

Review of General Practice Incentives

Expert Advisory Panel report to the Australian Government



30 September 2024

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Acknowledgement of Country

The Expert Advisory Panel acknowledges the Traditional Owners and Custodians of Country throughout Australia. We recognise the strength and resilience of Aboriginal and Torres Strait Islander people and acknowledge and respect their continuing connections and relationships to country, rivers, land and sea. We acknowledge the ongoing contribution of Aboriginal and Torres Strait Islander people across the healthcare system and in the wider community. We also pay our respects to Elders past and present and extend that respect to all Traditional Custodians of this land.

Overview

This Review of General Practice Incentives was developed by an Expert Advisory Panel (the panel). The panel comprised experts in primary care and health economics, and was supported by the Department of Health and Aged Care (the department). The panel met 15 times throughout 2023–2024. See Appendix 5 for a list of panel members.

The Review of General Practice Incentives is a direct result of the work of the Strengthening Medicare Taskforce and Australia's Primary Health Care 10 Year Plan (2022–2032). This review remains consistent with the direction outlined in these reports; that is, that Australia should increase blended payments in general practice. The panel recognises the contribution of the individuals involved in the processes that underpin this work.

Terminology used in this report

For the purpose of this report, the term 'general practice' refers to primary care services that provide holistic and comprehensive whole-of-life primary care. This includes private and not-for-profit general practices, nurse practitioner-led practices, Aboriginal Community Controlled Health Organisations (ACCHOs) and some Aboriginal Medical Services (AMS). Therefore, it is important to note that general practice is not synonymous with the presence of a general practitioner (GP) under this definition, but generally includes general practice team members.

Scope

This review focused on current and future payments to general practice that meet the definition of general practice above. Payments or funding to other types of primary care organisations was not in scope and therefore not considered. The panel acknowledges that sub-specialty primary care clinics – such as women's health and LGBTQIA+ clinics, and midwife-led services – play a critical role in providing primary care for specific populations at certain life milestones. The panel calls for the Australian Government to separately consider how it can ensure the ongoing sustainability, expansion and integration of these services with the work of the expanded general practice teams mentioned in this report.

The Practice Incentives Program Indigenous Health Incentive (PIP IHI) is outside the scope of this report. Following a national consultation process, the government announced changes to the PIP IHI as part of the 2021–22 Budget. PIP IHI is part-way through a 3-year phased transition to new arrangements. The changes are intended to improve the continuity of care and health outcomes of Aboriginal and Torres Strait Islander people with chronic diseases, and to streamline administrative requirements for practices. These changes should be implemented and evaluated before considering any further redesign.

Changes to Medicare Benefits Schedule (MBS) items and the level of funding for general practice and primary care are also outside the scope of this review.

Introduction

Australia has a good health system, but it fails to provide good outcomes for everyone. People in rural Australia have poorer access to health care than those in urban areas. Aboriginal and Torres Strait Islander people still have a shorter life expectancy than non-Indigenous people – a difference of a decade. In 2022–2023, about 7% of Australians deferred seeing or could not see a GP due to the associated costs.¹

Primary care – the foundation of the health system – is experiencing significant challenges. Fewer than one in 5 new medical graduates want to go into the specialty.² The system is fragmented as different options for care evolve. More GPs now work in larger practices or for corporate chains. Practice owners find it more difficult to find new GPs to take over their practices. New interpretations of payroll tax laws have imposed additional costs on general practices that, in some cases, are already experiencing economic challenges. All GPs found a long rebate freeze unfair and felt that it undermined their trust in the government.

The epidemiological transition – more Australians living with chronic conditions – means that the traditional monodisciplinary fee-for-service practice is not the best or only way to fund primary care. Some GPs want a multidisciplinary practice that gives them more team support, but this is hard to sustain with existing payment models. Nurses and allied health professionals are struggling because of constraints on their ability to work in a truly integrated way in primary care. These issues are amplified outside of major cities.

One solution has been around for decades: moving primary care away from excessive reliance on fee for service as the primary source of practice income. Despite being recommended by every major review of the health system over the past 25 years, there has been little progress. Many countries that are similar to Australia rely less on fee-for-service funding and have moved to blended funding models.³

Most recently, the *Primary Health Care 10 Year Plan* released by the previous government and the current government's *Strengthening Medicare Taskforce Report* pointed to a future in which practices could adapt to contemporary needs by adopting more flexible blended payment models.

The panel is proud to be part of this process to create a new reality for primary care in Australia. Importantly, our recommendations are designed to make multidisciplinary care sustainable for general practices supporting patients with increasingly complex healthcare needs. A significant transition won't happen overnight, and many practices may choose not to change. More flexible blended payment models can be achieved through new ways of paying for primary care, providing general practices with more autonomy and flexibility to use funds to better support team-based care. The intention is for fee-for-service payments to remain but as a smaller percentage of many general practices' total revenue.

The panel envisages a primary care system that is funded using a blend of fee-for-service and other payments made directly to practices, where an average of about 60% of the practice's income will be from fee-for-service payments, down from about 90% now. Other practice payments will be simplified and focused on supporting team-based care, with some payments based on the characteristics of the practice's patients and the practice location. The remaining 40% is designed to allow other health professionals to join primary care teams and is not conceptualised as an alternative to fee-for-service income for the GP. The 60:40 split would be an average. Some practices may have a larger flexible payment share, while others may choose to remain with current funding arrangements.

The workforce mix would change too. The panel envisages a future in which the ratio of GPs to other health professionals would shift to about 1:1 – one GP to one other health professional. This will generally include

¹ Australian Institute of Health and Welfare (2024) [General practice, allied health and other primary care services](#), AIHW.

² Medical Deans (2024) *Medical Schools Outcomes Database – National Data Report 2024*, [MSOD-National-Data-Report-2024.pdf](#) (medicaldeans.org.au).

³ The Commonwealth Fund (2020) [International Profiles of Health Care Systems](#).

a nurse and, depending on the needs of the practice, a pharmacist, physiotherapist, psychologist, social worker, dietitian or mix of providers who can respond to patients' needs. Some of these team members might not require university training – for example mental health and other peer workers, health coaches and link workers. There will need to be more support staff, as larger teams require more assistance from receptionists, medical practice assistants, clinical directors and practice managers. Aligning the interests, plans, work and performance of these teams to address the rapidly rising needs of patients will take an investment in clinical and practice governance unlike anything seen in Australia to date. These new leadership functions will be fundamental in transitioning to new models of care.

Rural practice is already changing rapidly, with the introduction of single-employer models and other adjustments. The panel's recommendations will strengthen rural practice, ensuring more flexibility in rural areas and hopefully facilitating positive developments that are already underway.

Our recommendations aim to ensure that this transition is supported and occurs at a staged pace. Guided by our responsibility to ensure that taxpayer support is well spent, we have recommended increased accountability but a light touch. The intent is to avoid the additional recommended investment being consumed by excessive red tape. If practice software is upgraded to seamlessly generate the data required for providers, practices and funders to make better decisions, experienced clinicians should be relieved of much of the administrative burden of the transition. Where other reporting is required,⁴ other members of the practice administration team should be engaged to ensure clinical efforts are concentrated on patients, not processes.

The panel has recommended that the level of different payment types to general practices be set independently. In terms of business planning, this will help reassure practices that their income is based on the actual costs of delivering care, rather than subject to political decisions. We also couch our recommendations not in terms of a program that can be ceased at any point, but as a core corollary of the Medicare system as an institutional arrangement likely to continue for decades. Such a horizon means that educational institutions delivering the required workforce can be confident that primary care roles will expand in scope and number over time, justifying efforts to ramp up enrolments and program offerings. Practice owners can be assured that investment in larger buildings, improved systems and expanded teams will deliver a return measurable in both profitability and patient outcomes. Those with aspirations to lead change and teams (such as clinical directors and nurse managers) can prepare for a future where their role as a clinical team lead or practice manager is recognised and well rewarded.

The panel acknowledges the extensive feedback from consultations and recognises that positive change is difficult to envisage for some, especially in a context of past underinvestment in primary care that has built a lack of trust. Our emphasis on a voluntary approach for practices is a deliberate one. If patients are unwilling to sign up to MyMedicare in these early days, we have recommended provisions so practices can still benefit from funds to retain a broader range of disciplines. GPs may also wish to continue with their current operating model. The panel believes that the change in primary care needs to happen, and each practice will need to assess if and when it feels comfortable making the shift. We also acknowledge that the speed at which practices embrace change will be influenced by the amount of certainty the government provides around implementation and funding, the latter of which is beyond the scope of this report.

For early adopters, the opportunity to innovate would be supported by funding. Those already on the path to team-based care would see their current team better recognised and funded. We have recommended funding directed at capturing, replicating and promoting successful models, so the system does not bear the cost of duplicated effort. Creating a collective effort across primary care will be a role for peak bodies, Primary Health Networks (PHNs) and local area collaboratives to undertake, and we have recommended funding for this change support role.

⁴ PHN Hunter New England and Central Coast (2021) [Embedding and optimising a Medical Practice Assistant in General Practice](#).

We see an exciting future for primary care in this country, but only if we act now to address the requirements of the epidemiological transition and the need for multidisciplinary teams to be funded in a more flexible way. The changes we have recommended are interdependent, so implementation must proceed carefully if we are to see overall success. There is no 'one size fits all' solution, and we recognise the diversity of business and clinical models of care that drive local innovation to meet community needs.

We want a stronger primary care system, with much better funding and delivery, that better meets the needs of every Australian – no matter who they are and where they live. We want clinical and non-clinical professionals to see primary care as a long-term career choice. We want primary care to be a respected partner with the hospital sector, ensuring better value in care provision as the centre of gravity in health care shifts towards community settings. This transformational change is necessary to deliver a system that can address the challenges we are experiencing now and which will increase over time.

Summary of recommendations

1. Simplified general practice payment architecture

Recommendation 1a: The Australian Government should introduce a new opt-in, simplified general practice payment architecture that better supports community and patient needs and encourages high-quality, accessible and multidisciplinary care.

The new blended payment architecture should:

- include a new Baseline Practice Payment that:
 - enables general practices to flexibly use funds to provide appropriate multidisciplinary care to the populations they serve
 - includes funding for coordinating the primary care team
 - is calculated based on patient needs, socio-economic status and location
- include funds and/or programs to promote quality and innovation, teaching, after-hours care and targeted initiatives
- require general practices to participate in MyMedicare to access these payments, so that all patients, whether registered in MyMedicare or not, will benefit from the MyMedicare system
- require general practices to provide comprehensive service delivery information and data, to support quality improvement, monitor health outcomes, calculate reimbursements, and inform planning and evaluation.

The panel believes the new payment architecture will require increased Australian Government investment to ensure its effectiveness, fund the necessary change supports, and ensure practice viability during and after the transition.

The government should further consider how sub-speciality primary care providers can be funded to work with general practices as part of a multidisciplinary team that delivers comprehensive primary care for specific populations. The lesson that must be reinforced for all elements of the primary care system is that mono-provider models of care are becoming outdated, can be more expensive, and will not scale up in an era of increasing workforce shortages and rapidly rising demand.

Recommendation 1b: In the short term, the Australian Government should retain the Workforce Incentive Practice – Doctor Stream (WIP-DS) and Workforce Incentive Practice – Rural Advanced Skills Stream (WIP-RAS) as an incentive to doctors working in rural and remote areas, and refine these to increase their effectiveness in promoting continuity of care.

Within 3 years, the government should consider the evidence and impact of redirecting Workforce Incentive Program (WIP) funding from providers to practices. This redirected funding would enable flexibility and agility in line with the original intention of attracting, recruiting and retaining health professionals in rural and remote practices.

Over time, existing PIP and practice payments – and other relevant programs and payments – should be rolled into the Baseline Practice Payment to ensure general practices remain viable, meeting patient needs and supporting continuity of care. In doing so, the new Baseline Practice Payment should continue to support rural and remote workforce objectives, such as maintaining services and increasing comprehensive primary care in underserved communities.

2. Support for quality care

Recommendation 2: The Australian Government should invest in enabling reforms such as accreditation and a performance framework to support the new general practice blended payments architecture within the context of a cohesive vision for primary care by 2032.

The enabling reforms should:

- promote the provision of safe, accessible, high-quality and value-based care across all primary care services, by reforming accreditation systems
- achieve accountability and support fairness for general practices, providers and patients.

3. Independent pricing of general practice and primary care payments

Recommendation 3: While maintaining the principle that general practices can charge fees for medical services that take into account the practice's own costs and economic imperatives, the Australian Government should establish an independent primary care pricing authority to provide advice on the design and pricing of Commonwealth payments to general practices and primary care providers.

The independent primary care pricing authority should:

- provide evidence-based recommendations and advice to the Minister for Health and Aged Care (the Minister) on the payment design and level of MBS rebates and other Commonwealth payments to general practice and primary care providers, including the level of blended payment mix in primary care expenditure
- make these recommendations based on evidence, including evidence of the costs of providing team-based primary care services, that will underpin pricing recommendations to the Minister
- contribute to the growth in publicly available data on the primary care sector, including its scale, performance, infrastructure, training activities and research engagement
- support the government and the Department of Health and Aged Care in the ongoing design, implementation and evaluation of general practice payments
- regularly report on the financial sustainability of the primary care sector, including the cost-effectiveness of providing primary care compared to the secondary and tertiary care sectors
- monitor, support and conduct research on innovations in funding arrangements (for example, pooled funding across hospital and primary care settings) and other value-based healthcare initiatives.

4. Effective transition to the new payment model

Recommendation 4: The Australian Government should facilitate an effective transition to the new payment model to achieve the future vision for general practice.

The transition should include:

- a phased approach to implementing the reforms, delivering more funding to primary care in the early phases of the rollout

- a 10-year funding commitment (with the majority of investment achieved by 2032) that includes:
 - additional funding for new general practice payments under the new payment architecture
 - specific funding and support for change management activities to enable general practices to transition to new arrangements, including education and training for practices and clinicians, investment in digital maturity, and support for clinical governance and practice management
- seed funding and support for primary care services to become eligible for Commonwealth payments, so these services can expand their infrastructure to facilitate in-house multidisciplinary care
- deep partnership and engagement with the primary care sector during the design and implementation of these reforms, including investment in education and training as the sector transitions to the new payment model
- clear and continuous communication with stakeholders and the primary care sector
- deliberate sharing of innovation and best practices to stimulate replication across the sector
- government commitment to continuity of services and funding, including research, data and modelling of the effects of reforms on the primary care sector, through the Medical Research Future Fund (MRFF) and otherwise
- a continuous cycle of monitoring and evaluating reform outcomes, and using these learnings to refine and test the subsequent evolution of the funding model.

Policy context

The Review of General Practice Incentives

Building on the *Primary Health Care 10 Year Plan*, the Australian Government commissioned reviews to provide advice on reforms required to support the effective implementation of the *Strengthening Medicare Taskforce Report*. The Review of General Practice Incentives was announced in the 2023–24 Budget. It aims to improve access to quality, multidisciplinary, patient-centred primary care by redesigning current general practice incentive programs to better align with Strengthening Medicare recommendations. The review includes an examination of payments currently made through the PIP and WIP – further information on these programs is provided in Appendix 3.

The review considered the role of nursing, allied health, pharmacy, midwifery and other specialist medical service provision as part of a person's primary care team. It recognised that these healthcare providers all play a role in enriching the multidisciplinary teams available to patients in general practice and broader primary care settings.

The Department of Health and Aged Care established the Expert Advisory Panel (the panel) to oversee the review. Panel members were selected as eminent individuals in the fields of general practice administration, health system financing and funding, state and territory hospital and community health financing, health economics, primary care nursing, Aboriginal and Torres Strait Islander health, rural and remote health, and general practice (see Appendix 5 for a list of members and Terms of Reference).

The panel's work was supported by 2 projects:

- An Effectiveness Review of General Practice Incentives, conducted by KPMG, found that WIP – Practice Stream (WIP-PS) and PIP are perceived as sustaining basic general practice operations and ensuring consumer access to general practice rather than as incentivising any particular behaviours. The sector regarded these programs as administratively burdensome, difficult to understand, insufficiently funded and not strategically aligned. A summary of findings is provided in Appendix 6.
- A national and international literature and evidence review conducted by the University of New South Wales found that blended payment models can enhance care quality and deliver greater value to providers and patients when planned carefully alongside analysis of the changes in costs and changes in benefits to patients and providers. A summary of findings is provided in Appendix 7.

A consultation process in August and September 2024 sought stakeholders' views on the emerging recommendations of the review. We heard views from a diverse and passionate range of stakeholders through a series of roundtable meetings, webinars, department stakeholder committees and meetings with peak organisations.

This review is one of a few reviews that aim to support the evolution of primary care in Australia towards a patient-centred, contemporary, integrated system. Other complementary government-initiated reviews include the following:

- The *Independent review of health practitioner regulatory settings* was endorsed by National Cabinet in December 2023. The final report included recommendations to ease health workforce shortages while maintaining high standards in healthcare quality and patient safety.
- The *Unleashing the Potential of our Health Workforce – Scope of Practice Review* is an independent review currently examining the barriers to and enablers of health practitioners working to their full scope of practice in primary care. The final report of this review is due in October 2024.
- The *Working Better for Medicare Review* examined the effectiveness of current distribution levers. This review, completed in mid-2024, makes recommendations on current laws and policies that can further encourage health professionals to work in areas of workforce shortage.

- The *Review of after hours primary care policies and programs*, completed in mid-2024, considered the need for after hours primary care services, the current state of after hours service provision, and successful models of primary care after hours service provision.⁵
- The Medicare Benefits Schedule Review Advisory Committee (MRAC) *Review of allied health services accessible under the MBS Chronic Disease Management arrangements* will assess whether these services are adequately supporting patients with chronic conditions, and whether individual and group MBS allied health services could be improved to better support eligible patients. MBS general practitioner planning items will not be considered in the review. The review commenced in August 2024 and is anticipated to take approximately 18 months to complete.
- Renegotiation of the *National Health Reform Agreement (NHRA) Addendum* to embed long-term, system-wide structural health reforms, including considering the NHRA Mid-Term Review findings.
- The *MBS Review Taskforce Final Report* outlined the taskforce's approach and achievements in continuous review and reform of the MBS. This review recommended rebalancing healthcare financing from a near-exclusive reliance on fee-for-service payments to complementing fee-for-service income with blended payments.⁶

The panel was briefed on these reviews and engaged with other review teams to ensure alignment of focus and outcomes.

General practice business models and funding flows

In Australia, general practices are owned and managed under various business structures. Each business structure has different obligations, advantages and drawbacks, along with different risk profiles, tax implications and levels of complexity. The most common business ownership structures are sole trader, partnership, company (corporate), service entity (such as tenant models) and trust.

