# The new "Indigenous health" incentive payment: issues and challenges

Sophie Couzos and Dea Delaney Thiele


## ABSTRACT

- Paying incentives above the baseline Medicare Benefits Schedule to health services for the additional work required to meet the health needs of Aboriginal people or Torres Strait Islanders might mitigate inequalities of care, but evidence supporting this is lacking.
- The proposed "Indigenous health" incentive payment to reduce Aboriginal health disadvantage, which is largely aimed at increasing the responsiveness of mainstream general practices, provides an opportunity to examine the assumptions behind this and other recent health reform bids.
- Contentious implementation issues include: the ineligibility of several Aboriginal community controlled health services (ACCHSs) to receive this payment; determining Aboriginality and the potential for misappropriation of payments; the difficulty accounting for practice population diversity and patient mobility; and concerns about the benefits or otherwise to the Aboriginal community.
- Evaluation of the measure will present problems: to attribute outcomes, an evaluation must disaggregate outcomes by type of service provider (general practice or ACCHS).
- If these challenges are not addressed, this initiative may end up merely funding coordination of care for those Aboriginal people and Torres Strait Islanders who are already regular users of the health system.


MJA 2010; 192: 154–157

eMJA Rapid Online Publication 7 December 2009

Rewarding health services that provide quality care through "pay for performance" is a feature of health systems worldwide, but evidence that these payments can reduce health inequalities is lacking.[1,2] The Practice Incentives Program (PIP), through Medicare Australia, finances incentive payments to general practices and Aboriginal community controlled health services (ACCHSs) accredited against the standards of the Royal Australian College of General Practitioners (RACGP). One premise is that if, on top of baseline fee-for-service payments, practices are financially rewarded for providing quality care to subgroups of the population (eg, those underscreened or with chronic disease), then health outcomes might improve.

To date, there is little evidence that the PIP has improved health outcomes for the Aboriginal and Torres Strait Islander population (hereafter referred to as the "Aboriginal" population). For example, the Senate Community Affairs Committee could not ascertain whether incentives for cervical cancer prevention had improved Pap smear coverage in Aboriginal women,[3] and "very poor uptake" of incentives relating to asthma in the Aboriginal population suggests that the PIP has had little effect on disease management in this context.[4,5]

In November 2008, the Council of Australian Governments announced a new PIP to encourage better care, particularly from mainstream general practices, of Aboriginal people with chronic disease, and to help "close the gap" by reducing Aboriginal health disparity. The PIP "Indigenous health" incentive is due to commence in May 2010. Funding of $28 million over 4 years[6] will provide incentive payments to general practices and ACCHSs caring for Aboriginal patients, and benefits to registered patients with chronic disease who identify as Aboriginal (Box 1).[7]

This measure aims to (i) mitigate health inequalities by rewarding practices for the additional work required to meet the health needs of Aboriginal peoples; and (ii) encourage practices to better identify Aboriginal patients, and encourage patients to more readily declare their Aboriginality in exchange for better care. However, this measure was *not* conceived through consultation with Aboriginal community bodies.

As we move towards greater use of blended payment financing schemes for primary health care, identified in recent health reform bids,[8,9] this new health incentive will test assumptions that this type of financing can foster equitable and flexible care for those most in need. We identify here some of the contentious issues surrounding the implementation and evaluation of this measure.

## Eligibility of health services

There are two eligibility issues. First, although this health incentive should benefit ACCHSs because of their high Aboriginal patient load,[10] we estimated that, as of August 2009, a third of the 150 ACCHSs are not accredited against the RACGP standards. This is an improvement; in 2005–06, only 41% of Aboriginal medical services (58/140) with a general practitioner were accredited against the RACGP standards.[11] However, a substantial number of ACCHSs will continue to be ineligible for the incentive, as they lack GPs and the necessary capital works and other infrastructure supports required to achieve accreditation. "Locking out" any Aboriginal health service undermines the integrity of the new measure, especially when unaccredited practices are often in regions with higher proportions of Aboriginal people.[11]

Second, the health incentive would be more likely to be effective if mainstream general practices were "accredited" to receive payments by undertaking "cultural safety training" endorsed by the ACCHSs sector.[12] Recent health reform proposals[8] and Aboriginal leaders[13] have made similar calls for such credentialling of health services and doctors.

