should thus be at the heart of efforts to more systematically monitor and evaluate PIP in the future.

Costs and Savings

The cost of PIP is significant, reaching nearly A$300 million per year in 2008-09, with almost A$3 billion in cumulative expenditures since its inception. The cost of the program increased 25 percent over the six-year period from 2002-03, although it has been declining as a share of all government expenditure on primary care in Australia, from 8 percent in 2002-03 to 5.5 percent in 2008-09 (Australian National

Audit Office, 2010). The costs to GP practices of participation, including accreditation and administrative burden, has not been quantified.

Provider Response

The response of providers to the PIP was less than enthusiastic in the early stages of implementation. A government review of the program in 2000 found that GPs claimed to participate in the program mainly to supplement their income and fund maintenance of equipment and facilities (Wendy Bloom and Associates, 2000). During the Productivity Commission's review of the administrative burden of PIP in 2002, the Australian Medical Association submission was critical of the program overall and particularly opposed to the perceived level of administrative burden of the program(Australian Medical Association, 2002), which has been an ongoing source of dissatisfaction since the program began. In its 2002 Annual Review of Regulatory Burdens on Business, the government's Productivity Commission found that PIP participation accounted for nearly 33 percent of GP practice administrative costs (Productivity Commission, 2003). The issue was taken up again by the Regulation Task Force in 2006 (Commonwealth of Australia, 2009).

The DoHA and Medicare Australia have been responsive to many of the concerns of providers, particularly attempting to simplify the administrative burden. Over time the providers have acknowledged a more positive role for the program. In a survey of GPs conducted as part of the latest ANAO review, 88 per cent of PIP practices responded that they consider that PIP provides at least some support to them for providing patients with quality care and improved access. Views are still mixed, however, with 27 percent of providers responding that PIP gives significant benefit to their practice, 36 percent responding that there is medium benefit, and 27 percent responding that the benefit is minor(Australian National Audit Office, 2010).

Overall Conclusions and Lessons Learned

Has the program had enough of an impact on performance improvement to justify its cost?

PIP appears to have gained gradual support among GPs. The supplemental payments to practices appear to have contributed to enhancing quality of care to some degree, especially for chronic conditions. The structure of PIP –the umbrella structure for 13 different incentives- has allowed the DoHA to provide flexible and tailored responses to quality of care in different areas. The emphasis put on quality and accessibility of care in rural and remote areas (by the different incentives and also the calculation of payment) also has contributed to addressing the crucial issue of care gaps between rural and urban areas. There is recognition that accountability has been improved to a certain extent, as well as reporting. The introduction of the new on-line system will also contribute to reducing the administrative burden associated with the implementation of the scheme.

The level of spending on the program (over A$2.7 billion since 1998), however, seems to be disproportionate to the overall results. Although there are modest impacts observed on service delivery and quality of care, the PIP has not been fully leveraged to drive performance improvement in primary

care. There are several aspects of the design of the program that limit the ability of PIP to significantly impact service delivery and reward real improvements in quality and outcomes:

(1) **Complex and non-transparent scheme structure**. The structure of the program (13 incentives with requirements that can change from year to year) does not allow for a coherent set of policy objectives with clear priorities. In the New Zealand primary care P4P scheme, for example, clarifying policy objectives and establishing priorities are seen as major benefits of the schemes to improving overall system performance (Buetow, 2008). Moreover, the mix of different payment mechanisms within PIP (between target and key performance indicators, sign-on, take-up of the incentive, etc.) has rendered monitoring difficult and payments less transparent. The calculation of payment levels based on SWPE has also added further confusion to the actual link between performance of practices and payments. The strength of the incentives and accountability also could be further enhanced by the publication of payment levels and rankings on performance, but limitations due to privacy regulations prevent the publication of payment levels and rankings for individual practices.

(2) **Selective participation in lower effort incentive streams**. The structure of the incentive schemes allows providers to select those areas in which they have the greatest potential for award. This has resulted in a high uptake of an incentive that is relatively easy to achieve and that comes with a big reward (eHealth) and much lower uptake of the incentives related to service delivery for chronic conditions, which require much more effort on the part of the practices. The relative contribution of the two incentive areas to overall quality of care and performance is not known, but unlike computerization, it seems that increasing screening and appropriate management of chronic diseases is an essential element of providing good quality of care. The incentive structure of PIP does not appear to adequately reward this activity.

(3) **Inadequate use of performance data for improvement processes**. Although IT-related incentives show the highest uptake, the potential of improved data, reporting and performance monitoring has not been fully exploited by the Australia PIP. No reports are available showing trends in performance against the different indicators, which would provide valuable information both for policy purposes and management of service delivery at the provider level. The possibility of monitoring trends is further diminished by the design of PIP, which allows PIP practices to move in and out of specific incentive schemes, rendering aggregate trends in indicator performance meaningless. Again, improved health information reporting, availability and use is found to be one of the main potential benefits of P4P schemes in a range of countries(Galvin, 2006; Sutton & McLean, 2006).

Conclusion: The evidence that the PIP has had impacts on quality of care and outcomes that justify the costs of the program is limited. Furthermore, there are serious concerns about the role of the program in exacerbating inequity across large urban practices and smaller practices serving more disadvantaged populations, and the possible spillover effects of the scheme into other areas of service delivery and performance have not been addressed. Evaluation of both the impacts and spillover effects of the scheme, particularly on small practices and those located in disadvantaged areas, should be the priority

of the DoHA. In the absence of such evaluation, conclusive evidence on the overall effectiveness of the scheme is limited.

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