As part of designing and implementing a new payment model, consideration will need be given to how funding is managed within a practice (fee-for-service and blended funding), including the remuneration and engagement structure for healthcare providers. This may involve alternatives to the contractor/tenant model for GPs – including single-employer models that provide GPs and rural generalist registrars guaranteed income and entitlements such as annual and sick leave through partnerships between the Australian and state governments. This could also involve support for new ownership models in addition to for-profit private practice in areas with large populations and high demand.

Parity of income for GPs and primary care nurses in comparison with the hospital sector also needs to be considered, to prevent loss of providers to the acute care sector and to make general practice a more attractive and sustainable career.

The Royal Australian College of General Practitioners *General Practice: Health of the Nation 2023* survey showed that 81% of GPs who received a salary in 2022 and 2023 reported moderate to high job satisfaction, compared to only 66% of GPs who are remunerated by proportion of billings. GPs working in ACCHOs reported the highest level of overall job satisfaction, at 88%.⁷

Business models for private practice are increasingly focused on other speciality care needs like skin, cosmetic, workplace and travel medicine, which offer higher income potential but a narrower scope of lower-value services, diverting the primary care workforce away from clinical areas of higher need. Addressing the income disparity and clinical risk reduction some of these models offer, and ensuring

⁵ The panel provided advice to the department to inform the review of after-hours primary care policies.

⁶ Department of Health and Aged Care (2020) [An MBS for the 21st Century: Recommendations, Learnings and Ideas for the Future](#).

⁷ Royal Australian College of General Practitioners (2023) [General Practice Health of the Nation 2023](#).

broader general practice retains its appeal, would be a consideration for the proposed review of sub-specialty services.

Specialty services have evolved to meet the specialised needs of migrant and high-needs communities – such as the LGBTQIA+ community, and those with alcohol and other drug issues. These services have been hampered in their growth because their teams often do complex work for poor remuneration, limiting access to staff. Under the panel’s vision, these services would benefit from a disproportionately increased ratio of doctors to other care team members, which may make working in these services more attractive. Availability of staffing could then free these services to pursue an expanded vision for more comprehensive whole-of-life care, enabling their whole business model to evolve.

A unified system for general practice funding

A vision for general practice

Funding for general practice should be redesigned to align with a vision of what improved general practice looks like. Figure 1 shows a vision for the future of primary care and general practice. It focuses on the needs of the patient, and the capabilities of the provider and system.

The health system, including general practices, exists to enable consumers to receive the care they need for better health and wellbeing. A high-performing primary care system is key to achieving proactive, coordinated care that integrates the services offered across the health spectrum. Consumers and their carers and families should be at the core of all efforts to reform and improve general practice and primary care. Funding should be designed to promote quality care and the best possible health outcomes delivered at best value. Services should be accessible to all, with a focus on those who have higher care needs. New blended funding models, introduced as part of a long-term commitment from the government, should build confidence in the continued financial viability of primary care services. These blended funding models should send signals to doctors, nurses and other provider groups that careers in primary care are attractive at all levels. This is especially important in geographic areas of high need and for priority populations that have difficulty accessing quality, comprehensive, primary care.

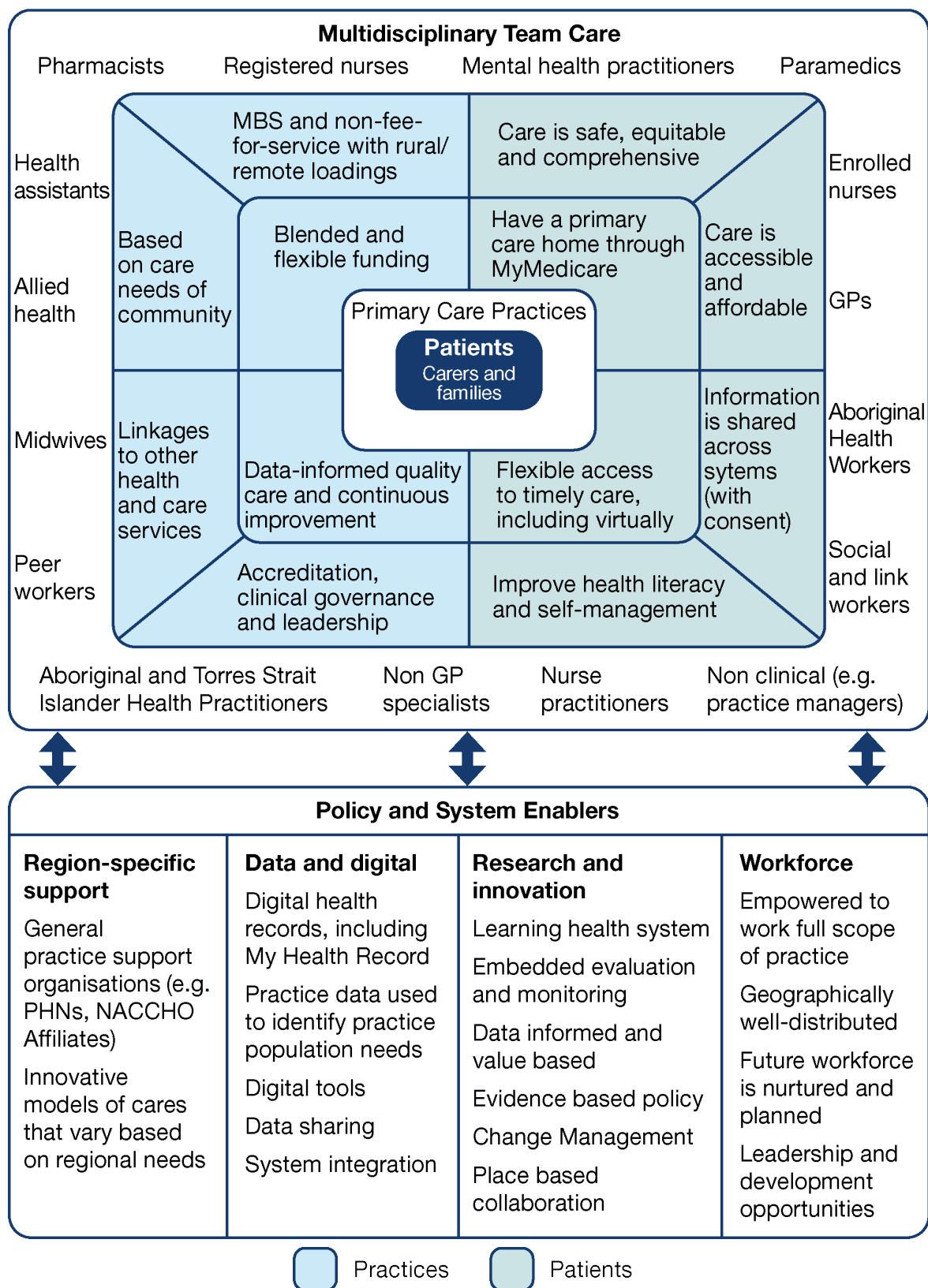
The vision focuses on general practices working to improve the overall health of individuals by building primary care system capacity and service capability to improve access and strengthen integration across the healthcare system. This includes ensuring patients can move seamlessly:

- within and between different primary care settings
- between primary care and hospital-based care and aged care settings.

To achieve this long-term vision, reforms should be planned and staged to provide a clear path forward for the sector, patients and the government. Chapter 4 of this report discusses the requirements for effectively transitioning to and implementing these reforms.

Figure 1: Long-term vision for practices and patients

In 2032, primary care practices should look like...



Principles to inform general practice funding policy

Any future general practice funding reforms should be designed to deliver on this report's vision. The design, implementation and evaluation of reforms should be underpinned by guiding principles based on the *Primary Health Care 10 Year Plan*, the *Strengthening Medicare Taskforce Report* and the Quintuple Aim Framework.⁸ These guiding principles are set out below.

Principle 1: Patient and carer centred

Patients' and carers' experience of health services, are at the centre of primary care funding reform. Models of funding should enhance patient access and experience, and enable patients to better self-manage (if they choose) as a precursor to better health outcomes.

Principle 2: Enabling team care

To promote multidisciplinary teams, funding should encourage all team members to work to their full scope of practice. Funding should support a minimum ratio of 1:1 GPs to other healthcare professionals in multidisciplinary teams, with more in high-needs settings. Funding should enable a broad range of primary care models that deliver comprehensive primary care. The achievements of the ACCHO model, public community health centres, and some not-for-profit and privatised solutions in primary care demonstrate the potential to encourage flexible uses of funds to achieve team care. This may include GP- and nurse-led models, and embedding allied health professionals and pharmacists in general practice. Progress in this area should involve comprehensive discussions among all the stakeholders involved to ensure smooth implementation and broad acceptance of the changes by patients, providers, practice owners and funders.

Principle 3: Enabling equity

Funding should encourage sustainable models of care that respond to determinants of health, and address high-needs groups, rural and remote Australia, and marginalised groups. This includes supporting improved access to primary health care, including care that is closer to home, more convenient and at a lower cost to consumers. Funding should be available to enable place-based solutions in hard-to-serve and marginalised communities, which are co-designed and evaluated with providers and the communities they serve.

Principle 4: Contemporary and evidence-based

Models of funding and care should be based on data, evidence and sharing of best practice. To facilitate this, a shared national primary care data resource should be developed, with data collected once and used for multiple purposes. It can collect evolving data on the work, needs, outcomes and costs in primary care. Growth in digital maturity, leadership and clinical governance functions across the sector – from government investment in education, training, and new clinical leadership and practice management roles – can support this. Data and data exchange will increasingly be used to inform planning and decision making for primary care and across the health system.

Principle 5: Transparency, simplicity and accountability

Funding models should be easy to understand, and efficient to administer for general practices and funders, enabling planning and minimising unintended consequences. General practices should be held accountable for the delivery of care, use of funding, and provision of data on service delivery and health outcomes. Indicators will be used to show ongoing improvement in infrastructure (digital, physical and systems), knowledge sharing, replication of success, data use and team impact.

⁸ S Nundy, LA Cooper and KS Mate. [The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity](#). *JAMA*. 2022;327(6):521–522.

Principle 6: Integration and prevention

Funding should promote integration across the continuum of health and social care. Health funding should encourage community development, including care pathways, care neighbourhoods and place-based responses. Patient outcomes will be improved through general practices and providers working together across the health and social care system, including state and territory health services. This will help to create a health system that is patient-centred and promotes wellness, rather than the current 'sickness model' that overly focuses on acute and crisis presentations. Social prescribing, care coordination and system navigation will be instituted across general practice.

Chapter 1 Payments and programs to Strengthen Medicare

Recommendation 1a: The Australian Government should introduce a new opt-in, simplified general practice payment architecture that better supports community and patient needs and encourages high-quality, accessible and multidisciplinary care.

The new blended payment architecture should:

- include a new Baseline Practice Payment that:
- enables general practices to flexibly use funds to provide appropriate multidisciplinary care to the populations they serve
 - includes funding for coordinating the primary care team
 - is calculated based on patient needs, socio-economic status and location
 - include funds and/or programs to promote quality and innovation, teaching, after-hours care and targeted initiatives
- require general practices to participate in MyMedicare to access these payments, so that all patients, whether registered in MyMedicare or not, will benefit from the MyMedicare system
- require general practices to provide comprehensive service delivery information and data, to support quality improvement, monitor health outcomes, calculate reimbursements, and inform planning and evaluation.

The panel believes the new payment architecture will require increased Australian Government investment to ensure its effectiveness, fund the necessary change supports, and ensure practice viability during and after the transition.

The government should further consider how sub-speciality primary care providers can be funded to work with general practices as part of a multidisciplinary team that delivers comprehensive primary care for specific populations. The lesson that must be reinforced for all elements of the primary care system is that mono-provider models of care are becoming outdated, can be more expensive, and will not scale up in an era of increasing workforce shortages and rapidly rising demand.

Recommendation 1b: In the short term, the Australian Government should retain the WIP-DS and WIP-RAS as an incentive to doctors working in rural and remote areas, and refine these to increase their effectiveness in promoting continuity of care.

- Within 3 years, the government should consider the evidence and impact of redirecting Workforce Incentive Program (WIP) funding from providers to practices. This redirected funding would enable flexibility and agility in line with the original intention of attracting, recruiting and retaining health professionals in rural and remote practices.

Over time, existing PIP and WIP practice payments – and other relevant programs and payments – should be rolled into the Baseline Practice Payment to ensure general practices remain viable, meeting patient needs and supporting continuity of care. In doing so, the new Baseline Practice Payment should continue to support rural and remote workforce objectives, such as maintaining services and increasing comprehensive primary care in underserved communities.

Overview

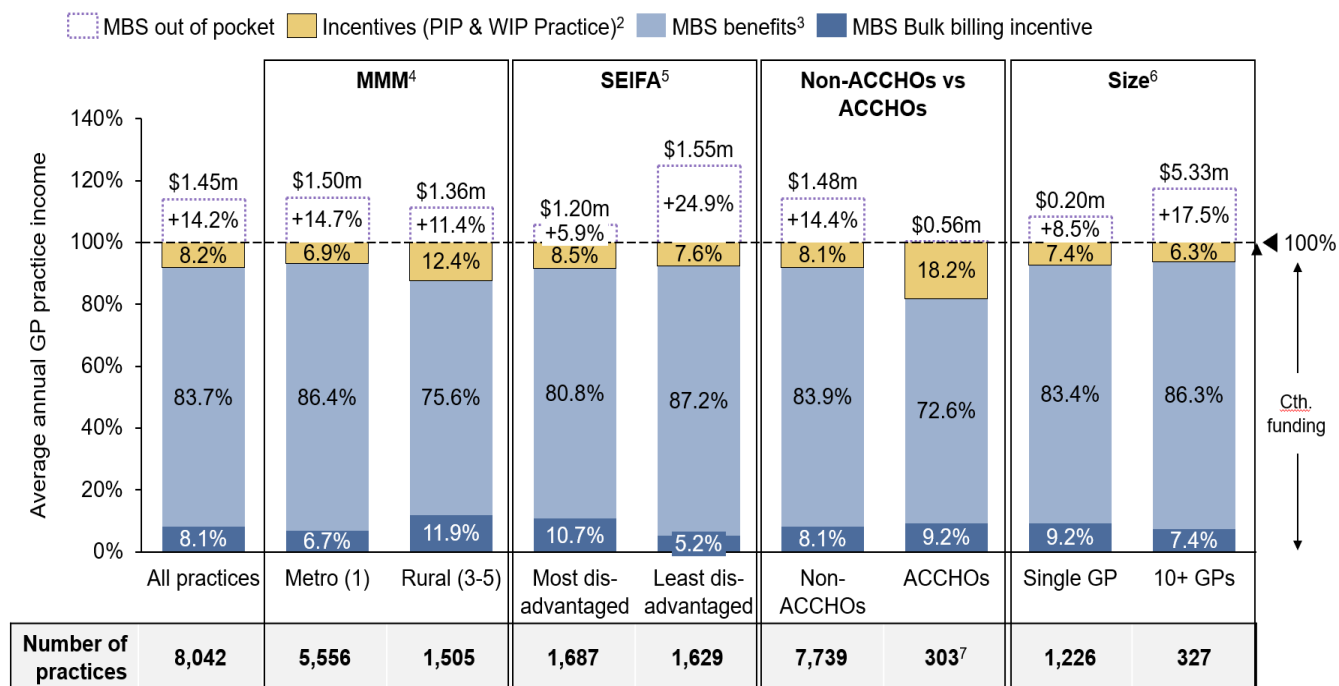
A simplified payment architecture should be implemented to promote access to quality, multidisciplinary primary care, and should contain the following elements.

- **Baseline Practice Payment:** financial support provided to practices to embed multidisciplinary care in their service delivery. This is the core of the new payment architecture because eligibility for other incentives depends on first meeting the eligibility criteria for this payment. This payment would be higher for general practices that have patients with more complex needs, practices in rural areas, and practices serving patients of lower socio-economic status.

- **Quality and Innovation Program:** a structured program of payments to promote data-informed continuous improvement and innovation. It would enable general practices to work with their PHN or other sector support organisations to develop and implement a continuous quality improvement (CQI) plan informed by reliable benchmarks across a growing variety of indicators.
- **Teaching payment:** a payment for providers and general practices to support quality teaching and supervision in general practices for the entire practice clinical team.
- **Targeted programs:** support for general practices and providers to provide specific bundles of care to priority high-needs populations that are not effectively supported through existing funding mechanisms.
- **After-hours care support payment:** financial support to general practices providing or deputising after-hours services for their patients.

Currently, the MBS accounts for an average of over 90% of Commonwealth funding paid to general practices at a system level. The remaining 10% of funding is a combination of the PIP, WIP, and other government grants and programs. This funding split varies significantly across practice types and by regionality. For example, practices in the least disadvantaged Socio-Economic Indexes for Areas (SEIFA) received on average 7.6% of their income from blended payments compared to an average of 18.4% for ACCHOs (see Figure 2).

Figure 2: Average general practice income from the Commonwealth by practice type and funding source¹



1. Data in this chart covers the period 1 February 2023 to 31 January 2024. 2. Includes ACAI, After-hours PIP, eHealth PIP, Indigenous health PIP, Procedural GP PIP, Quality Improvement PIP, Teaching PIP, PIP and WIP rural loading, and WIP Practice for the reference period 1 February 2023 to 31 January 2024. Does not include WIP Doctor Stream, WIP Rural Advanced Skills and IAHP funding. WIP – Doctor Stream data is not available at the provider level and cannot be attributed to a practice. WIP Rural Advanced Skills commenced on February 2024 and data is limited. IAHP funding was excluded as data on other types of grant funding (such as PHN grants) was not readily available. ACCHOs received approximately \$539 million in FY24 IAHP funding to deliver comprehensive primary health care. 3. MBS data covers services rendered between 1 February 2023 to 31 January 2024, processed prior to 9 August 2024. Only covers services that are considered a primary care service according to the primary care service types in the Medicare quarterly statistics and were claimed by a provider in a GP practice during the reference period. GP practices are those in the Department's practice list that have been identified as a GP practice based on manual review including PHN review. The practice list uses the physical location of providers to derive a set of practices and cross-checks this against existing datasets such as PIP data. The list is then reviewed manually, including by PHNs. 4. Based on the postcode of the practice location. 5. SEIFA refers to the Index of Relative Socio-economic Disadvantage quintile of the postcode of the practice. 6. Based on the number of GPs full-time equivalent (FTE) in the practice. 1x FTE defined as a GP claiming for 240 days in the MBS. 7. These represent 300 ACCHO sites that have Commonwealth income data available. Excludes an additional 15 ACCHO sites that do not have data.