## Determining Aboriginality

The new health incentive is based on identification of a patient's ethnic background. The RACGP has developed a guide to assist GPs who have difficulty identifying Aboriginal patients,[14] and practices have to show that they are working towards such identification to meet accreditation standards.[15] Acceptable evidence for proof of Aboriginality,[16,17] based on the report of the Constitutional Section of the Department of Aboriginal Affairs in 1981,[18] is given in Box 2.

**1 The Practice Incentives Program "Indigenous health" incentive[7]**

*The incentive will provide:*

- a ***start-up payment*** to health services agreeing to care for Aboriginal patients, aged ⩾15 years, with a chronic disease;
- a ***registration payment*** for every such patient registered with the health service per year; and
- an ***outcomes payment*** paid when a health service reaches certain targeted levels of care for these Aboriginal patients every year.

*Registered patients with chronic disease identifying as Aboriginal will receive:*

- care coordination (eg, arranging services required by the patient);
- support to attend appointments (eg, by providing transport);
- supported access to specialist and allied health services;
- lifestyle modification and chronic disease self-management advice; and
- copayment relief for medicines on the Schedule of Pharmaceutical Benefits. ◆

There are arguments that GPs should not have to identify a patient's ethnicity, as it is viewed as a social and cultural issue, rather than a biological one,[19-21] and there are patients who believe that ethnicity is irrelevant to their care.[19] However, closing the health gap for Aboriginal people depends on targeting specific health initiatives to improve their access to health services, and prevent disease and early death.

Aboriginal peoples and/or Torres Strait Islanders make up 80%–90% of attendees at ACCHSs,[10] compared with 0.7%–1.6% of those attending private general practices, but the latter proportion is considered an underestimate.[22] There is a potential for general practices to make an incorrect identification, or for a patient to incorrectly claim to be Aboriginal, leading to inappropriate targeting of the initiative.

Putting the onus on disadvantaged and unwell clients to provide proof of Aboriginality creates a perverse situation. However, Aboriginal people are often asked to confirm their ethnic origin, and ACCHSs regularly provide this service for clients and the community. The National Aboriginal Community Controlled Health Organisation (NACCHO) recommends that, for Aboriginality to be recognised, all three parts of the definition in Box 2 should be fulfilled.[23] However, Centrelink (the Australian Government's social security agency) and the Voluntary Indigenous Identifier used by Medicare accept self-identification as sufficient evidence, although this is not the case with all government programs.

Adopting self-identification of Aboriginality as the sole criterion for the incentive payment may be justified, if a pilot study could confirm that the risk of "leakage" is small. Mechanisms to prevent and audit false claims by both practices and patients will be important. Potential funds leakage in two directions will mean fewer resources for Aboriginal people with chronic and complex disease. In addition, privacy constraints might preclude the use of the Medicare Voluntary Indigenous Identifier as an alternative mechanism to inform practices or to calculate payments.

## Practice population diversity

The health incentive does not take into account the heterogeneity of Aboriginal populations, "the great variation nationwide in the characteristics, exposures and genotypes of people identifying as Indigenous".[24] Deprivation is not necessarily defined by ethnicity alone. If health outcomes (eg, Medicare Benefits Schedule [MBS] claims) determine payments, health services with patients from impoverished environments may be less likely to reach the specified outcome thresholds than those with more health-literate patients (irrespective of the quality and quantity of care provided). Given that Aboriginal patients attending ACCHSs have more complex disease than those attending private general practices,[10] we may see a differential in payment for the level of effort expended. Moreover, some private practices may be more inclined to direct attention to patients with uncomplicated chronic disease, as "needy" patients may interfere with payment thresholds (inverse care law).

Health outcomes need to be selected carefully; health improvements are influenced as much by social and environmental influences as by health care. Mediating social change and supporting communities is but one facet of the broad activity of ACCHSs.[11] It is worth considering whether health services providing care to more complex and "hard to reach" Aboriginal patients could be eligible for outcomes payments at different thresholds to other services.