The panel supports the proposal in the *Primary Health Care 10 Year Plan* that an average of 40% of practice income should not come from fee-for-service payments. Some practices may have more than 40%, some less.

Increasing the proportion of general practice revenue from non-fee-for-service payments from 10% towards 40% will provide practices the opportunity to be more flexible with how they fund their team's time. This will enable practices to:

- engage and coordinate multidisciplinary teams, tailored to need
- allocate time outside of consultations for clinical planning and follow-up
- engage in more proactive and preventive care
- schedule additional time with the multidisciplinary team for patients with complex and chronic needs
- facilitate ongoing clinical governance and continuous conformity with accreditation standards
- participate in quality improvement (QI) activities in general practice and with PHNs (or other relevant organisations)
- engage in research, training, and system integration and transformation efforts, including place-based responses.

Blended funding already comprises a much greater proportion of funding for ACCHOs than for other service types. They already have more mature teams and governance, and will start the change journey from a

more advanced position. Similarly, many Victorian community health centres already incorporate multidisciplinary teams, albeit with much of the funding for those teams coming from the state government.

The new funding approach will provide a more attractive work environment for GPs and nurses, and will assist in recruiting more new medical graduates and other trainees to work in primary care. Eligible general practices and providers, especially those willing to drive innovation and research, will have access to additional funding. The Baseline Practice Payment is primarily to enable practices to become truly multidisciplinary, so patients can benefit from a wider range of disciplines than most practices provide today. Remuneration for GPs may not change substantially and may still be primarily from fee-for-service payments, augmented by top-ups for involvement in care coordination, teaching and other roles.

The Baseline Practice Payment is not intended to replace other forms of block funding that some primary care organisations receive outside PIP and WIP. For example, the ACCHO sector receives block funding through the Indigenous Australians' Health Programme.⁹ This funding helps ACCHOs deliver comprehensive primary care as articulated through the National Aboriginal Community Controlled Health Organisation (NACCHO) Core Services and Outcomes Framework.¹⁰ The Baseline Practice Payment is not intended to replace this funding but should support more equitable funding to assist the delivery of multidisciplinary clinical care in ACCHOs.

The following are case studies of organisations that deliver comprehensive primary care that align with the panel's vision.

Box 1: Adapted from Inala Primary Care Business Rules

- Patients are at the centre of care and part of the care team alongside their carers and families.
- GPs are the centre of the patient care coordination team.
- Patients nominate a preferred GP and practice nurse to oversee their care.
- The medical workforce mostly comprises fellows, ensuring great training for registrars and quality and safety for patients.
- The medical team has time to spend with each patient and can deal with complexity.
- Quarantined time for 'on the day' appointments enables us to deal with acute care needs.
- Patients are informed of their choices and have time to consider what is best for them.
- The team builds safety by communicating about concerning patients and trends.
- If a therapeutic relationship cannot be sustained, handover of care is arranged.
- Systems are in place so everyone works to the top of their scope of practice.
- Continuity of care is embedded, including in patient homes, aged care and hospitals.
- Value is delivered by integrating with hospitals and other care providers.
- Care can be delivered in the right place at the right time by the right person.
- Teaching is a key contributor to continuous education, innovation and workforce development.
- Social prescribing is a key part of care and supports integration with local services.
- Technology is adopted early and supports efficient care support systems.
- The workplace is attractive, and work arrangements are flexible and foster teamwork.
- Data is integral to operations and is used to support evidence-based decisions.
- Data is used to monitor performance and share responsibility.

Disclaimer: Expert Advisory Panel member Tracey Johnson is CEO of Inala Primary Care.

Box 2: The Alaskan Nuka System of Care

The Alaskan First Nations 'Nuka' model of primary care has been adapted by some primary care organisations in Australia.

⁹ Department of Health and Aged Care (2024) *Indigenous Australians Health Programme*, DoHAC.

¹⁰ National Aboriginal Community Controlled Health Organisation (June 2021) [Core Services and Outcomes Framework: The Model of Aboriginal and Torres Strait Islander Community-Controlled Comprehensive Primary Health Care](#). National Aboriginal Community Controlled Health Organisation, Canberra, ACT.

1. Teamlets (within the practice) include a GP and one or more supporting clinicians who work within the practice. Practically, this can incorporate a nurse, medical assistant, Aboriginal health workers, and a practice manager or senior receptionist. In some cases, other health professionals may lead a teamlet depending on the practice business model, including nurse practitioners. The teamlet is responsible for **care coordination and timely access to care** of the patient. There are often multiple teamlets within a practice (depending on practice size).

2. Practice-wide teams (within the practice) include an interdisciplinary range of health professionals that support numerous teamlets and sit across the practice. These team members can include dietitians, diabetes educators, podiatrists, pharmacists, social workers, behavioural health consultants, other allied health professionals and midwives.

3. Shared services (outside the practice) include a further layer of clinicians who are chosen based on patient need and are available to the team (subject to funding and workforce). These team members can include a range of allied health professionals, psychologists and psychiatrists, pain and addiction physicians, lactation consultants, paediatric nurse practitioners, HIV and hepatitis nurse consultants, infectious disease physicians, and home-care nurse practitioners.

Speciality resources (outside the practice) include specialists who are generally available through referrals. These professionals provide specialist care to patients. These professionals include (but are not limited to) surgeons; oncologists; dentists; ear, nose and throat specialists; cardiologists; and geriatricians.

Box 3: Institute for Urban Indigenous Health model



The Institute for Urban Indigenous Health (IUIH) is a large regional Aboriginal Community Controlled Health Service (ACCHS), established in 2009 by its 4 founding-member ACCHSs to drive a unified vision for strong and healthy Aboriginal and Torres Strait Islander children, families and communities in urban South East Queensland (SEQ).

The IUIH Network collectively provides comprehensive primary healthcare services from 19 clinic locations across SEQ, covering a region that includes 12% of Australia's Aboriginal and Torres Strait Islander population.

In an effort to keep up with population growth, to expand access and to secure continuity of relational care, the IUIH Network has been trialling a reform of its model of care – known as the IUIH System of Care 2 (ISoC2). The development of ISoC2 builds on over 50 years of knowledge and experience from the ACCHS sector, and over a decade building a networked system of care in SEQ. It incorporates extensive research into, and adaptation of, international best practice, including the Alaskan Nuka System of Care.

At the heart of the ISoC2 model is the 'pod' – a core team of 4 care providers with whom clients and families develop an enduring, ongoing relationship, and who provide the majority of care. The 4 core care providers in a pod are:

- a health and wellbeing worker
- a nurse
- an administration worker
- a GP.

A social healthcare coordinator also works across a maximum of 2 pods.

Within the pod, a range of system drivers ensure care is distributed across the care team, with each care provider working to the top of their licence. Clients are able to access and communicate with their care team directly, with care provided by the most appropriate pod team member, in the most appropriate mode, according to client and family needs and goals.

As the IUIH Network moves from smaller clinic environments and teams to establishing larger-scale primary healthcare 'hubs' in areas of rapidly growing Aboriginal and Torres Strait Islander populations in SEQ, the ISoC2 approach enables clients and families to build and retain trusting, connected and continuing care relationships with their pod team, within the broader hub environment.

The pod facilitates coordination of care and connection to the breadth of available multidisciplinary specialist, allied and related services – including mental health and wellbeing, oral health, birthing and early childhood, child and youth, and elder care services. This may be done under one roof in the ACCHS clinic, or walking alongside clients and families to access and engage with required services and supports in the broader health ecosystem.

Box 4: OneBridge nurse practitioner-led model

OneBridge, located on Queensland's Sunshine Coast, is a nurse-led mobile health and social service organisation aimed at addressing healthcare disparities among marginalised and priority populations in Australia, particularly those experiencing poverty, homelessness or any form of vulnerability. It was founded by Sonia Martin – a registered nurse, Churchill Fellow and associate professor – and operates as a social enterprise in New South Wales and Queensland, with a national focus on expansion to provide equitable, accessible health care to all Australians.

The services OneBridge provides include:

- primary health care delivered face to face and in person by enrolled and registered nurses (place-based and outreach)
- nationally available telehealth video consultations with specialist nurse practitioners
- links to local bulk-billing GPs
- chronic disease management (such as chronic obstructive pulmonary disease, diabetes and heart disease)
- dental and podiatry care pathways
- wound care (chronic and acute)
- sexual health care
- mental health care, and suicide prevention or postvention services
- flu vaccinations for priority populations
- skin cancer screenings and pathways to treatment
- naloxone supply and needle/syringe provision
- hepatitis C testing and treatment pathways
- assistance navigating social determinants of health for individuals and families, and consequential barriers
- social prescriptions for vulnerable populations
- migrant and homelessness support services
- nursing student placements
- referrals to specialists and local support organisations.

The OneBridge model employs a 'nurse up front' approach, whereby enrolled and registered nurses provide place-based or outreach healthcare services. Central to the OneBridge model is the relational dynamic between the nurse and the individuals served. In this model, trust, empathy and compassion form the basis of care delivery, and are essential to the framework of care in each consultation. OneBridge providers also dedicate time to the social aspects of health care including social determinants of health.

On-site OneBridge nurses are supported by nurse practitioners specialising in various fields such as women's health, diabetes, Indigenous health, rural and remote care, skin cancer treatment, and youth health and paediatrics, offering consultations via video-based telehealth access. This enables the provision of specialist care directly in diverse Australian community settings, such as on park benches (for rough sleepers), in transitional or social housing environments, and at specialist homeless community centres.

OneBridge adopts a harm-minimisation approach, offering support for substance use through the distribution of safe-use needle kits, and provision of drug and alcohol interventions as a registered alternative supplier of naloxone, a registered member of the needle and syringe program, and the national hepatitis C testing program.

In addition to direct healthcare services, OneBridge conducts equity-based community mapping in the regions where it operates, facilitating integration with broader primary (local GP medical centres), secondary and tertiary healthcare services. It collaborates with specialised organisations in local communities to ensure a holistic and integrated approach to care, contributing to the broader health landscape. Its patient population is diverse, including individuals recently released from incarceration, those experiencing homelessness, unaccompanied minors, LGBTQIA+ persons, families residing in temporary or social accommodation, sex workers, migrants, and Indigenous Australians. OneBridge operates with no eligibility criteria, ensuring open access to all Australians in need of healthcare services.

Furthermore, OneBridge emphasises the importance of social prescriptions as an alternative mental health support mechanism. Recognising the financial barriers that vulnerable and priority populations face, the service supports activities such as art therapy and Australian Bush Therapy (inspired by Japanese Forest Therapy) for individuals who cannot afford traditional leisure or therapeutic activities. These interventions not only support mental health but also foster the restoration of joy and wellbeing, particularly for individuals with histories of complex trauma.

Figure 3: Proposed payment architecture

A simplified general practice payments architecture to promote multidisciplinary and patient-centred primary care

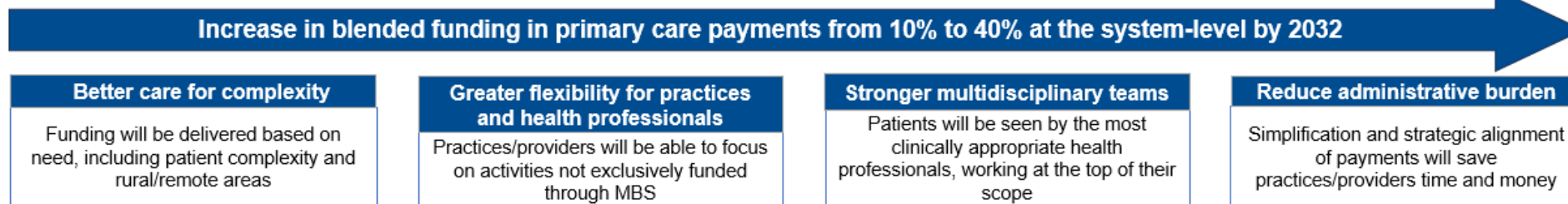
	Baseline Practice Payment		After hours	Quality and innovation program	Teaching Payment	Targeted programs
Outcome	Practice focused			Practice and provider focused		
	Patients with complex and chronic conditions have their healthcare needs met through a multidisciplinary team-based approach integrated within their general practice	Patients and communities in rural and remote areas get the care they need, provided locally where possible	Patients can access affordable after hours primary care	Patients receive contemporary high-quality and best practice services that are agile to meet their changing healthcare needs	Medical and non-medical students can receive high-quality teaching and training in general practice	New programs in <u>exceptional</u> circumstances to address health challenges for specific populations (e.g. GPACI, First Nations)
Approach	Core funding to practices weighted by patient need/ characteristics	Consider the impact of redirecting WIP rurality provider payments to practices	Support continuity of care with regular practice/ provider	Promote practice-led CQI through financial support for general practice and system-wide support through PHNs (or other sector support organisations)	Support practices to offer high-quality training, including through supervision	Regularly review to assess effectiveness

New payments are supported by enabling reforms and ...

Accreditation	Compliance	Change management	Workforce	Pricing authority
Promote the provision of high-quality care across all general practice services through accreditation reforms	Promote accountability	Support practices to transition to new arrangements	Workforce is strengthened to enable access to health and social care (also supported in other government reviews)	Independent pricing authority to advise on pricing Commonwealth payments to general practice and primary care

... data-driven costing advice

On average, new payments will result in ...



Baseline Practice Payment

Multidisciplinary teams and doctors in rural and remote areas are currently supported through \$489 million in WIP payments annually. These payments flow to more than 5,900 general practices and around 8,500 doctors nationally. Around 98% of these practices engage a nurse. However, many of these nurses are not working to their full scope of practice.¹¹ Around 28% of practices engage an allied health professional for at least part of the week. The role of multidisciplinary teams in primary care is also supported by a number of other arrangements such as chronic disease management MBS items, an MBS special aged care item, MBS delegated (for and on behalf of) items and medication review items. New MBS items were added in November 2021 to allow allied health professionals to claim for participating in case conferences.

The *Primary Health Care 10 Year Plan* identifies payment systems that can be used as a mechanism to embed multidisciplinary team care in primary health care, including supporting providers to work to their full scope of practice. The *Strengthening Medicare Taskforce Report* recommended prioritising increased investment to support multidisciplinary teams in general practice. Additionally, combining the various incentive payments into a single payment for multidisciplinary care would simplify payment administration. It would also encourage the engagement of a range of health professionals in general practice and reduce billing complexity. Appropriate accountability mechanisms would need to be in place. Extra investment is also required to ensure that payments adequately account for general practice costs. The payment calculation settings must be updated periodically to reflect changes to general practice costs.

The Baseline Practice Payment will provide predictable funding, in addition to the MBS, that practices can use as they wish to support and build multidisciplinary teams, both in house and through collaboration with partners. The objective is to give general practices flexibility to create care teams for their patients. Core team members would work together to plan and deliver clinical care, and coordinate and access supports based on patient need. Typically, a core team would include a GP, nurse and case manager who could be a medical practice assistant or receptionist. They would access support from an extended care team that would include services such as pharmacy, midwifery, social support (e.g. a link worker or social worker), allied health and mental health providers and, where desirable, specialist physicians.

The ACCHO sector has already implemented care teams such as that under the IUIH model (see Box 3). In these settings and other practices with large Aboriginal and Torres Strait Islander populations, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers are an integral part of the central care team. Consultation with First Nations consumers as part of this review substantiates that those consulted recognise the strong benefits of a culturally safe multidisciplinary model of care.¹²

The Baseline Practice Payment would be provided quarterly to eligible general practices, providing certainty about funding each financial year. It would contribute to the costs of employing or commissioning a multidisciplinary team or services, leadership and governance of the team, and care support. It would enable the core values of effective multidisciplinary teams, including clear communication, coordination, and respect and trust among team members, along with well-defined roles and protocols. The Baseline Practice Payment would allow:

- employment or other contractual arrangements with nurses, allied health professionals and peer workers, especially in practices serving many people with mental health conditions, trauma or where English is a second language (replacing WIP-PS funding)
- more flexible use of the time of embedded health professionals (e.g. care coordinators, practice nurses, midwives, pharmacists, allied health professionals and peer workers) for follow-up and patient support

¹¹ Australian Primary Health Care Nurse Association (2023) [APNA Workforce Survey](#).

¹² Consultation with First Nations consumers was undertaken with a select group in one geographical area and cannot be extrapolated across all First Nations communities without further validation.

- further support for coordinating care for patients with complex needs
- planning, implementation and review of QI activities and new initiatives
- review of patient data to enable planning for population-based approaches
- prevention and public health outreach, including through community organisations and participation in place-based initiatives and integrated models of care planning
- reimbursement for GP involvement in care planning and coordination of patients with complex needs.

Based on their level of need, patients will benefit from some free or low-cost (subsidised) services provided within the practice or through a referral to a provider working with the general practice care team. In lower socio-economic areas, additional payments for supporting the team and/or PHN and NACCHO affiliate commissioning of services would minimise any out-of-pocket costs.

As contemplated in the issues papers from the parallel review of scope of practice, this could include seeing a nurse practitioner, physiotherapist, pharmacist, practice nurse, allied health worker or another type of healthcare provider working to the top of their scope, where appropriate, instead of seeing a GP for the same care.

Depending on the quantum of additional funding a general practice receives, team members could support patients with a range of services, such as:

- managing and coordinating appointments and diagnostic tests
- navigating the broader health system
- managing medication
- empowering and supporting patients to practice self-care
- using social prescribing services to address broader social and cultural determinants of health
- following up to ensure patients undertook diagnostic tests or attended referral appointments
- attending in-house appointments or visiting allied health services
- planning discharges and participating in case conferences to manage transitions in care.

The Baseline Practice Payment should be structured to give general practices flexibility to target support to patients with the highest needs or those who would benefit most in their patient population. Practices have many options for the design of process flows and business models to incorporate this payment. They will make choices based on their circumstances, the skills and knowledge of team members, the characteristics of their patient population, and the characteristics and access to local healthcare providers. The payment should include a loading for general practices servicing rural and remote areas as well as areas of increased need and disadvantage. It should recognise the additional costs of providing care in these areas, including less income from fee for service, which cross-subsidises care in most practices.

The panel acknowledges that the current shortages in the primary care workforce in some regions of Australia may impact the implementation of this payment. This should be considered in the design of the payment, noting that the issue may be resolved in the medium term (4–7 years) in response to other government initiatives aiming to boost the health workforce. Other risks that must be considered as part of design and implementation include:

- feasibility for smaller practices that do not have the economies of scale to deliver multidisciplinary care (e.g. limited space and funds for additional consultation rooms or not enough patient activity to justify hiring other health professionals)
- feasibility across rural and remote practices where allied health professionals may be available less frequently (e.g. every 4–6 weeks).

Baseline Practice Payment eligibility

To be eligible for this payment, general practices must:

- be accredited under an approved accreditation scheme (or be exempt)
- provide an agreed set of deidentified data to their PHN (or sector support organisation), including data about the practice team and their contractual arrangements
- participate in MyMedicare.

Over time, the intention is to support all general practices in Australia to become eligible for this payment. In the medium term, eligibility criteria should be extended to include minimum requirements for digital maturity and connectivity. Further, data collection should be expanded to include some organisation-level data to support program design and implementation (e.g. reporting data on practice staff FTEs, their involvement in occasions of service, the reasons for patient visits or chart reviews, and records of work undertaken that is not patient facing). In parallel, work will be needed to develop a national general practice dataset and data standards, as per the *Digital Health Blueprint and Action Plan 2023–2033*.

There should be a risk-based approach to accountability and compliance for the Baseline Practice Payment. As a basic principle, general practices should have the autonomy to design the right team mix for the practice’s population, reporting on payments to PHNs (or sector support organisations). This will ensure that health professionals use the funding to apply their skills, that management overheads are set at reasonable levels, and that payment levels to staff reflect local market conditions, aiding recruitment and retention.

Calculating the Baseline Practice Payment

The payment should be designed to be higher for general practices with more patients per GP and patients with higher health needs (including those impacted by socio-economic determinants of health). It should also be higher where the costs of delivering care are greater (e.g. rural or remote status, serving a higher proportion of marginalised patients or those needing interpreters).

In the first time horizon, the Baseline Practice Payment should be calculated using existing data such as the number of patients (registered with MyMedicare or an estimate of patient numbers from MBS data) and patient socio-demographic factors that are predictors of health needs. This is a common approach in calculating population-based payments.^{13, 14} Weighted Standardised Whole Patient Equivalent (SWPE) method could be used to provide a payment to a practice when more than 75% of a patient’s interactions with general practice occur at that practice. This would be an alternative to MyMedicare for patients who have not registered anywhere and may have good reasons for not enrolling in MyMedicare.

Socio-demographic factors such as sex, age, First Nations status, non-English speaking background and lower socio-economic status are well recognised in many countries and contexts as important predictors of high needs, higher general practice workloads and higher costs of providing care.^{15, 16, 17} Over time, practice-level data on patient morbidity (e.g. chronic conditions) and service delivery costs might be used to calculate payments to general practices. However, current data constraints mean it is not possible to transition immediately to this model. In the longer term, the government should explore the use of improved data to calculate payments collected through the MyMedicare platform and/or patient information systems to calculate care needs and, therefore, payments.

In addition to weightings based on patient need, loadings based on general practice location should be applied to recognise the additional costs associated with delivering care in rural and remote areas, and with

¹³ E Penno, R Gauld and R Audas (2013) ‘[How are population-based funding formulae for healthcare composed? A comparative analysis of seven models](#)’, BMC Health Services Research 13.470.

¹⁴ US Department of Health and Human Services (2022) [Landscape of Area Level Deprivation and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments](#).

¹⁵ Australian Institute of Health and Welfare (2022) [Australia’s health](#).

¹⁶ W Liaw et. al. (2018) ‘[Living in “Cold Spot” Communities Is Associated with Poor Health and Health Quality](#)’ *The Journal of the American Board of Family Medicine*, 31(3): 342–350.

¹⁷ Ministry of Health (2004) Population-Based Funding Formula 2003.

servicing areas with low populations and long travel distances. Loadings should also be used to attract and retain workforce in rural and remote areas. In the short term, for the purposes of the Baseline Practice Payment, patients registered with MyMedicare could be paid at a slightly higher rate to encourage practices to enrol more patients.

Additional weightings should also be used for any other populations where the need is shown to be higher and/or care delivery is more expensive after socio-demographic factors have been accounted for and where data are routinely available. This could include patients who live in aged care homes or disability share homes, areas of social housing with higher rates of non-attendance, patients who need help with navigating care and populations with addictions or mental health diagnoses who need more health coaching and social supports.

Supporting rural and remote Australia through a rural and remote loading in the Baseline Practice Payment

In rural and remote communities, primary care can be provided by private business general practices, non-government organisations, ACCHOs, AMSs, state and territory governments (including public hospitals) and multipurpose health service facilities. Many healthcare providers working in rural and remote areas are on call to provide care 24 hours a day, 7 days a week. Primary care is funded through MBS fee for service, incentive payments and block funding to support rural hospitals and Aboriginal health services.¹²

Health outcomes for Australians vary by location, with mortality rates 1.5 times as high for women living in rural and remote Australia as those living in major cities, and 1.3 times as high for men.¹⁸ The burden of disease from many preventable chronic illnesses is higher and the prevalence of people living with 2 or more long-term health conditions is highest in regional areas.¹⁹ Despite this inequitable distribution of disease, GP availability is lower in rural and remote areas. In 2022–23, Modified Monash Model MM 1–4 areas had between 109.0 and 126.8 FTE GPs per 100,000 population, whereas in MM 6–7, there were between 68.5 and 78.7 FTE GPs per 100,000 population.

The *Primary Health Care 10 Year Plan* identified improved access to primary care in rural and remote areas as a key action to support person-centred primary health care. The *Strengthening Medicare Taskforce Report* highlights the importance of providing rural and remote communities with the tools and resources necessary to flexibly design and fund local solutions.

There is a need for improved continuity of care and access to care as close to home as possible, supplemented with access to telehealth and virtual services. Comprehensive primary care in rural communities that offers care ranging from preventive care to complex chronic disease management is necessary to address the rural burden of disease and problems with accessing health care.

Including rural and remote loading in the Baseline Practice Payment would contribute to the viability of general practices and other primary care organisations in rural and remote communities. It would also support the creation of teams to improve patient outcomes. Providing additional funding for services in rural areas would support:

- differing models of care, broader scopes of practice and team structures to meet community need
- a workforce that delivers care that is patient-focused rather than scoped to practitioner availability
- areas with workforce shortages to supplement or substitute care through other arrangements such as nurse practitioner-led care or care coordinators
- collaborative arrangements such as subsidised care through other regional providers for disadvantaged or targeted groups

¹⁸ L Bishop, FW Gardiner, B Spring, L Gale, Z Schofield and F Quinlan (2023) [Best for the Bush](#). Canberra, Royal Flying Doctor Service of Australia, p 7.

¹⁹ National Rural Health Alliance (2023) [Rural Health in Australia Snapshot 2023](#), p 5.

- virtual healthcare models that complement face-to-face care to assist patients to access timely and safe, quality care
- general practices to offer other non-financial incentives, such as additional leave to visit family, accommodation subsidies, and professional development support, that will attract and retain providers.

The rural and remote component of the Baseline Practice Payment would recognise the higher costs of delivering services in these areas and the need to attract a workforce to sustain quality patient care. Rural practices are often smaller, with fewer opportunities to benefit from economies of scale in operating costs. The need and demand for primary care services are greater than what is currently being met. The business and healthcare model could be adapted to support different arrangements to engage health providers. It could be through salary support or MBS billing percentage splits across providers and practices. Consistent with the panel's emphasis on practice autonomy in determining the composition of multidisciplinary teams, practices should have autonomy about allocating rural supplement funding, subject to light touch accountability to the PHN or other support organisation.

Currently, a significant amount of WIP investment is paid to general practices and doctors in MM 3–7 areas to support workforce engagement in primary care. The WIP – Doctor Stream (WIP-DS) provides funds directly to doctors, based on length of service and remoteness (MM 3–7). All the WIP and PIP rural loadings could be consolidated into the one rural loading in the Baseline Practice Payment formula. MBS rural loadings remain separate from this. This offers choice to how general practices operate their businesses and flexibility to apply financial and non-financial incentives to attract and keep their workforces. A range of Australian Government measures aim to improve access to health providers and services in rural and remote areas. Rural loadings are applied through general practice incentives, such as the WIP, PIP, Rural Bulk Billing Incentive and Rural Procedural Grants Program (see Appendix 3).

The proportion of WIP payments and total payment amounts by MM have remained generally consistent since 2020, with approximately 80% of payments made to doctors who had worked for 5 years or more in an eligible MM region. Conversely, the WIP-PS appears to have contributed to growth in non-medical primary care providers in rural and remote areas. Nationally, the number of general practices, including ACCHOs, receiving WIP-PS payments has remained static, with 23% of practices in rural locations classified as MM 3–7. Practice participation in MM 7 has grown by 4% a year over the past 3 years. The number of providers recorded under the WIP-PS increased 15% between 2020 and 2023. The greatest growth was 52% in MM 6–7, followed by 22% in MM 3–5. We recommend that the new Baseline Practice Payment maintain the value of these loadings for each practice, though they would be delivered in a different way.

The Effectiveness Review of General Practice Incentives found the following in relation to the rural and remote workforce:

- The WIP-DS appears to have had minimal effect in relation to the aim of increasing the number of doctors working in primary care in rural and remote areas.
- Providers' choice of where to work is influenced by multiple factors. Financial rewards are not working to encourage GPs to work in rural and remote areas. Other factors include, but are not limited to, work–life balance, professional support and community engagement.
- The WIP-PS, WIP-DS and PIP rural loadings are perceived as sustaining basic general practice operations and ensuring consumer access to general practice in rural and remote areas.
- There is a need to improve the supply and distribution of GPs and other healthcare providers in underserved areas such as MM 6–7.
- The limited pool of health providers in rural and remote areas leads to competition between sectors for the workforce.

- General practices tend to prioritise familiar roles, such as nursing, over more diverse multidisciplinary roles.

There is a lack of available evidence that financial incentives paid directly to doctors improves geographical distribution of doctors providing primary care in rural or remote communities.^{20, 21} Consultation on the panel's draft recommendation to redirect health provider funding (WIP-DS and Rural Advanced Skills Stream (RAS)) to general practice showed that an impact assessment and modelling, along with further consultation with the sector about the change, would be beneficial. The panel subsequently revised its recommendation to allow time for this to occur. Meanwhile, modifications should be made to the WIP-DS and WIP-RAS to provide greater assurance that the program improves recruitment and retention of doctors and other health professionals, giving patients greater access, continuity and engagement in multidisciplinary care.

Feedback received during this review had a strong message that small changes to the current incentive programs would have a limited impact on increasing the supply of health professionals and associated access problems in rural and remote areas. Any potential additional funding for current programs is likely to be absorbed in general practices' operational costs and have limited effect on improving the models of primary care on offer.

General Practice Quality and Innovation Program

Achieving the priorities set out in the *Primary Health Care 10 Year Plan* and the *Strengthening Medicare Taskforce Report* will require QI methods that can help improve outcomes across existing and new areas of care, address inequities, and adapt to rapidly changing healthcare contexts. QI initiatives take many forms but, at their core, all seek to improve measured patient outcomes through improvements to care processes.

The ultimate purpose of the proposed opt-in General Practice Quality and Innovation Program (the Program) is to improve health outcomes. It will achieve this by enabling general practices to use data to support a learning system that delivers systematic CQI initiatives that are accessible, equitable and adaptable to community needs. The program would support practices to be innovative, providing funding for practice-level programs and measures that target social determinants of health. Funding would support the adoption of new technologies, participation in research, models of care that foster system integration and value-based care outcomes, and the sharing of models of care.

Payments should be provided to participating:

- general practices – quarterly
- primary care practice support organisations (e.g. PHNs and NACCHO affiliates) annually.

To be eligible for this payment, general practices must:

- be receiving the Baseline Practice Payment
- participate in a structured CQI program with the support organisation which complies with the national framework.

The government should co-design all elements of the program with the sector and include consumer representation. The program would include:²²

- a guiding national framework and standards
- capacity-building CQI support and infrastructure
- quality and innovation payments to general practices

²⁰ A Scott et al. (2013) [Getting doctors into the bush: general practitioners' preferences for rural location](#), *Soc Sci Med*; 96: 33–44.

²¹ J Yong et al. (2022) [Do rural incentives payments affect entries and exits of GPs? Social Science & Medicine](#), *Soc Sci Med*; 214, 197–205.

²² Department of Health and Aged Care (2023) [The Digital Health Blueprint and Action Plan 2023 – 2033](#), DoHAC.

- ongoing general practice CQI and innovation support and diffusion, facilitated through general practice support organisations (PHNs and NACCHO affiliates)
- ongoing reporting on primary care data via the national dataset held by the Australian Institute of Health and Welfare (AIHW), which currently includes practice data provided through PHNs and ACCHOs.

These elements are described further below.

A guiding framework and standards

The Program would be guided by a national general practice quality and innovation program framework (the Framework) to be developed by the government in partnership with leading stakeholders. The Framework, supported by national quality and innovation plans developed every 2 to 3 years, would:

- be developed in cooperation with the PHNs, NACCHO affiliates, medical colleges, peak organisations, communities and consumers
- provide a link to other national frameworks and strategies
- provide a strategy that addresses transitions from existing infrastructure to national digital health initiatives, to keep pace with technology developments in primary care and the health sector more broadly, and enable more rapid adoption of services that meet community expectations
- enable adoption of, and support for, clinical governance for adopting new technologies, systems, decision supports and care solutions, including genomics (which will become prevalent over the next decade)
- identify methods of CQI, measurement standards, tools and technologies to be established, and define roles and responsibilities
- provide principles to guide general practice and support innovation funding for organisations
- allow for flexible implementation to ensure general practices and their support organisations are empowered to implement approaches based on practice-level demographics and social gradients of health, and with community input
- detail arrangements for governance, reporting, evaluation and monitoring.

Rather than focus on a standard set of Quality Improvement Measures (QIMs), a national quality and innovation plan would be developed to guide general practices and support organisations in aligning their activities to locally relevant, meaningful objectives and outcomes. This plan would define:

- a set of focus areas (e.g. patient cohorts, conditions and regions) – these will be chosen to encompass a range of prevalence levels, and opportunities for impact (e.g. reducing low-value care, increasing prevention and optimising outcomes)
- an AIHW-developed report on the health needs related to the focus areas to provide a set of key insights to guide general practice and support organisations
- a set of national projects aligned with select focus areas to encourage support organisations to align and drive common activities
- a description of how general practices develop their annual CQI plans (further outlined below)
- strategies to support best practice in implementing plan priorities (e.g. upskilling PHNs and other support networks).

Capacity-building CQI support and infrastructure

Clinical governance in general practice and primary care has been lacking due to underfunding for the time needed to manage practice operations and clinical planning. Establishing a clinical governance approach in each participating practice that enables all team members to contribute is vital. It will be fundamental to shifting primary care from a reactive and often siloed workforce into a system capable of transformative change.

Lessons from the Health Care Homes trial (see Box 9) highlight the importance of investing appropriately in the establishment and capacity-building phases of new programs. General practices will need different levels of support to build their capacity to understand and use their data for CQI. This includes support to release healthcare providers to participate directly in CQI activities, rather than seeing CQI as either a tick-the-box exercise or the responsibility of the practice manager. Support organisations will also need to build their capacity to support general practices to undertake structured and data-informed QI activity and provide strong and accountable leadership.

Box 5: Examples of capacity-building support

These include:

- foundational infrastructure and capacity-building grants, facilitated through support organisations. Eligible general practices could apply for funds to enable the purchase of hardware or software infrastructure and to support training for practice teams in data literacy and CQI. This could, for example, include buying software to support the implementation of Patient Reported Experience Measures (PREMs), Patient Reported Outcome Measures (PROMs) and Patient Activation Measures (PAMs)
- funding allocated to a commissioning body (e.g. PHNs and NACCHO affiliates) for capacity building of support structures, teams and processes.

Quality and innovation payments to general practices

By agreeing to participate in the CQI program, general practices would commit to working with their support organisation and potentially other local practices to undertake an ongoing and structured CQI program. The program would be reviewed and updated at least annually. It would require sharing data and using benchmarks to assess performance in at least some of the QI activities undertaken.

Once registered in the program, general practices could opt into different elements. For example, a practice would receive the core CQI payment and may opt to participate in any of the linked programs or payments (see Box 6 for examples). General practices, supported by their support organisations, would have flexibility to build appropriate systems and approaches to address focus areas at a local level, including the focus areas they choose to target.

Improving patient outcomes would be at the centre of the program, with general practice-led QI activities, identified through practice-level data. The phased introduction of PREMS, PROMs and PAMs across participating practices could also inform targeted QI activity. Existing government infrastructure should be used where possible to support the collection of PREMS and PROMs data. PAMs data should be collected at the practice level. PREMS, PROMs and PAMs should be applied locally to inform QI activity, with national support where required.

Funding should be available for adopting new and emerging digital capabilities to support general practices in implementing the digital health initiatives, guided by the Digital Health Blueprint and Action Plan 2023–2033. The funding could be used to:

- embed the use of Healthcare Identifiers within general practices
- prepare practices for future regulations that will require the adoption of Fast Healthcare Interoperability Resources capabilities within primary care in advance of planned extensions to the government's Share by Default agenda
- uplift cybersecurity standards by establishing baseline cybersecurity requirements for all participating general practices
- transition to trusted and secure cloud-based platforms for patient data, generating faster delivery of data and results. This would also lead to continuous improvement cycles and provide broad access to services that would, over time, include asynchronous delivery and use of patient self-service options via patient portals
- implement and adopt new digital capabilities, such as eReferral and eRequesting, and clinical decision-support tools to enable growth in digital maturity and connect health professionals across the sector.

In the longer term, funding for digital adoption should be rolled into the proposed Baseline Practice Payment. At that point, eligibility criteria for the Baseline Practice Payment could be expanded to include minimum requirements for general practice software, systems and security. Such minimum requirements would be updated annually and support organisations that have to map and report on digital maturity in their regions. This would guide local supports and ongoing investment to ensure primary care can safely and effectively participate in national digital architecture and adopt new technologies and decision supports.

Box 6: Examples of quality and innovation payments to general practices

Core payment – annual participation payment based on levels of achievement. This would be shown through the general practice's CQI plan, which would be endorsed by its support organisation. The general practice would report on progress against the plan annually. Such plans should be incorporated into overall clinical governance routines, with the clinical governance model adopted at the practice level being assessed as part of improved accreditation standards.

- Optional extra payments for:
 - national quality and innovation plan projects – a payment to general practices when they participate
 - PREMs, PROMs and PAMs – a payment to general practices for reporting to a central data repository using funded tools
 - digital health uplift program – a time-limited refreshed eHealth payment aligned with new and emerging digital tools and capabilities. Initially, this could ensure that practices can participate in the national digital infrastructure to safely and securely exchange data, enabling effective planning of care, transitions in care and monitoring of care outcomes
 - innovation payment or competitive grant program – facilitated by support organisations to fund general practice or local-level innovations that target the social determinants and gradients of health as they apply to the practice's registered patients. Such payments could also support the adoption of new technologies, models of care that foster system integration and value-based care outcomes, and sharing or replication of models of care
 - research and clinical trials support program – funding through support organisations to enable general practices to participate in research and trials, including to translate research findings into practice and engagement with centres of excellence to be funded via a dedicated program.