## Patient mobility

The Australian Government will pay practices to register Aboriginal clients, but "the maintenance of Aboriginal relationships to places, and to country, and ... the maintenance of social relationships" is dependent on mobility.[25] Voluntary enrolment of patients with complex needs with a single health service of their choice (their "health care home"), with grant funding tied to levels of enrolment, has been proposed by the National Health and Hospitals Reform Commission.[8]

As Aboriginal patients travel between services, often visiting clinics only once, competition for patient registration and outcomes payments (if directed only to registrant services) may not support best practice. Some practices may be discouraged from caring for highly mobile Aboriginal patients, while other practices would be driven by payments to "poach" Aboriginal patients. Rorting of MBS payments has been reported: unscrupulous practices claim for health assessments or care plans with no intention of providing follow-up care for anyone who is not one of their usual patients. The patients' usual practices subsequently have their MBS claims rejected.[26]

**2 Acceptable evidence for proof of Aboriginality[16,17]**

(I) Evidence of Aboriginal or Torres Strait Islander descent:

- birth records or genealogies verified by a suitable authority as applicable; or
- a letter signed by the chairperson of an Aboriginal and/or Torres Strait Islander incorporated organisation (if records are not available).

(II) Evidence of self-identification as an Aboriginal or Torres Strait Islander:

- a signed affirmation that the applicant identifies as an Australian Aboriginal or Torres Strait Islander.

(III) Evidence of community recognition:

- confirmation in writing by the Chairperson of an Aboriginal or Torres Strait Islander incorporated organisation in a community in which the applicant lives or has previously lived. ◆

This situation could be prevented if patients had to declare that the registering practice was their usual care provider and agree to the transfer of their medical records to fulfil the requirements of the health incentive. There should be a complaints mechanism to monitor any inappropriate registration of Aboriginal clients.

## Will the initiative benefit the Aboriginal community?

ACCHSs, as non-profit organisations, return any funds generated to the Aboriginal community. For private general practices, participation in practice incentive programs is largely a business decision. The current PIP makes up only a very small proportion of general practice income,[27] and even if revenue from the new PIP health incentive within mainstream services could be appropriated for Aboriginal programs, the quantum would make little difference to Aboriginal community care.

The current PIP absorbs significant administration costs, which make up 39% of the total government outlay on this initiative.[27] Thus, assuming similar levels, about $11 million over 4 years might be spent in administering the new PIP health incentive. As this expenditure would not make its way back to Aboriginal community programs, we would define this as "leakage" at a program level. Moreover, the incentive may not offset the possibly substantial administrative burden on ACCHSs (by virtue of their Aboriginal patient load).

There is also the potential for the new health incentive to fuel discriminatory attitudes within Australian society to the detriment of Aboriginal peoples, as, within private general practices, ethnicity-based benefits and financial relief to Aboriginal patients would be denied to other patients.

## Uptake and evaluation

The government expects that around 4500 practices per year will sign up for the health incentive payment,[6] and 55% of the adult Aboriginal and Torres Strait Islander population will receive a health assessment over the next 5 years,[28] with treatment of illnesses delivered mainly through the mainstream health system.[10] Will these expectations be met?

Given that there are currently 4798 practices participating in the PIP,[29] and 70% of private practices do not see a single Aboriginal client,[10] it is unlikely that the expected number of practices will sign up for the new health incentive.

In 2008–09, 6.5% of all Aboriginal or Torres Strait Islander adults (15–54 years) had a health check for which an MBS rebate was claimed (the rate is calculated based on 2006 census population estimates for the 15–54-year-old Indigenous Australian population [282755]).[30] This rate is much less than the 21% of older Australians (>75 years) who received a health check in 2006–07.[11] However, of 4386 Aboriginal and/or Torres Strait Islander patient encounters within private general practices over the period 2004–2008, there was not a single encounter for which any of the MBS rebates for Aboriginal health assessments were recorded.[31] Of the general practices in the Australian Capital Territory Division of General Practice surveyed in 2006–07, few knew of these rebates and none had claimed for them,[32] suggesting attribution of most Aboriginal health assessments to the single ACCHS in the ACT. Many ACCHSs also undertake health assessments without claiming the Medicare rebate.[33]