Ongoing general practice CQI and innovation support and diffusion – support organisations

Part of the remit of the support organisations (PHNs and NACCHO affiliates) is to build capacity among – and provide support to – general practices to deliver quality care. This includes supporting practices to improve quality, continuity and integration of care, and use of data and digital health systems. It also means sharing best practice and lessons learned with all providers to enable continuous improvement. PHNs and NACCHO affiliates also work with state and territory Local Health Networks (LHNs) and their equivalents to improve system integration and commission services using pooled Commonwealth and state funding, as detailed through the NHRA.

Given these existing functions, support organisations could take a leadership role in supporting the transfer of good models of care and service approaches across general practices and systems. Such a role would promote innovation. PHNs already receive data from general practices through PIP Quality Improvement (PIP-QI) and provide this data to the AIHW for national reporting. General practices will be required to provide more comprehensive anonymised data to PHNs or other support organisations (of the kind most practices supply now) to receive the CQI payments. ACCHOs already report on a set of more comprehensive national key performance indicators to the Australian Government. They are also building improved models of data sharing, guided by principles of Indigenous Data Governance. CQI activities could be developed, delivered and monitored under the national general practice quality and innovation program framework, which would require support organisations to provide nationally consistent, structured support to practices participating in the program. Support organisations should share their support models to ensure more beneficial models are adopted nationally.

The role of support organisations could also be expanded to manage ongoing CQI and innovation funding pools within their regions. This could be tied to the national quality and innovation plan. CQI funding could be used to support individual general practices to undertake CQI activity in their CQI plan, or to commission regional-level activities to improve QIMs concurrently across local areas. General practices would need to apply for funding through a competitive process. Examples of such activity could include forming local collaboratives and implementing PAMs at regional levels, including hospitals sharing access to such data.

Innovation funding could be used to support regional-level activities, such as practice-led research, implementing new models of care and commissioning community programs or supports. This could include buying new equipment, receiving funding to enrol patients in treatment or prevention programs, commissioning services to bridge gaps, trialling new models of care and evaluating their impact. It could also support spoke sites, working with hubs in the centres of excellence. Funds could support generating new knowledge, disseminating that knowledge across the hub and spoke network, funding the costs of replicating new models of care and evaluating the differences achieved between sites in the network.

As part of their role, support organisations should work with medical colleges and other relevant bodies to determine how CQI programs could also support health professionals' continuing professional development requirements, including enabling seamless reporting against the requirements.

Box 7: Examples of ongoing general practice support

General support includes:

- a bolstered role and accountability for support organisations
- ongoing flexible funding to support organisations, including a CQI funding pool and an innovation funding pool
- a national funding pool to create centres of excellence (as proposed in the Primary Health Care 10 Year Plan) and stimulate general practices to collaborate with consortiums of peak bodies, universities, PHNs and other organisations to drive innovation in priority areas of service delivery development.

Calculating payments under the quality and innovation program

The government should review existing payments to general practice for QI and work with support organisations and practices to determine the value of payments to be made under this program. Key considerations would be the costs of scaling up an organised and ongoing clinical governance system, of which CQI is a component. The scope would enable general practices to plan for innovation, workforce changes, upskilling needs, and data cleansing and reuse, and to embrace responses at the level of population health.

Teaching Payment

The *Primary Health Care 10 Year Plan*, the *National Medical Workforce Strategy 2021–2031* and the *Strengthening Medicare Taskforce Report* highlighted the need to build a skilled, dedicated and diverse primary care workforce. The payment for teaching will assist general practices and providers to take opportunities to teach medical students and other health professionals, building the workforce of the future. The current PIP Teaching Payment supports this objective by providing a financial incentive for general practices to provide practical exposure for medical students completing core general practice units. However, the time individual general practitioners spend providing training needs to be recognised. Providers' opportunities for billing are reduced when they are engaged in teaching. Therefore, the government should consider an incentive focused on general practices and providers to strengthen their participation in building the future primary care workforce.

Financial support for health workforce teaching and training is complex and fragmented. There is an opportunity to review and streamline current arrangements. Therefore, the review proposes using 6 conceptual parameters to determine the most effective mechanism for paying general practices for teaching (see Box 8). Note: the current Teaching Payment should continue, with a new approach to be resolved and implemented quickly. The Teaching Payment includes a rural loading, so any review, redesign or replacement payment should consider scaling of payments for this loading.

When designing new arrangements for supporting teaching in general practice, the government should consider introducing centres of excellence in teaching. Given the resourcing required to create meaningful training environments, there could be merit in supporting a number of general practices to offer teaching services, either in-house or as a hub and spoke model. This would improve the quality of teaching provided and could reduce costs over time. Some centres of excellence could be based in rural and disadvantaged communities, creating safer and more interesting exposure to the boundaries of primary care and attracting more members of the workforce to this type of service.

Box 8: Conceptual parameters for the new teaching payment

General practice funding for teaching students should involve the following.

1. Be designed as part of a unified, streamlined workforce development strategy

Any new or redesigned general practice teaching support payments or program should form part of a unified workforce development strategy and be administratively straightforward.

2. Include innovative models such as general practice centres of excellence

This could include innovative models such as a network of general practice centres of excellence recognised for their role in providing standardised and quality general practice workforce training and development opportunities across the trainee and practitioner workforces. This should include interdisciplinary teaching and supervision, with appropriate guardrails supporting the multidisciplinary team model. This could include funding to enable mentoring and study tours to more quickly disseminate some of the new models of care among experienced clinicians of all types.

3. Include quality assurance standards

General practices should be required to meet certain quality standards around the teaching and supervision they provide. Accreditation standards and GP supervisor professional development could operate across the continuum of learning; for example, from medical student to junior doctor to GP registrar, and from enrolled nurse to registered nurse and nurse practitioner.

4. Support non-GP primary care professionals to conduct teaching and training of GPs

Non-GP primary care professionals, such as nurses, nurse practitioners and allied health providers should be able to provide some training in general practice to medical students. Given the increasing importance of multidisciplinary team-based care, this would allow medical students more and earlier experience working in such teams. Safeguards would have to be developed to ensure GPs still provide the majority of training.

5. Divide payments between the general practice and the training supervisor

Redesigned payments would be payable to both the general practice and the supervising healthcare provider(s). Such split payments would recognise opportunity costs both the practice and the provider face when providing quality teaching and training. Consideration would need to be given to how this principle might apply to salaried and contracted supervisors.

6. Support training of non-medical students

General practice teaching payments and programs should be expanded to compensate practices and supervisors for providing training to non-medical students. This could include nursing, allied health, pharmacy and paramedic students, and support the increasing importance of multidisciplinary care in general practices.

7. Provide more support for mentoring and training of GP registrars and early-career healthcare providers

This could include supporting innovations such as the Single Employer Model, which supports rural training of early-career doctors and primary care placements with non-GP medical specialties; for example, psychiatrists, endocrinologists and gerontologists.

8. Include rural loadings and scaling of payments by remoteness

Loadings based on teaching location should be applied to recognise any additional costs associated with working in rural and remote areas and/or enable flexibility to support people on placements or support the travel of supervisors to rural locations.

Calculating teaching payments

The government should review existing payments to general practice for teaching. It should also work with relevant peak bodies to determine the value of these payments, noting that current payments made under PIP are not sufficient to support quality teaching in the medical workforce. The review should include a study to determine the costs of teaching, including the opportunity costs. In addition, the panel calls for an extension to the Teaching Payment across the clinical workforce in primary care. This means that the traditional apprentice models of teaching will no longer be sustainable and general practices will need to include the new approach in their clinical governance and approach to workforce development and oversight structures.

Targeted programs

Targeted programs are sometimes necessary for addressing inequitable health outcomes in specific priority populations. The *Strengthening Medicare Taskforce Report* recommended bundles of care payments for people who need them. Programs can incorporate multiple interventions and providers working together towards a common purpose. Payments support general practices, healthcare providers and support organisations to undertake the additional work needed to effectively deliver the specified bundles of care. Targeted programs can incorporate innovative funding components that calculations of patient complexity, or the MBS alone, cannot achieve.

Targeted programs can focus on general practice and broader health system resources to address areas of concern. They will also be required to address components of the National Preventive Health Strategy 2021–2030, which focused on social prescribing, earlier interventions for priority populations, and new partnerships between providers, patients and communities. These will require new skillsets and staffing and implementation planning, so they are worthy of consideration for time-limited initiatives until workforce and models of care are established.

To date, targeted programs have been funded for Aboriginal and Torres Strait Islander people (PIP IHI) and residents in aged care homes (General Practice Aged Care Incentive). These types of programs should continue to be implemented in exceptional circumstances, based on evidence and be time limited, with specific goals and review points. Targeted programs, however, carry a risk of adding complexity, increasing administrative costs and providing selective or targeted care, contrary to general practices' strength in looking after the whole patient. Targeted payments should be rolled into the Baseline Practice Payment, once arrangements become routine.

The *Primary Health Care 10 Year Plan* stated that payments linked to registered patient populations will be considered as a mechanism for incentivising quality care and improving outcomes. This includes for older Australians, people experiencing mental illness, people with complex chronic disease, parents and children in the first 2,000 days of life, people with disability (including intellectual disability) and people in socio-economically disadvantaged circumstances. Other priority populations identified in the *Primary Health Care 10 Year Plan* as requiring specialised best practice models of care include people from culturally and linguistically diverse backgrounds and LGBTQIA+ people. The panel also identified people with drug dependency and refugees as groups that could benefit from targeted programs, support, and funding streams. The MBS review noted the need for special services for those recently released from prison. All such priority populations warrant a higher ratio of GPs to non-GP clinicians to address the social determinants and complexity of such patients. As a result, consideration should be given to ratios exceeding 1:1 (GPs to other health providers) in these specific contexts.

The *Primary Health Care 10 Year Plan* identified centres of excellence as a potential way to support these populations. This would be achieved through providing expert care and supporting other primary healthcare practices and professionals in providing more appropriate care. Such centres would have a role across co-design, the resulting innovation implementation, research, teaching and systematisation. Additional funding to general practices participating as spoke sites would need to be considered to

facilitate exchanges that develop new knowledge, replicate agreed models and measure benefits to patients and providers.

Eligibility and payment details should be determined as targeted programs are developed. They should be tailored to the specific circumstances of the population and general practice models of care.

Calculating the payments for targeted programs

For each targeted program, the government should review relevant existing payments and consult with relevant organisations on payment design. Any future targeted payments should be based on evidence that specific populations require more (or different) general practice resources for their care. This would be over and above additional blended funding that accounts for complexity through age, gender and socio-economic status.

This would help determine the value of these programs, noting each program will likely target different groups and use different implementation methods. The collection of broader and more accurate data from general practices that identifies targeted populations would also be necessary to design and facilitate such payments. Consequently, software providers need to be engaged in augmenting system capability to collect more demographic data and service provider information, and increase the level of automatic atomisation of data from patient notes, as has been the case overseas for many years.

After-hours care support payment

An after-hours care support payment enables general practices to assist consumers to receive affordable, appropriate after-hours care. The new payment should ensure that a broader range of providers are eligible to receive incentive payments for providing after-hours care, and that new modalities (e.g. telehealth) can be used. Accreditation models will need to adjust to reflect changes to hours, with general practices incentivised to participate, reinforcing their primary care role. This will help ensure access to after hours and acute care on the days and at the times when patients need it.

A concurrent review of after hours primary care policies and programs will help determine the new payment model and arrangements. Therefore, rather than propose details, the review proposes using the following parameters in developing the new payment:

- Funding should be offered to providers delivering after-hours care that matches the clear goals developed for the after-hours program:
 - This should encompass a range of providers, including general practices providing afterhours care to their own patients, Medical Deputising Services, dedicated after-hours services, nurse-led clinics and others.
 - These services should be better coordinated and community awareness about their availability increased by developing a 'single virtual front door'.
 - Funding should support the delivery of services.
- better monitoring of after-hours delivery to consumers
- Communication about when, where and how people can access after-hours care should be improved.
- Funding should support continuity of care with consumers' regular primary care providers and after-hours providers, reducing the burden on hospital emergency departments.
- Funding should support organisations to link patients who don't have a usual general practice to a general practice team.
- All general practices should be required to demonstrate how they are providing adequate access to in-hours appointments for patients with their practice who are registered via MyMedicare.
- PHNs, support organisations and peak bodies should be supported to provide education to reception, practice management and nursing staff to improve the filtering, triage and systems that enable patients to access care when an acute need arises.

Calculating the after-hours care support payment

The value of the payment should be determined as part of the review of after-hours primary care policies and programs.

Chapter 2 Supporting quality care

Support quality care

Recommendation 2: The Australian Government should invest in enabling reforms such as accreditation and a performance framework to support the new general practice blended payments architecture within the context of a cohesive vision for primary care by 2032.

The enabling reforms should:

- through reforms to accreditation, promote the provision of safe, accessible, high-quality and value-based care across all primary care services
- achieve accountability and support fairness for general practices, providers and patients.

Overview

Enabling reforms are required to support the effective delivery of the new general practice payment architecture, including reforms to:

- accreditation
- the performance framework.

Investment in these enablers will be crucial to the new payment architecture's success.

Accreditation

Accreditation is the mechanism for verifying compliance with standards. Implementing standards is important to ensure patients receive safe, high-quality care. Eligibility for accreditation should be expanded to include non-traditional general practice models that deliver high-quality, holistic and comprehensive primary care. The accreditation scheme itself must have sufficient rigour and validity to ensure the confidence of patients and primary care professionals. Currently, PIP and WIP-PS payments are restricted to general practices accredited under the National General Practice Accreditation (NGPA) Scheme.

Non-traditional general practices are defined as contemporary primary healthcare business models that provide primary healthcare services, such as nurse-led, some outreach, medical deputising and after-hours services. These models do not fit the current Royal Australian College of General Practitioners (RACGP) definition of a general practice and cannot be accredited against the RACGP Standards. Therefore, they cannot participate in the NGPA Scheme and are currently not eligible to participate in government-funded general practice incentive programs.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed the National Safety and Quality Primary and Community Healthcare (PCH) Standards with the input of general practitioners and other primary care providers. The PCH Standards are for primary and community-based healthcare services. They are patient-centred and outline a framework for safe and high-quality primary and community healthcare delivery. The PCH Standards could be used for general practices to become accredited if they do not fit the RACGP's definition of a general practice. It is important to note that the RACGP Standards should remain in use for practices and health services that fit that definition. The RACGP Standards will need to be refined to address the themes emerging from this review.

The use of the PCH Standards could increase the participation of non-traditional practice models in government-funded programs. More broadly, this would drive safety and quality in primary health care while improving the financial capability of general practices to deliver the holistic primary care services their patients need.

It is important that accreditation works for and is valued by everyone. Patients should know whether their general practice is accredited and be confident this equates to safety and quality. General practices should

have equitable access to accreditation, with transparent fees, and should not face barriers to accreditation due to their rurality or size.

Performance framework

Robust accountability arrangements are necessary to support the effective implementation of the new payment architecture to ensure quality and equity.

Flexibility in blended funding models is important for meeting patients' complex needs. Australians have a varying range of health conditions, and it is vital they receive tailored, patient-centred care in primary care settings. Flexibility in funding gives providers autonomy and fosters accountability within general practices as they are empowered to make decisions about how to use their blended payments.

However, flexibility in blended funding models must be accompanied by an appropriate, robust and unified accountability and performance framework. The performance framework should ensure continuous quality and safety assurance and enable the policy intent of the various payments. Accountability requirements should not involve significant additional data collection but rather should draw on existing general practice data provided seamlessly in accordance with agreed-upon national data collection and provision standards.

The framework should be developed in collaboration with the sector to ensure it is fair, administratively simple and easy to understand, and that it facilitates primary care reform. Legislation could be an option for regulating the framework; however, enacting legislation should not delay the implementation of these new reforms.

Chapter 3 Independent pricing of primary care payments

Independent pricing of general practice and primary care payments

Recommendation 3: While maintaining the principle that general practices are able to charge fees for medical services that consider the practices' own costs and economic imperatives, the Australian Government should establish an independent primary care pricing authority to provide advice on the design and pricing of Commonwealth payments to general practices and primary care providers.

The independent primary care pricing authority should:

- provide evidence-based recommendations and advice to the Minister for Health and Aged Care (the Minister) on the payment design and level of MBS rebates and other Commonwealth payments to general practice and primary care providers, including the level of blended payment mix in primary care expenditure
- make these recommendations based on evidence, including evidence of the costs of providing team-based primary care services, that will underpin pricing recommendations to the Minister
- contribute to the growth in publicly available data on the primary care sector, including its scale, performance, infrastructure, training activities and research engagement
- support the government and the Department of Health and Aged Care in the ongoing design, implementation and evaluation of general practice payments
- regularly report on the financial sustainability of the primary care sector, including the cost-effectiveness of providing primary care compared to the secondary and tertiary care sectors
- monitor, support and conduct research on innovations in funding arrangements (for example, pooled funding across hospital and primary care settings) and other value-based healthcare initiatives.

Overview

Fairness in setting the levels and mix of payments to general practices is essential to help ensure financial sustainability. It will also reinforce that general practices are being rewarded for the care they provide under a blended payments model. Good primary care can only be delivered over the long term if practices and clinicians receive remuneration that is commensurate with the skills, training and industry needs for delivering care. Efficient pricing signals, including payments that cover costs and provide incentives for high-value care, are critical to sustaining an effective system that rewards integration, shared risk, and community-based and patient-centred health care.

Independent pricing of rebates and payments

The Independent Health and Aged Care Pricing Authority (IHACPA) independently sets the national efficient price and national efficient cost for public hospital services and private aged care providers, using data on cost and pricing models. The efficient price and cost are used to determine Australian Government's contribution to public hospital services, and aged care services. Independently set pricing allows for a transparent and nationally equitable approach Commonwealth contributions to the costs of these services recognising variations in costs and prices that are outside providers' control. IHACPA also advises the government on the National Disability Insurance Scheme pricing reforms.

An independent approach to pricing for primary care services should include payments in the new architecture outlined in this report and those made through the MBS, including the bulk billing incentive. A new independent pricing authority should also have a role in developing, implementing and evaluating new general practice payments. Over time, consideration should be given to whether payments to other primary care services (for example for state services and community health providers) should also be independently priced.

An effective pricing model must be underpinned by comprehensive information, data and research about the costs of delivering primary care, how these costs vary over time, geography and specific populations, and what drives the variations. Data sources such as the Australian Bureau of Statistics Business Longitudinal Analysis Data Environment (BLADE) and the Person Level Integrated Data Asset could be used for this. BLADE data could be used for initial examinations of cost variations, supplemented with confidential practice-level data collection.

It will be important to establish how general practices are operating now, the gap between their operations and the vision set out in this report, the areas that most need more investment (for example people, information and communications technology systems, and physical infrastructure) and the mechanics for attracting the required investment. This should include private capital. So, an appropriate planning horizon and the return to investors – whether that means practice owners, the property sector or other sources of capital – need to be established.

To support the growth of mature primary care data, the government could consider investing in mechanisms for gathering, analysing and publishing (while maintaining privacy) information on the scale of primary care, ownership structures, and the costs of delivering primary care in Australia. An independent pricing authority should use data to recommend pricing changes to the government based on changes in the cost of delivering services. The pricing authority would also need to engage with ACCHOs and other non-private primary care providers with different financing arrangements and data governance (such as principles of Indigenous Data Governance).

As part of its role in determining efficient prices for general practice, an independent pricing authority would need to consider:

- how prices can support the future vision of primary care outlined in this report, including incentives to make changes
- how prices may have different impacts on general practices, especially solo practitioners and small general practices
- the method for indexing payments and the role of patient co-payments in the mix of funds available to general practices
- benchmarking costs and primary care expenditure, based on the size, location and care activities of the general practice (for example multidisciplinary care versus GP-only care)
- the current workforce composition of different practices and care teams, including multidisciplinary teams, and the ratio of chronic disease to care coordination
- the transformation required in general practice equipment, layout and scale to support the care teams to improve the patient and provider experience, including creating more clinical and practice leadership roles, given the expanded teams and scope of work
- providing evidence to use in negotiating bargaining agreements for health professionals and general practice staff as the sector achieves income parity between the primary care, hospital and aged care sector workforces
- the costs associated with maintaining and upgrading current infrastructure (physical and digital), especially in the context of the uptake of new digital and team-based care technologies
- operational costs, including for management, planning, governance and risk management activities
- change management costs, especially in relation to adopting new primary care reforms and models of care.

Regular pricing reviews, and the ability of key stakeholders to submit evidence, would ensure that government funding for primary care takes into account actual changes in the costs of delivering care, and is fair and transparent.

Chapter 4 Effective transition to the new payment model

Effective transition to the new payment model

Recommendation 4: The Australian Government should facilitate an effective transition to the new payment model to achieve the future vision for general practice.

The transition should include:

- a phased approach to implementing the reforms, delivering more funding to primary care in the early phases of the rollout
- a 10-year funding commitment (with the majority of investment achieved by 2032) that includes additional funding for new general practice payments under the new payment architecture
- specific funding and support for change management activities to enable general practices to transition to new arrangements, including education and training for practices and clinicians, investment in digital maturity, and support for clinical governance and practice management
- seed funding and support for primary care services to become eligible for Commonwealth payments, so these services can expand their infrastructure to facilitate in-house multidisciplinary care
- deep partnership and engagement with the primary care sector during the design and implementation of these reforms, including investment in education and training, as the sector transitions to the new payment model
- clear and continuous communication with stakeholders and the primary care sector
- deliberate sharing of innovation and best practices to stimulate replication across the sector
- government commitment to continuity of services and funding, including research, data and modelling of the effects of reforms on the primary care sector, including through the Medical Research Future Fund (MRFF)
- a continuous cycle of monitoring and evaluating reform outcomes, and using these learnings to refine and test the subsequent evolution of the funding model.

Overview

A carefully planned and implemented change management program will be critical to the transition to the new payment model. It should include:

- a commitment to continuity of existing services and funding during the transition period
- a phased approach
- genuine partnership and engagement with primary care stakeholders
- communication
- change management
- a continual cycle of monitoring, evaluation and learning.

Commitment to continuity of services and funding

The new payment model represents a significant reform. It should be implemented carefully and thoughtfully but purposefully, and preferably in clearly defined phases (see below). As it is implemented, patients will continue to need care and providers will need financial certainty to plan for transitioning to the new arrangements.

The government should commit to not reducing total funding for primary care during the transition and should carefully consider increasing net investment in line with the new model. In particular, additional investment will be required to achieve the goal of block funding, which will comprise 40% of system-level revenue for primary care providers. It will also be necessary to inject funding for transition costs to catalyse efforts to achieve fundamental operational changes.

As part of planning for the transition, research and modelling should be undertaken to determine the impact of the changes on the many different general practice types, the broader primary care market, and patients. This will help with identifying the investment needed to achieve the expected levels of service delivery (for example in care coordination) and changes in practice and provider income. Some current incentives pay providers and practices to offer specific types of care, or care to priority populations. Disrupting these funding streams could adversely impact access to primary care if the activities they fund are not seen to be included in the new funding structure.

Practices and providers are familiar with current funding arrangements

General practice incentives have long been a component of primary care funding in Australia. Therefore, practices and providers are generally familiar with the PIP and WIP requirements and payments. Most practices access the same PIP and WIP incentives for many years and expect payment amounts²³ remain the same. They²⁴ are typically considered a practice income stream, absorbed as revenue, and viewed as critical to support practice operations and sustainability, especially in rural and remote areas. This reliance means any changes to funding arrangements should be carefully phased and communicated to minimise unexpected disruptions to practices' ability to continue to meet patient needs. The panel recognises the importance of stability, but also the need to evolve the current incentives and address some of the shortcomings in their design.

The changes recommended in this report should not reduce funding for primary care. Indeed, they are designed to be the basis for increased investment in primary care over time. However, any reforms could mean a shift in the distribution of payments, with some general practices receiving more funding and others receiving less, even if investment increases overall.

The sector has shown the ability to respond well to change, including adapting to the introduction and evolution of PIP and WIP payments. However, adapting to change requires time and resources. GPs report experiencing increasing time pressures that limit their ability to engage with the PIP and WIP incentives. It follows that GPs will have limited capacity to engage with and understand a new payment architecture. Similarly, practice managers, who take on most of the PIP and WIP administrative burden, report that current processes can be overwhelming and time-consuming.²⁵ This suggests the sector is already at or beyond capacity and there is limited time and energy to spend on adapting to change.

A phased approach

Transitioning to the new model in phases would benefit general practices and providers by giving them time to adjust and enabling successful change management. Further consideration needs to be given to whether phasing in of general practices to the new model should also be considered. Feedback received from consultations included suggestions that rural and remote general practices and those serving high-needs communities could be transitioned to the new model first. Other feedback included concerns that a phased approach could result in tweaking of the current incentive programs rather than the wholesale reforms that are needed.

For all payments, existing funding from the PIP and WIP should continue until new arrangements are seamlessly implemented. The implementation approach should align with the implementation of recommendations arising from the concurrent reviews and those in the *Mid-term Review of the National Health Reform Agreement 2020-2025 Final Report*.²⁶

²³ KPMG(2024) [Effectiveness Review of General Practice Incentives](#), report to the Australian Government Department of Health and Aged Care, p. 63.

²⁴ KPMG (2024) [Effectiveness Review of General Practice Incentives](#), report to the Australian Government Department of Health and Aged Care, pp. 59 and 65.

²⁵ KPMG (2024) [Effectiveness Review of General Practice Incentives](#), report to the Australian Government Department of Health and Aged Care, p. 54.

²⁶ Department of Health and Aged Care (2023) [NHRA Mid-term Review Final Report](#), DoHAC.

To support an effective transition, the government should articulate and communicate a clear roadmap or blueprint explaining the ideal state it anticipates it will achieve, and the key milestones. This certainty will enable general practices to formulate plans, assess funding and workforce impacts, and gear up for change, having identified relevant partners and supports. It is likely that some general practices will be willing and able to transition to the new model more quickly than others. They should be identified and incentivised to be used as test cases for studying the impact of change.

As part of implementation planning, the government should investigate a model that allows general practices to gradually adopt the new arrangements over time, with support, encouragement and investment (financial and in kind). Not all practices will need to adopt the new model straight away. However, in moving to a primary care-centred healthcare system, the incentives for change (including support to change) should be sufficient to ensure that the majority of practices have transitioned by the medium term. Late adopters should be identified and impediments to adoption – cultural, financial, physical and systematic – analysed to enable ways to modify implementation of the reforms.

In terms of implementing the new payments system, the Baseline Practice Payment should be prioritised for implementation as it is the foundation of the new model. Ideally, the new payment would be implemented in the short term, to signal the government's commitment to the reforms and provide momentum for the other reforms recommended under this review. The sector will need certainty to embrace the change, so the government will need to establish this payment shift with a program that has a sustained and increasing budget to signal the seriousness of these reforms.

The reformed after-hours care support payment should be implemented as soon as possible. This payment would in many ways be an evolution of the current PIP After Hours incentive payment. Therefore, practices and providers should find the transition to this new payment, and its reframed obligations, relatively straightforward. The General Practice Quality and Innovation Program should be phased in over several years to allow for collaborative design and stepped implementation of its different elements. As a starting point, the PIP eHealth incentive payment should be refreshed immediately to align with the National Digital Health Strategy. It should also offer rewards for more comprehensive data sharing, and other incentives to improve digital maturity. Finally, implementing a reformed Teaching Payment will depend on government decisions about the most appropriate service delivery model. However, initial implementation should include payments to support quality teaching and supervision in general practice across the entire practice clinical team.

The government should also design and implement enabling reforms, and ensure ongoing investment in improving primary care infrastructure, data collection and safe data sharing. More government investment in education and training will also be required to assist practices and providers to transition their care and business models towards using more blended funding. Forums and opportunities such as conferences and gatherings to share experiences and success stories should be funded, to enable wider participation by practice teams. This will accelerate their capacity to understand the reforms and drive change at local levels.

Partnership and engagement

Partnering and engaging with the sector will be critical for the successful implementation of these reforms. Implementation must be informed by input from key stakeholders and primary care providers from all parts of the system.

The sector has emphasised its desire to reform, if not rebuild, the current system of incentives to create a streamlined, simpler approach. Working with the sector on designing and implementing new programs has

been shown to improve the effectiveness and uptake of these programs. Co-design is also key to successful implementation, and principles of collaborative design should underpin the reform process.²⁷

To ensure success, it is important for general practices, providers and consumers to feel invested in the reforms.²⁸ The value proposition must be clearly articulated to achieve ‘buy-in’ from influential practices, providers and peak bodies. It should also be adaptable to being communicated to different audiences. The messaging around change should be supported by data that makes it more persuasive. Messaging should also centre on improvements to patient care and outcomes, and include the benefits of reform for practices and providers. Colleges, peak bodies and NACCHO affiliates need to be consulted to guide this process.

Communication

Clear and consistent communication will be required to explain the reforms and the transition pathway. The government should develop and implement a national communication strategy to deliver information to the primary care sector. This should include strategies for engaging across the sector (including all health professionals), at all levels (through peak bodies and directly to general practices), and using multiple channels and approaches. Engaging practice owners, practice managers and professional services providers to the sector in new and escalating ways must be a priority. These players are conduits to the wider team and need to understand all aspects of the reform program, including its phases and milestones, so they can make plans to address the impact across their practices and wider teams.

Change management

Changing the culture of general practices to adapt to team-based care will require changing the status quo. Investment and supports are critical to realising this change. General practices will also need support to manage the transition to the new payment architecture. The government should design and implement a change management program that includes appropriate phasing of reforms, resourcing, communication and training. It will be easier for general practices to manage change if they have a clear blueprint to work towards – one in which the direction of change over the long term is known, and details are filled in incrementally over time.

Change that is not well managed can lead to disruptions in general practice services that can negatively impact patient care. It can also change the appetite for practice ownership and ownership of practice infrastructure more broadly. Most practices are privately owned and occupy private property, so commercial risk and the horizon for a return on investment must be considered within program changes. Not taking these factors into account risks them affecting the overall success of the reforms. The Health Care Homes (HCH) trial (see Box 9) did not achieve its intended outcomes, partly due to issues with how the transition was managed.

²⁷ M Kidd et al (2024) [Review of General Practice Incentives – International Evidence and Literature Review Report](#), report to the Australian Government Department of Health and Aged Care, Faculty of Medicine and Health, University of New South Wales, Sydney.

²⁸ J Pearse et al. (2022) [Health Care Homes trial final evaluation report, Volume 1: Summary report](#). Commissioned by the Australian Government Department of Health, DoHAC, p. 36.

Box 9: Health Care Homes Trial

Case study: Health Care Homes trial and change management

The HCH trial took place between 2017 and 2021 across 10 diverse PHN regions. The HCH model allowed patients to voluntarily enrol with a participating general practice and GP. Practices received bundled payments, based on tiers for patient complexity, replacing MBS items for participating patients.

During the trial, 53% of participating general practices withdrew. The evaluation found that the trial's success was hindered by issues with implementing the change. For instance, information and guidance about the program was provided late and inadequately prepared practices and providers for the change. The one-off grant, intended to incentivise participating practices and support their preparation for the trial, was insufficient to cover information technology costs for many practices. While practices and PHNs had access to online training programs, these were long and lacked practical examples, so they were underused. Additionally, no funds were available for training time, let alone change management. These factors meant that changing to new models of care was a slow process, as few providers saw the new possibilities included in the training materials. PHN support staff were similarly uninformed and therefore unable to share in ways that drove change.

The trial produced no meaningful changes to the measured patient experience, outcomes or use of diagnostic and hospital services. Overall, the approach taken to change management did not account for the limited time and capacity of practices to engage with the process of change.

The evaluation of the HCH trial made key recommendations for future programs and reforms. These included:

- making the case for change to practices, providers and consumers through multiple channels
- allowing adequate time to prepare for this change
- developing succinct and practical training materials delivered through multiple modes and tailored to different roles within a practice
- offering financial support that reflects the true costs to practices of preparing for change
- considering a staggered or phased implementation to allow for refinement and to apply learnings
- sharing innovation and learning early and often to enable PHNs and practices to adopt change.

Adapted from Evaluation of the Health Care Homes trial – final evaluation report 2022²⁹

Investing in multiple streams of change management is required

A single approach to change will not be sufficient to support the breadth of individuals and organisations impacted by funding reform. It will be necessary to invest in tailoring approaches for different audiences.

Changes need to be well explained and everyone will need to be supported to adapt. To achieve this, change management will need to occur through various means and be targeted at different players in primary care. The support a sole GP in a small regional practice will require is likely to be different to that of a practice manager in a large metropolitan general practice. Special consideration will need to be given to changes to clinical governance, teaching models, and data and digital health processes. It should be noted that staff will have varying degrees of technological literacy, meaning they will have different learning curves.

To bridge the gap between present operations and the new system, general practices will need to embed the role of clinical leads and practice managers in order to drive change. The new system will require clinical improvements, and new models of care and ways of working, while systematising increasingly

²⁹ J Pearse et al. (2022) [Health Care Homes trial final evaluation report, Volume 1: Summary report](#). Commissioned by the Australian Government Department of Health, DoHAC.

complex workflows and using data to make more decisions. The status of clinical and practice leaders should be raised through regular reference to these important team roles, which sit beyond direct patient contact but enable far better health outcomes and provider experience.

Organisations will also need to adapt as their staff members' skills and attention are diverted from their usual activities to enabling this transformation. Given the variability in practices' organisational capabilities, sector leaders who understand general practice business operations and best practice team-based care will be critical to supporting practices and fostering the required changes. Maturity levels and skills within support organisations should be monitored to ensure that primary care receives the necessary support.

Rural and remote general practices have unique models for serving their communities. They also have unique barriers and challenges to overcome, such as the distance between services, and workforce shortages. Any reforms would need to consider additional change management and transitional supports for practices and providers operating in rural and remote areas. Transitioning to a new blended funding model will require support at the local level to account for regional differences.³⁰ PHNs (or other sector support organisations) should be used to support the transition in their regions and provide guidance appropriate to the local context.³¹

NACCHO affiliates in the states and territories must also be engaged and resourced to provide change management support relevant to ACCHOs. The NACCHO Core Services and Outcomes Framework outlines the breadth of services delivered through ACCHOs. Their data sharing systems are already more mature than mainstream practices, so implementation activity will need to be tailored appropriately.

Planning and strategies will be needed to improve staff skills, practice systems, frameworks, employment models, contracting relationships and infrastructure (digital, physical and systems). Cultural change will be necessary for success, and this must start with university and TAFE curricula that support the new model for primary care. Multilayered supports for change must include:

- providing teaching and equipment
- making tools, templates and systems available
- setting targets and milestones on the phased implementation
- creating new tasks and roles at general practices and support organisations
- sharing best practice across the system
- tallying the costs so that enablement can occur through appropriate funding.

Peak bodies and support organisations are well placed to deliver much of this assistance if they have funding to do so. This would enable staff at general practices to attend multiple training sessions, strengthening the relevance of messages and supports available at practice and provider levels. Sectors and regions that don't have a peak body or support organisation will have access to an array of inputs, increasing the opportunity to participate in well-structured training. The government should also consider investing in online resources, which would have legacy value and complement any face-to-face delivery. They could provide a higher-quality and more cost-effective solution.

A balance needs to be struck between providing appropriate time for change management, and implementing important reforms in a timely manner to improve the quality of and access to health care for all Australians. Change management needs to be seen as an enabler that ensures streamlined implementation of the reforms, and ensures they are understood and accepted.

³⁰ J Pearse et al. (2022) [Health Care Homes trial final evaluation report, Volume 1: Summary report](#). Commissioned by the Australian Government Department of Health, DoH. p. 9.

³¹ Department of Health and Aged Care (2022) [Strengthening Medicare Taskforce Report](#), DoHAC.

Monitoring, evaluation and learning

The reforms should be transparently monitored and evaluated. The new payment model and enabling reforms should be continuously tested to ensure they are delivering as expected. Eventually, this would be a role of the newly proposed independent primary care pricing authority.

The reforms should be evaluated and the results published. Where shortcomings are identified, the government should review and revise the reforms, based on learnings and best available evidence. Evaluations need to be supported by developments in data infrastructure and data linkage that support CQI activities and independent research.

To be effective, monitoring and evaluation arrangements must be streamlined and clearly communicated. Without this, it will be difficult to gather the information required to assess progress, and providers may perceive their time is not being valued.

Monitoring and evaluation must include a focus on the effects of the programs, the costs of their associated activities and any unintended consequences. These reforms represent a significant shift in primary care payments, requiring ongoing commitment and support to align them with the broader primary care vision.