While Divisions of General Practice have been unable to influence general practice performance, as measured by claims for cervical, asthma and diabetes service incentive payments (2000–2005),[34] Divisions will be funded for up to 80 project officers to assist practices with the new health incentive.[35]

To estimate any gains from the new initiative, an evaluation must be based on outcomes disaggregated by type of service provider. The 2008–09 National Performance Indicators for Divisions require them to report on the number of MBS health checks for Aboriginal people (Items 710 and 708) provided "by GPs within the Division". However, the indicators' technical specification does not differentiate health checks undertaken by ACCHSs from those done by general practices,[36] as Medicare Australia does not capture data by type of service provider and is unable to extract data by using practice names.

The proposed outcome measures for the new PIP health incentive are similar to those of the current PIP: the number of PIP practices signed on to the incentive; the number of practices receiving payments for registering patients; the number of Indigenous clients registered with a PIP practice for chronic disease management; and the number of Aboriginal and/or Torres Strait Islander people receiving an MBS adult health check.[35]

Registration and outcomes data could be disaggregated by service type, if this was supported. However, proposed sources of health assessment data, such as from sentinel sites[35] or Healthy for Life services (an Australian Government program to improve the health of Aboriginal mothers and children), of which 70% are ACCHSs, could introduce selection bias. New performance indicators for Divisions of General Practice are needed to measure their impact on Aboriginal health outcomes.

## Conclusions

The "Indigenous health" incentive may reduce Aboriginal health disparities caused by poor access to mainstream health services, but "closing this gap" requires much more than improvements to clinical care and increased MBS claims. Comprehensive primary health care, fostering Aboriginal community governance and action, which is the function of ACCHSs, is critical to all "close the gap" measures. However, funding for the new incentive will be channelled largely through general practices. This means that careful attribution of outcomes from these services will be vital to assess the effectiveness (or otherwise) of blended payment financing to mitigate health inequalities.

Certain assumptions underpin the rationale for this health incentive:

- that it will increase Aboriginal people's attendances for general practice care;
- that the increased attendances will be from Aboriginal people with chronic and complex diseases who are not currently accessing the health system; and
- that each consultation will deliver better care.

If these assumptions are not fulfilled, the incentive will merely fund practices to coordinate the care of Aboriginal people who are already regular users of the health system (thereby diminishing returns), and make little difference to those Aboriginal people this Council of Australian Governments measure is meant to assist.

## Acknowledgement

This article is a modified extract from the *Indigenous health incentive payment: NACCHO Issues Paper* (May 2009) produced for the Aboriginal Community Controlled Health Services.

## Competing interests

None identified.

## Author details

**Sophie Couzos,** FRACGP, FACRRM, FAFPHM, Public Health Officer[1]
**Dea Delaney Thiele,** PGDipHlthMgt, Chief Executive Officer[2]

1 National Aboriginal Community Controlled Health Organisation, Townsville, QLD.

2 National Aboriginal Community Controlled Health Organisation, Canberra, ACT.

*Correspondence:* scouzos@tpgi.com.au

## References

1 Witter S, Kessy FL, Fretheim A, Lindahl AK. Paying for performance to improve the delivery of health interventions in low and middle-income countries (Protocol). *Cochrane Database Syst Rev* 2009; (3): CD007899. DOI: 10.1002/14651858.CD007899.

2 McLean G, Sutton M, Guthrie B. Deprivation and quality of primary care services: evidence for persistence of the inverse care law from the UK Quality and Outcomes Framework. *J Epidemiol Community Health* 2006; 60: 917-922.

3 Senate Community Affairs Legislation Committee. Examination of the Budget Estimates 2005–06. Volume 6 Health and Ageing Portfolio: Additional information received, outcomes 1,2,3,4,6. Feb 2006: 251–256.