Appendix 1 – Glossary

Term	Definition
Aboriginal Community Controlled Health Organisation (ACCHO)	A primary healthcare service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to its community, through a locally elected board of directors.
Accreditation	Public recognition by a healthcare accreditation body of a healthcare organisation's achievement of accreditation standards, demonstrated through an independent external peer assessment of the organisation's level of performance in relation to the standards.
After hours	Defined by the current Royal Australian College of General Practitioners Standard for general practices as a service that provides care outside a general practice's normal opening hours. It does not matter if that service deputises for other general practices, or if it provides the care within or outside the clinic.
Allied health services	Allied health professionals provide a broad range of diagnostic, technical, therapeutic and direct health services to improve the health and wellbeing of the people they support. They work in a range of settings, including hospitals, private practice, community health and in-home care. These health professionals, mostly with university qualifications, are not part of the medical, dental, nursing or midwifery professions. Allied health represents the second-largest clinical workforce in Australia, after nursing and midwifery.
Blended funding	Funding that encompasses a combination of different sources and mechanisms.
Block funding	Population-based funding of service providers, based on the population served and the community's health needs. The payments are made in a lump sum on a periodic basis.
Bundled payments	A method of payment where services, or different elements of care, are grouped together in one payment.
Chronic conditions	<p>Various terminology is used to describe chronic health conditions, including 'chronic diseases', 'non-communicable diseases' and 'long-term health conditions'. The term 'chronic conditions' encompasses a broad range of illnesses, including mental illness, trauma, disability and genetic disorders. Chronic conditions:</p> <ul style="list-style-type: none"> • have complex and multiple causes • may affect individuals in isolation or as comorbidities • usually have a gradual onset, though onset can be sudden and in acute stages • occur across the life cycle, though they become more prevalent with older age • can compromise quality of life and create limitations and disability • are long term and persistent, and often lead to a gradual deterioration in health and loss of independence • while not usually immediately life threatening, are the most common and leading cause of premature mortality.
COAG Section 19(2) Exemptions Initiative	This initiative aims to improve access to primary care in rural and remote areas. These are exemptions under the <i>Health Insurance Act 1973</i> to allow exempted eligible sites to claim against the MBS for non-admitted, non-referred professional services (including nursing,

Term	Definition
	midwifery, and allied and dental services) provided in emergency departments and outpatient clinic settings. Queensland, Western Australia, New South Wales, South Australia, the Northern Territory and Victoria all participate in the initiative via memorandums of understanding (MoUs), with Tasmania eligible to participate. The 2016–2020 MoUs were updated to a single criterion that requires an eligible public health site to be located within MM 5–7 locations.
Collaborative practice in health care (also referred to as ‘multidisciplinary’ or ‘team-based care’ in this document)	When multiple health workers from different professional backgrounds provide comprehensive services to patients, their families, carers and communities to deliver the highest possible quality of care across settings. ¹ For example, this can be care provided by multidisciplinary care teams.
Commissioning	A strategic approach to procurement that: <ul style="list-style-type: none"> • is informed by a baseline needs assessment undertaken by PHNs, LHNs or their equivalents in a state or territory • aims to be more holistic and in which the planning and contracting of healthcare services are appropriate and relevant to the community’s needs.
Continuity of care	The provision of uninterrupted, coordinated care or service across programs, health professionals, organisations and levels over time.
Culturally and linguistically diverse people	Describes and reflects people from a diverse range of cultural and linguistic backgrounds. The Australian Bureau of Statistics (ABS) indicates the culturally and linguistically diverse population by country of birth, languages spoken at home, English proficiency, cultural heritage and religious affiliation.
Determinants of health (also referred to as ‘social determinants of health’)	Factors that influence how likely people are to remain healthy or become ill or injured. The Australian Health Performance Framework identifies four broad groups: health behaviours, personal biomedical factors, environmental factors and socio-economic factors. The cultural determinants of health are the protective factors that enhance resilience, strengthen identity, and support good health and wellbeing. These include, but are not limited to, country, kinship, language, self-determination and cultural expression.
Digital health	An umbrella term that refers to a range of technologies that can be used to enhance the efficiency of healthcare delivery and make medicine more personalised and precise. It refers to health and wellbeing in a digital world. It forms part of creating a connected health system and experience between health professionals and health consumers. Digital health includes new or changed ways of working and the cultural impact of digital enablement. It refers to mobile health and applications, electronic health records, telehealth and telemedicine, wearable devices, web-based analysis, emails, mobile phones and applications, text messages, wearable devices, and clinic or remote monitoring sensors. It can also extend to robotics and artificial intelligence.
Digital inclusion	Access to information and communications technology and the resulting social and economic benefits, sometimes described in terms of the ‘digital divide’ – the gap between people with effective access to digital and information technologies, in particular the internet, and those with limited or no access. Lack of access and affordability can be barriers to digital inclusion, but digital literacy, perceptions of relevance, motivation

Term	Definition
	and concerns about safety can also affect an individual's digital engagement and confidence.
Fee for service	A primary healthcare funding method that pays for individual services through specific, itemised fees (e.g. the Medicare Benefits Schedule). Typically, this is transactional, based on a single episode of service.
Full scope of practice	Professional activities that a practitioner is educated (skills/knowledge), competent and authorised to perform, and for which they are accountable. Individual scope is time-sensitive and dynamic. Individual practitioners' scope of practice is influenced by the settings in which they practise, their individual competence and confidence level, people's health needs and the service provider's policy requirements (authority/governance).
General practice	For the purposes of this report, the term 'general practice' includes primary care services that provide holistic and comprehensive primary care. This includes private general practices, nurse practitioner-led practices, not-for-profit organisations and ACCHOs.
GP-centred primary healthcare model	Refers to the central role that GPs play in primary care.
Health Care Home (HCH)	Was developed for patients with chronic and complex conditions to create a home base where a team of healthcare providers develop and implement a shared care plan. An existing general practice or ACCHO provide comprehensive primary health care in one place.
Healthdirect	A national, government-owned, not-for-profit organisation supporting Australians in managing their own health and wellbeing through a range of virtual health services. Its role is to work in partnership with the Australian, state and territory governments to help address key priorities and challenges across the health, ageing and social service sectors.
Health literacy	People's ability – their skills, knowledge, motivation and capacity – to access, read, understand and use information about health and the healthcare system to make decisions about their health.
Health professionals	For the purpose of this document, this term includes regulated and self-regulated health professionals and the para-professional workforce; for example, health assistants, technicians, care workers and peer support workers.
Incentive payment	A type of payment aimed at changing the behaviour of practitioners or practices. These payments encourage the adoption of arrangements that contribute to an objective of the payer.
Interprofessional education/learning	Educational experiences where students from 2 or more professions learn from and with each other to enable effective collaboration and improve health outcomes. ³
Lived experienced	The knowledge and understanding people gain when they have lived through something. This includes family members or friends who supported someone through an experience. People with lived experience are considered experts on their lives and experiences. These insights, combined with health practitioners' expertise, knowledge and skills, promote a focus on people's needs rather than on organisational or provider priorities or processes.
Local Hospital Network (LHN)	An organisation that directly manages single or small groups of public hospital services and their budgets and is directly responsible for hospital performance. An LHN can be defined as a business group, geographical area or community. Every Australian public hospital is part of an LHN. The title can vary from state to state – for example,

Term	Definition
	Queensland refers to 'Hospital and Health Services' and Tasmania refers to 'Tasmanian Health Organisations'.
Medicare Benefits Schedule (MBS)	A national, government-funded scheme that subsidises the cost of personal medical services for all Australians to help them afford medical care. The MBS lists the Medicare services that are subsidised by the Australian Government.
Modified Monash Model (MMM) classifications	The classification of metropolitan, regional, rural and remote areas according to geographical remoteness, as defined by the ABS and town size. It covers: MM 1 Metropolitan; MM 2 Regional centres; MM 3 Large rural towns; MM 4 Medium rural towns; MM 5 Small rural towns; MM 6 Remote communities; and MM 7 Very remote communities. The MMM is used to determine eligibility for a range of health workforce programs, such as rural Bulk Billing Incentives, the Workforce Incentive Program (WIP) and the Bonded Medical Program.
Multidisciplinary care team	Collaborative care occurs when multiple health professionals from different professional backgrounds work with each other, and with patients, their families, carers and communities, to deliver the highest possible quality of care across settings.
Multi-professional learning	Involves health professionals from different disciplines learning together, either face to face or virtually.
My Health Record	An online platform for storing individuals' health information, including their Medicare claims history, hospital discharge information, diagnostic imaging reports, and details of allergies and medications.
MyMedicare	A new voluntary patient registration model that aims to formalise the relationship between patients, their general practice, GP and primary care teams.
National Aboriginal Community Controlled Health Organisation (NACCHO)	The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national leadership body for Aboriginal and Torres Strait Islander health in Australia. Our organisation provides advice and guidance to the Australian Government on policy and budget matters while advocating for community-developed health solutions that contribute to the quality of life and improved health outcomes for Aboriginal and Torres Strait Islander people.
Nurse practitioner	A registered nurse endorsed as a nurse practitioner by the Nursing and Midwifery Board of Australia. A nurse practitioner practises at an advanced level, meets and complies with the nurse practitioner standards for practice, has direct clinical contact with patients and practices within their scope under the legislatively protected title 'nurse practitioner' under the Health Practitioner Regulation National Law.
Patient activation	The process through which health providers engage or motivate a patient to play an active role in their own health and care. This is instead of the more traditional and passive role of being 'told what to do' by a health professional.
Person-centred care	Also referred to as 'person-led care', it describes treatment, care and support that places the person at the centre and in control of the design and delivery of their own care. It also considers the needs of the person's carers and family.
Population health	Typically, this is society's organised response to protect and promote health and to prevent illness, injury and disability. Population health activities generally focus on: <ul style="list-style-type: none"> • prevention, promotion and protection rather than treatment • populations rather than individuals

Term	Definition
	<ul style="list-style-type: none"> the factors and behaviours that cause illness. <p>The term can be used to refer to the health of subpopulations, and to compare the health of different populations.</p>
Practice Incentives Program (PIP)	Payments that support general practices to make ongoing improvements to enhance capacity, improve access and deliver quality care to patients.
Practice standards, professional standards	Guides health professionals' behaviour and may include codes of conduct, standards of practice and codes of ethics.
Preventive health care	<p>Refers to approaches or activities that aim to prevent illness, assist in the early detection of specific diseases and encourage the promotion and maintenance of good health. Approaches and activities include reducing the likelihood of a disease or disorder affecting an individual, interrupting or slowing the progress of a disorder or reducing disability. Within this broad definition, more specific characterisations include:</p> <ul style="list-style-type: none"> primary prevention, which reduces the likelihood of developing a disease or disorder secondary prevention, which interrupts, prevents or minimises the progress of a disease or disorder at an early stage tertiary prevention, which halts the progression of damage already done.
Primary health care	<p>A whole-of-society approach to health that:</p> <ul style="list-style-type: none"> aims at ensuring the best possible health and wellbeing ensures equitable distribution focuses on people's needs, and as early as possible includes the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care offers care as close as feasible to people's everyday environment.
Primary Health Networks (PHNs)	Primary healthcare organisations that are mainly funded by the Australian Government and that support primary healthcare delivery and address local health needs and service gaps within their allocated funding envelope. Their purpose is to drive improvements in primary health care and ensure that services are better tailored to the needs of local communities.
Provider	Health professionals as individuals who deliver services to the community. Many will have a provider number with Services Australia.
Rural and remote	All areas outside Australia's major cities, metropolitan areas and regional centres that are classified according to the Modified Monash Model MM 3–7 or Rural, Remote and Metropolitan Area (RRMA) 3–7 classification.
Scope of practice	Professional activities that a practitioner is educated (skills/knowledge), competent and authorised to perform, and for which they are accountable. Individual scope is time-sensitive and dynamic. The scope of practice for individual practitioners is influenced by the settings in which they practise, their individual level of competence and confidence, people's health needs and the service provider's policy requirements (authority/governance).
Secondary health care	Medical care provided by a specialist or facility upon referral by a primary care physician. This usually happens in a hospital or clinic, though it may be community based. It may include planned operations,

Term	Definition
	specialist clinics such as cardiology or renal clinics, rehabilitation services such as physiotherapy, or specialist mental health services.
Social prescribing	Also known as ‘community referral’, social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings; for example, GPs or practice nurses. Recognising that people’s health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people’s needs in a holistic way. It also aims to support individuals in taking greater control of their own health.
Team-based care	The provision of health services to individuals, families and/or their communities by at least 2 health providers who work collaboratively with patients and their caregivers within and across settings to achieve the shared goal of coordinated, high-quality care.
Tertiary health care	Highly specialised consultative medical care that involves advanced and complex procedures and treatments that are performed by medical specialists in state-of-the-art facilities. Examples include bypass, renal and plastic surgery.
Thin markets	Refers to the inadequate provision via market mechanisms for certain populations or in certain regions. In thin markets, some people requiring care and support may miss out on services or be forced into services that do not meet their needs (including services that are far away from their homes). ³²
Value-based health care	Typically refers to the value of a service to a patient relative to the resources consumed in delivering that service. ³³
Workforce Incentive Program (WIP)	Part of the Stronger Rural Health Strategy, this program provides targeted financial incentives to encourage medical practitioners to deliver primary care services in regional, rural or remote Australia and to support eligible general practices to engage nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals.

³² Department of Prime Minister and Cabinet, [Well-functioning markets](#), PM&C 2023.

³³ ME Porter. [What is value in health care?](#) N Engl J Med. 2010; 363(26): 2477–81.

Appendix 2 – Acronyms

ABS	Australian Bureau of Statistics
ACAI	Aged Care Access Incentive
ACCHO	Aboriginal Community Controlled Health Organisations
ACCHS	Aboriginal Community Controlled Health Service
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
BBI	Bulk Billing Incentive
COAG	Council of Australian Governments (replaced in May 2020 by the National Federation Reform Council)
CQI	Continuous quality improvement
FHU	Frequent Hospital Users incentive
FIFO	Fly in fly out
GP	General practitioner
ePIP	eHealth Practice Incentive Payment
LHN	Local Health Network
MBS	Medicare Benefits Schedule
MM	Modified Monash (MM 1–7)
NACCHO	National Aboriginal Community Controlled Health Organisation
NGPA	National General Practice Accreditation
NHRA	National Health Reform Agreement (between the Australian Government and the states and territories)
PAMs	Patient Activation Measures
PBS	Pharmaceutical Benefits Scheme
PCH Standards	Primary and Community Healthcare Standards
PHN	Primary Health Network
PIP	Practice Incentives Program
PIP IHI	Practice Incentives Program Indigenous Health Incentive
PIP QI	Practice Incentives Program Quality Improvement Incentive
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
QI	Quality improvement
RACGP	Royal Australian College of General Practitioners
RBBI	Rural Bulk Billing Incentive
RN	Registered nurse
SWPE	Standardised Whole Patient Equivalent
UK	United Kingdom
UNSW	University of New South Wales
USA	United States of America
VPR	Voluntary Patient Registration
WIP	Workforce Incentive Program
WIP-DS	Workforce Incentive Program – Doctor Stream
WIP-PS	Workforce Incentive Program – Practice Stream
WIP-RAS	Workforce Incentive Program – Rural Advanced Skills Stream

Appendix 3 – Practice Incentives Program, Workforce Incentive Program and workforce supports

Background on the Practice Incentives Program

The PIP was established to complement fee-for-service funding arrangements available through the MBS. It is an important revenue stream for general practices and encourages continual improvements and improved access and patient health outcomes.

The PIP consists of several individual and unique incentive payments for general practices or GPs and is facilitated through a payment platform administered by Services Australia (see Table 1). General practices' participation is voluntary, subject to eligibility criteria. As at May 2024, 6,656 accredited general practices were registered for the PIP.

Table 1: Short description of PIP payments

PIP incentive	Short description
After Hours	Incentivises general practices to provide appropriate access to after-hours primary health care.
eHealth	Encourages general practices to keep up to date with digital health and adopt new health technology.
Indigenous Health	Supports practices and Indigenous health services to provide better health care to Aboriginal and Torres Strait Islander patients.
Procedural GP Payment	Encourages general practices in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services.
Quality Improvement	Payment to general practices that participate in quality improvement activities to improve patient outcomes and deliver best practice care.
Rural Loading	Recognises the difficulties of providing care in rural and remote areas.
Teaching Payment	Encourages practices to provide teaching sessions to undergraduate and graduate medical students who are preparing to enter the Australian medical profession.
General Practice in Aged Care Incentive	Encourages GPs to provide increased and continuing services in Australian Government-funded residential aged care homes.

There are 2 types of payments: practice incentive payments, made to general practices, and service incentive payments (SIPs), made directly to GPs. According to the PIP Guidelines, a practice may use the payment to buy new equipment, upgrade facilities or increase pay for practitioners, noting that the department does not undertake any compliance activity to monitor how the funding is used. SIPs recognise and encourage GPs to provide specific services to patients. The General Practice in Aged Care Incentive is a SIP and practice incentive payment.

Over the past 2 decades, the PIP has evolved as a range of incentives have been added, reworked and, in some cases, withdrawn.

History of the Practice Incentives Program

The development of the PIP can be traced back to the introduction of the General Practice Reform Strategy in 1992, which aimed to address specific issues facing general practice in Australia. The government committed funding in the 1992–93 Budget to establish the Divisions of General Practice to support general practitioners' collaboration with each other and other health professionals to improve the quality of service delivery at a local level. It continued focusing on strengthening primary care throughout the 1990s.

In 1997–98, there was a focus on the General Practice Strategy on outcomes. The government announced a new measure to change the focus of the Better Practice Programme (BPP) to generate savings from reduced Medicare benefit payments.

At the time, the BPP eligibility criteria were based mainly on operational aspects of medical practices, such as after-hours service provision, patient continuity, minimum average consulting time and rural loading. To receive a BPP grant, a practice had to satisfy all the eligibility criteria.

As part of a review of the General Practice Strategy and the BPP, the government proposed to negotiate with the medical profession to structure the BPP payments in a way to:

- make the BPP more attractive to the profession and increase its uptake
- change the emphasis of the BPP to focus more on medical outcomes (not operational aspects)
- encourage the profession to adopt best practice in the diagnosis and treatment of certain prevalent conditions, such as asthma and diabetes.

The PIP commenced in 1998 following recommendations by the General Practice Strategy Review Group. Its aim was to encourage continuing improvements in general practice through financial incentives to support quality care and improve access and health outcomes for patients. The original (1998) objective of the PIP was to recognise general practices that provide comprehensive, quality care and that they are accredited or working towards accreditation against the RACGP Standards for General Practice.