4 Beilby J, Burgess T, Lokhorst J, et al. Evaluation of the Asthma 3+ Visit Plan. University of Adelaide, University of New South Wales, and National Aboriginal Community Controlled Health Organisation, Dec 2004.

5 Urbis Keys Young. Aboriginal and Torres Strait Islander access to major health programs. Prepared for: Medicare Australia, and Department of Health and Ageing, Nov 2006. http://www.medicareaustralia.gov.au/public/services/indigenous/files/aboriginal_torres_strait_islander_access_to_major_health_programs.pdf (accessed Nov 2009).

6 Australian Government. 2009–10 Health and Ageing Portfolio budget statements. Budget related paper No.1.10. Outcome 5. Canberra: Commonwealth of Australia, 2009: 210, 213. http://www.health.gov.au/internet/budget/publishing.nsf/Content/2009-2010_Health_PBS (accessed Nov 2009).

7 Australian Government Department of Health and Ageing. Closing the Gap: tackling chronic disease. Overview of the Commonwealth Indigenous Chronic Disease Package. http://www.healthyactive.gov.au/internet/main/publishing.nsf/Content/health-oatsih-ctg-package (accessed Sep 2009).

8 National Health and Hospitals Reform Commission. A healthier future for all Australians: final report June 2009. Canberra: Department of Health and Ageing, 2009. http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhrc-report-toc (accessed Nov 2009).

9 Australian Government Department of Health and Ageing. Primary health care reform in Australia. Report to support Australia's first national primary health care strategy. Canberra: DoHA, 2009. http://yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc (accessed Nov 2009).

10 Couzos S, Delaney Thiele D. Closing the gap depends on ACCHSs [letter]. *Med J Aust* 2009: 190: 541.

11 Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses. Canberra: AIHW, 2008: 1161, 1494. (AIHW Cat. No. IHW 22.) http://www.aihw.gov.au/publications/index.cfm/title/10664 (accessed Sep 2009).

12 Aboriginal Health Council of Western Australia. Cultural safety training. http://www.ahcwa.org.au/index.php?option=com_content&view=article&id=64&Itemid=63 (accessed Nov 2009).

13 Donovan S. Indigenous leaders back "cultural awareness" exams. *ABC News* 29 Jul 2009. http://www.abc.net.au/news/stories/2009/07/29/2639404.htm (accessed Sep 2009).

14 Royal Australian College of General Practitioners. Fact sheet: the identification of Aboriginal and Torres Strait Islander people. August 2006. http://www.racgp.org.au/Content/NavigationMenu/PracticeSupport/StandardsforGeneralPractices/RACGPStandards3rdEdFactSheets/200608Identificationofpatients.pdf (accessed Sep 2009).

15 Royal Australian College of General Practitioners. Standards for general practices. 3rd ed. Melbourne: RACGP, 2007. http://www.racgp.org.au/standards (accessed Sep 2009).

16 Australian Government Department of Education, Employment and Workplace Relations. Primary eligibility criteria for ABSTUDY: Chapter 10 — Aboriginality or Torres Strait Islander status. In: ABSTUDY — the Aboriginal and Torres Strait Islander Study Assistance Scheme Policy Manual, 2005. http://www.deewr.gov.au/Indigenous/Schooling/Programs/ABSTUDY/PrimaryeligibilitycriteriaforABSTUDY/Pages/AboriginalityTorresStraitIslanderStatus.aspx#10.1_definition_of_aboriginality_or_torres_strait_islander_status (accessed Nov 2009).

17 Australian Institute of Aboriginal and Torres Strait Islander Studies. Fact Sheet 11. Proof of Aboriginality or Torres Strait Islander Heritage. Canberra: AIATSIS, Oct 2006. http://www.aiatsis.gov.au/fhu/docs/11_FHU_Aboriginality.pdf (accessed Sep 2009).

18 Gardiner-Garden J. The definition of Aboriginality. In: Research Note 18 2000–01. Parliament of Australia, Parliamentary Library, 2000. http://www.aph.gov.au/LIBRARY/pubs/rn/2000-01/01RN18.htm (accessed Nov 2009).

19 Varcoe C, Browne AJ, Wong S, Smye VL. Harms and benefits: collecting ethnicity data in a clinical context. *Soc Sci Med* 2009; 68: 1659-1666.

20 Doyle JM. What race and ethnicity measure in pharmacologic research. *J Clin Pharmacol* 2006; 46: 401-404.

21 Nuffield Council on Bioethics. Pharmacogenetics: ethical issues. London: Nuffield Council on Bioethics, 2003. http://www.nuffieldbioethics.org/go/ourwork/pharmacogenetics/introduction (accessed Sep 2009).

22 Britt H, Miller GC, Charles J, et al. General practice activity in Australia 1999–00 to 2008–09: 10 year data tables. Canberra: Australian Institute of Health and Welfare, 2009. (AIHW Cat. No. GEP 26.)

23 National Aboriginal Community Controlled Health Organisation. Aboriginality. 2007. http://www.naccho.org.au/definitions/aboriginality.html (accessed Sep 2009).

24 Hoy WE. "Closing the gap" by 2030: aspiration versus reality in Indigenous health. *Med J Aust* 2009; 190: 542-544.

25 Long S, Memmott P. Aboriginal mobility and the sustainability of communities: case studies from north-west Queensland and eastern Northern Territory, Working Paper 5. Alice Springs: Desert Knowledge CRC, 2007. http://www.desertknowledgecrc.com.au/publications/downloads/DKCRC-WP-05-Aboriginal-mobility.pdf (accessed Nov 2009).

26 Cresswell A. Doctors "rorting" care plans. *The Australian* 2008; Mar 15. http://www.theaustralian.news.com.au/story/0,25197,23377646-23289,00.html (accessed Nov 2009).

27 Parliament of Australia. The Senate. Select Committee on Medicare. Medicare — healthcare or welfare? Canberra: Commonwealth of Australia, 2003. http://www.aph.gov.au/senate/committee/medicare_ctte/fairer_medicare/report/report.pdf (accessed Sep 2009).

28 Council of Australian Governments meeting. Communiqué. 29 November 2008. http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/docs/communique_20081129.rtf (accessed Nov 2009).

29 Medicare Australia. Approved practices in the quarterly calculations by activity. (Quarter 2 2009). https://www.medicareaustralia.gov.au/statistics/div_gen_prac.shtml (accessed Dec 2009).

30 Medicare Item Reports. July 2008 – June 2009 (Item 710). https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml (accessed Dec 2009).

31 Britt H, Miller GC. General practice in Australia, health priorities and policy 1998–2008. Canberra: Australian Institute of Health and Welfare, 2009: 100. (AIHW Cat. No. GEP 24.)

32 Kehoe H, Lovett RW. Aboriginal and Torres Strait Islander health assesments. Barriers to improving uptake. *Aust Fam Physician* 2008; 37: 1033-1038.

33 Australian Government, Australian Institute of Health and Welfare, Menzies School of Health Research, SRA Information Technology. Technical specifications for 11 essential indicators. Version 3.3. SCARF Data Development Group, March 2009. http://www.health.gov.au/internet/h4l/publishing.nsf/Content/21D7AED124027F5DCA2571950002F31E/$File/20%20March%202009%20Technical%20specifications%20for%20Essential%20Indicators.pdf (accessed Dec 2009).

34 Scott A, Coote W. Do regional primary-care organisations influence primary-care performance? A dynamic panel estimation. *Health Econ* 2009; Jun 18. [Epub ahead of print]. DOI: 10.1002/hec.1509.

35 Council of Australian Governments. National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: implementation plan. Canberra: Commonwealth of Australia, 2009. http://www.healthyactive.gov.au/internet/main/publishing.nsf/Content/closinggap-tacklingchronicdisease (accessed Nov 2009).

36 Australian Government Department of Health and Ageing. Divisions of General Practice Program. National performance indicators, 2008–09. 22 Dec 2008. http://www.phcris.org.au/divisions/reporting/documents/techdetails/National_Performance_Indicator_Technical_Details_Dec08.pdf (accessed Sep 2009).

*(Received 6 Oct 2009, accepted 28 Oct 2009)* ❑