A 2003 Productivity Commission report on the administrative cost impact on GPs from government programs estimated that 32.8% of such costs were attributable to the PIP. A General Practice Red Tape Taskforce, established to respond to the report, provided advice to the government in 2003 on the need to streamline GP administrative arrangements across government programs, and sought a second-stage review to simplify the PIP. A range of changes were implemented to address red tape by simplifying the PIP program and its administration.

The Australian National Audit Office (2010), the World Bank, some Australian research organisations and the Organisation for Economic Co-operation and Development (OECD) each assessed the PIP and concluded it needed to be adjusted to promote a greater focus on monitoring quality health care. In May 2014, the government outlined an agenda focused on streamlining the PIP. From early 2016, 5 out of the 10 existing PIP incentives were to be streamlined into a single incentive, focused on continuous quality improvement in general practice.

In the 2016–17 Budget, the government announced changes to the PIP and proposed that 7 incentives cease and a new PIP Quality Improvement Incentive be introduced. The changes included a new quality improvement incentive payment to streamline and simplify several existing PIP incentives to help general practices achieve high-quality health care and improved patient outcomes.

In 2016, the PIP was funded through the Practice Incentives for General Practices Fund, which provided a flexible funding pool, predominantly for incentive payments to general practices.

[Background on the Workforce Incentive Program](#)

The WIP provides financial incentives to improve access to quality medical, nursing and allied health services in regional, rural and remote areas and support multidisciplinary teams in eligible general practice. The program includes 3 streams.

Table 2: A short description of the 3 WIP streams

WIP stream	Short description
Doctor Stream (DS)	Incentivises doctors working in primary care in rural and remote Australia. Provides additional financial incentives of up to \$60,000 per year for doctors working in rural and remote locations, based on their level of qualification and the number of years they have practised in MM 3–7 areas. The more remote, and the longer the duration of practice, the higher the incentive. Most payments for WIP-DS are generated automatically, based on MBS billings information.
Rural Advanced Skills (RAS)	<p>Recognises doctors working in primary care and using advanced skills in MM 3–7 areas. Payments of up to \$21,000 per doctor, per year may be applied retrospectively. Payments reward a GP's investment in specialist qualifications and encourage more doctors to use these skills in a variety of settings in regional, rural and remote areas.</p> <p>The new incentive payments commenced in 2024 for activity in 2023, 2024 and 2025. Payments support the implementation of the National Rural Generalist Pathway.</p>
Practice Stream (PS)	<p>Incentivises practices by providing payments of up to \$130,000 per practice per year. Incentives are paid to eligible general practices, Aboriginal Medical Services (AMS) and Aboriginal Community Controlled Health Services. WIP-PS payments are to facilitate clinical transition to new models of care that respond to community needs.</p> <p>WIP-PS is available nationally, with rural loading applied for practices in MM 3–7: 30% in MM 3, 40% in MM 4–5 and 60% in MM 6–7.</p>

History of the Workforce Incentive Program

The WIP-Doctor Stream (WIP-DS) was introduced in 2020 as part of the Stronger Rural Health Strategy (SRHS) – 2018-19.³⁴ It replaced the General Practice Rural Incentive Program (GPRIP), a former Rural Health Workforce Strategy (a 2009–10 Budget measure). While the program's name changed, its core design and associated payment values remained unchanged. The key change was the move from the 2015 to the 2019 MMM classification.

The WIP-Rural Advanced Skills (WIP-RAS) payment was announced as part of the October 2022 Budget and was made available to doctors from December 2023. The program was developed in response to recommendations in the 2018 advice to the National Rural Health Commissioner on the development of the National Rural Generalist Pathway.³⁵

The WIP-Practice Stream (WIP-PS) was introduced in 2020 as part of the SRHS. It replaced the Practice Nurse Incentive Program (PNIP) and expanded the scope of the program to better support multidisciplinary care by allowing practices to use the incentive to also recruit allied health professionals. The PNIP commenced in 2012 to improve patient access to clinically appropriate primary healthcare services and to expand and enhance the role of practice nurses. Allied health professionals could also be supported under PNIP with payments to GP practices, ACCHOs and AMSs. These built on the earlier Nursing in General Practice Program under the Nursing in General Practice Initiative established in 2001.

³⁴ Department of Health and Aged Care (2021) Stronger Rural Health Strategy, DoHAC.

³⁵ Department of Health and Aged Care (2018) [Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway](#), DoHAC.

In 2022–23, the WIP-PS provided more than \$400 million per year in baseline funding through financial incentives to help general practices engage a range of health professionals as part of a multidisciplinary team.

In the October 2022 Budget, the government committed a further \$29.4 million as an additional investment in the WIP-PS to expand the list of health professionals eligible for salary support to include a broader range of allied health and auxiliary health professionals. This funding will also support increased rural loading of payments to practices in MM 3–7 locations by 10%, and up to the maximum loading of 60% for MM 7 practices.

The May 2023 Federal Budget invested an additional \$445.1 million over 5 years in the WIP-PS. This includes increases to payments, indexation changes, and data and accountability changes as follows:

- \$356 million over 4 years to increase incentive payments to eligible practices, including:
 - from 1 July 2023, the maximum incentive amount for the program increased from \$125,000 to \$130,000 per practice, per annum
 - the SWPE cap was lowered from \$5,000 to \$4,000, meaning more practices will be able to access the maximum incentive cap
- \$60.2 million indexation boost applied to WIP-PS incentive payments from 2024–25
- \$11.3 million over 4 years to implement accountability measures, including enhanced data collection tools
- \$11.3 million over 4 years to improve the targeting of incentive payments
- the remaining funding will support Services Australia in implementing the measures.

These increases aim to improve practices' financial viability by supporting them to continue or start providing multidisciplinary team-based care.

Since 2020, the WIP-DS appears to have had minimal effect on increasing the number of doctors working in primary care in rural and remote areas. Conversely, the WIP-PS has contributed to growth in non-medical primary care providers in rural and remote areas.

For the WIP-DS:

- Between January 2020 and February 2024, the number of WIP-DS payments per year ranged from 8,347 to 8,516. The proportion of payments and total payment amounts by MM have remained generally consistent since 2020–21. Approximately 70% of WIP-DS payments were made to doctors who had worked in that MM for 5 years or more.
- It is too early to assess the impact of the WIP-RAS as applications and payments only commenced in January 2024.

For the WIP-PS:

- There were 5,166 practices engaged in the former PNIP in 2017–18.
- Since May 2020, the number of practices receiving quarterly WIP-PS payments has remained reasonably static at 5,583 (from 5,380).
- Approximately 23% of WIP-PS practices are in rural locations MM 3–7.
- The proportion of health practitioners by profession and MM have remained generally consistent over time, with nursing (NPs, RNs and ENs) the predominant health professional engaged (75–75%).
- The number of practitioners listed under the WIP-PS grew from 18,878 in May 2020 to 21,862 in November 2023 (15% growth). This growth has not been proportionate across rurality, with the greatest proportionate growth of 52% in MM 6–7, followed by 22% in MM 3–5.
- Approximately 28% (1,671) of WIP-PS practices recorded an allied health professional, with only 22% (280) of these practices located in MM 3–7.

Workforce support

The WIP provides targeted financial incentives to encourage medical practitioners and other health professionals to deliver primary care in rural and remote communities. Payments are made directly to doctors through the WIP-DS and WIP Rural Advanced Skills payments. The doctors delivering primary care receive payments that are tiered in line with MM, tenure and service delivery levels (including primary care and advanced skills services). The WIP-PS payments are paid to the general practice to support the costs of engaging a range of eligible health professionals as part of a multidisciplinary team.

The experience of primary health care and general practice in rural and remote areas is different to metropolitan areas. There are geographic disparities in access to care and in health outcomes. For example, GP availability varies based on remoteness, ranging from 109.0–126.8 FTE per 100,000 population in MM 1–4 to 68.5–78.7 FTE per 100,000 population in MM 6–7 (in 2022–23).

Table 3: GPs and GP services per MM

MM classification ³⁶	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6	MM 7
Number of GP FTE per 100,000 residents	116.6	109.0	125.2	126.8	78.7	68.5	68.7
GP services per capita	6.9	6.2	7.2	7.3	4.5	3.6	3.3
Bulk billing rate 2023–24 ^{37,38}	76.8%	74.8%	78.8%	80.2%	79.9%	77.4%	87.1%

Despite various efforts and incentives to increase the primary care workforce in rural and remote Australia, there is an ongoing shortage of primary healthcare professionals in these areas. Several general practice incentives, including the WIP, PIP, Rural Bulk Billing Incentive, and Rural Procedural Grants Program, recognise the additional costs of delivering care in rural and remote areas.

Table 4: Rural loadings and tiered payments available to support primary care

MM classification	WIP Practice Stream (Rural) Loading by MM	WIP Doctor Stream* (maximum payment)	WIP Rural Advanced Skills* (maximum payment)	PIP Rural loading**	Bulk-billing rural scaling rate (GP consultation items)
MM 1	0%	n/a	n/a	RRMA 1 0%	100%
MM 2	0%	n/a	n/a	RRMA 2 0%	150%
MM 3	30%	\$12,000	\$8,000	RRMA 3 15%	160%
MM 4	40%	\$18,000	\$19,000	RRMA 4 20%	160%
MM 5	40%	\$23,000	\$19,000	RRMA 5 40%	170%
MM 6	60%	\$35,000	\$21,000	RRMA 6 25%	180%

³⁶ All data 2022–23. WIP data is internal data. GP FTE and service-level data drawn from HeadsUpp 20/3/2024.

³⁷ Australian Government Department of Health and Aged Care (2024) [Medicare Statistics 2023–24 March Quarter](#), DoHAC.

³⁸ Bulk billing by MM region is also supported by bulk billing incentive rural loadings, which recognise that ACCHOs and state government primary care clinics generally bulk bill their patients, as required by COAG Section 19(2) Exemptions Initiative requirements.

MM 7	60%	\$60,000	\$21,000	RMMA 7 50%	190%
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* Both the WIP Doctor Stream and WIP Rural Advanced Skills Stream reward doctors providing primary care through state government clinics in MM 6–7.

** Please note that PIP payments are based on RRMA classifications.

Appendix 4 – Terms of Reference for the General Practice Incentives Review

Context

The *Strengthening Medicare Taskforce Report* recommended significant reforms to strengthen Medicare and rebuild general practice.³⁹ The report recommended the reform of primary care funding, including that general practice be supported in the management of complex chronic disease through blended funding models, integrating incentive payments with fee for service, and funding quality bundles of care for people who need it most. It also recommended the development of new funding models that are locally relevant for sustainable rural and remote practices.

The Review of General Practice Incentives (the Review) was announced in the 2023–24 Budget, with funding of \$1.3 million. It is an intensive review to redesign current general practice incentive programs to better support quality patient-centred primary care from multidisciplinary teams in accredited general practices and nurse practitioner-led practices, with redesigned blended models linked to better care and outcomes for patient populations registered under MyMedicare, with a comeback in the 2024–25 Budget to consider the review recommendations.

Scope of the Review – Terms of Reference

The Review of General Practice Incentives (the Review) will redesign current general practice incentive programs to better align with Strengthening Medicare recommendations for reform.

The Review will make recommendations on:

1. the effectiveness and efficiency of existing general practice incentives, including the Practice Incentives Program, Workforce Incentives Program and agreed other general practice incentive programs, to assess if they are fit for purpose to drive patient-centred multidisciplinary primary care
2. options for the design of new blended funding models to better address the future primary care needs of Australia, including the growth in complex chronic disease and multidisciplinary models of care.

In making recommendations, the Review will consider:

- existing data and evaluations on the effectiveness of current general practice incentives
- a literature and international evidence review on best practice blended funding models for general practice and primary care.
- opportunities to:
 - improve targeting of payments to support multidisciplinary, wholistic person-centred care for people who need it most
 - streamline and simplify the number of payments and payment requirements
 - support data-driven quality improvement, with a focus on complex and chronic disease management
 - implement more effective compliance arrangements
 - better support people facing barriers to access
 - prioritise options to redesign funding arrangements which will be reinvested into general practice, the Panel will not be asked to consider any cuts to funding
 - consider how to improve linkages to the secondary and tertiary care sectors and promote a One Health System approach.

³⁹ Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report, DoHAC.

- how to further enhance quality and continuity of care through new incentives supported by MyMedicare
- the role of accreditation as a prerequisite to receive incentive payments in ensuring safety and quality of care as a foundation for blended funding reforms
- the eligibility and role of emerging, non-GP-led and non-traditional models of primary care practice
- contributions from the primary care sector and consumers (see below)
- implementation options to support a transition from activity-based to quality- and outcomes-based payments.

The Review will seek contributions on the priorities for reform from:

- consumers and their representative groups, including people from regional, rural and remote areas, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, people with disability, LGBTIQ+ people, people experiencing disadvantage, older Australians, and people experiencing mental health issues, people with drug dependence and people at risk of suicide
- primary care peak organisations and colleges
- primary healthcare providers, through existing departmental forums
- state and territory governments
- other interested organisations, researchers and individuals.

Recommendations for new or amended Medicare Benefits Schedule items are out of scope, except where they are required to support blended funding models.

The Review will be overseen by an Expert Advisory Panel comprised of 6–8 primary care experts who will provide recommendations to the government on options for new blended funding models. The panel will be appointed by the Department.

The Review will commence in July 2023 and be completed by April 2024, with a draft report delivered by December 2023.

Note: The review was extended to 30 September 2024 to facilitate stakeholder consultation.

Appendix 5 – Expert Advisory Panel membership

Member	Representation	Background
Emeritus Prof Stephen Duckett AM	Individual Health system financing, policy and management/ former Commonwealth public servant	<ul style="list-style-type: none"> • Honorary – General Practice and Primary Care, University of Melbourne • Honorary – Melbourne School of Population and Global Health, University of Melbourne • Board member, Healthdirect Australia • Board chair, Eastern Melbourne Primary Health Network • Former Director, Health Program – Grattan Institute • Former Secretary of the Commonwealth Department of Health and Aged Care • Former member, Strengthening Medicare Taskforce
Prof Henry Cutler	Individual Health economist	<ul style="list-style-type: none"> • Director, Centre for Health Economy – Macquarie Business School • Chief investigator on several MRFF and NHMRC projects • Affiliated researcher, Centre for Emotional Health and the Centre for Hearing • Education Application Research – Macquarie University • Former lead of Health economics – KPMG • Former head, Sydney Health Economics and Social Policy – Access Economics • Former senior economic consultant, Centre for International Economics
Denise Lyons	Individual Nurse practitioner	<ul style="list-style-type: none"> • Nurse practitioner, Kotara Family Practice • Board member, APNA • Program Committee Member, Hunter Postgraduate Medical Institute • Clinical Editor, Health Pathways – Hunter New England and Central Coast PHN • Registered nurse
Dr Paul Mara	Individual Rural practitioner with experience in obstetrics, anaesthetics and emergency medicine	<ul style="list-style-type: none"> • Forty years' experience in rural practice • Managing Director, Quality Practice Accreditation • Adjunct Associate Professor, Rural Clinical Schools – UNSW • Member of the Order of Australia • Founding executive member and former president, Rural Doctors Association of Australia • Co-founder, Rural Doctors Association of NSW • Member of the AMA and inaugural director from 1990–91
Sinead O'Brien	Representative State and territory health department	<ul style="list-style-type: none"> • Deputy Chief Executive, Strategy and Governance, Department of Health and Wellbeing South Australia • Director and co-founder, Tinnitus Treatment • Former executive director, Northern Adelaide Local Health Network • Former director of consulting, Uncharted Leadership Institute • Former program director of ICT and Digital Transformation — Department of Premier and Cabinet, South Australia • Executive Director, Nursing and Integrated Performance, London Primary Care Trust • Former nurse
Tracey Johnson, Churchill Fellow	Individual General practice administration	<ul style="list-style-type: none"> • CEO, Inala Primary Care • Co-founder, Cubiko • Deputy chair, Primary Healthcare Advisory Committee – AIHW • Health Services Researcher incl. Chair Meso System Working Group of 'Getting Australia's Health on Track' • Practice Management Consultant and Trainer

Member	Representation	Background
		<ul style="list-style-type: none"> • Ambassador, Australian Association of Practice Management • Former member of Evaluation Committee Health Care Homes • Member, Women in Economics Network
Dr Clara Tuck Meng Soo	Individual General practitioner	<ul style="list-style-type: none"> • Practice Principal, Hobart Place General Practice, • Practice Principal, East Canberra General Practice • Immediate Past President, Australian Professional Association for Transgender Health • Member of the Order of Australia but returned it in 2021 in protest of Margaret Court's honour.
Dr Dawn Casey (Proxy Dr Jason Agostino)	Individual Aboriginal and Torres Strait Islander peoples	<ul style="list-style-type: none"> • Tagalaka Traditional Owner, Northern Queensland • Deputy CEO, NACCHO • Co-chair, Aboriginal and Torres Strait Islander Advisory Group on COVID-19 • Former chairperson, Indigenous Land Corporation • Former chair, Indigenous Business Australia • Previous director, Western Australian Museum, Powerhouse Museum and National Museum of Australia • Founder, Aboriginal Reconciliation Unit – Department of Prime Minister and Cabinet • Founder and Assistant Divisional Head, Land and Natural Resources Branch – Department of Family Services and Aboriginal and Islander Affairs, Queensland • Honorary Fellow, Australian Academy of the Humanities
Prof Anthony Scott (from January 2024)	Individual Health economist	<ul style="list-style-type: none"> • Current: Professor and Director, Centre for Health Economics, Monash Business School, Monash University • Former health economics research lead at the Melbourne Institute: Applied Economic and Social Research, University of Melbourne • Elected Fellow of the Academy of the Social Sciences • Immediate Past President of the Australian Health Economics Society • Former board director of the International Health Economics Association • ARC Future Fellow and NHMRC Principal Research Fellow • Consultant to World Bank, Australian and state governments, Medibank Private, ANZ Health, Independent Hospital and Aged Care Pricing Authority, Productivity Commission and Australian Institute of Health and Welfare

Appendix 6 – Effectiveness Review of General Practice Incentives: Summary

Aim of the review

- The Department of Health and Aged Care (the department) engaged KPMG in October 2023 to undertake a rapid review of the effectiveness of the Practice Incentives Program (PIP) and Workforce Incentive Program (WIP).
- KPMG assessed the PIP and WIP collectively and each incentive payment individually against 4 criteria:
 1. Impact – how the incentive aligns with broader government policy objectives.
 - The incentives do not have a clear alignment with broader policy and are not responsive to emerging sector trends.
 2. Effectiveness – how effective the incentive is at achieving desired outcomes and influencing behaviour.
 - The incentives have limited influence on behaviour, and poorly resourced practices lack the administrative capacity to fully engage in them.
 3. Efficiency – the administrative efficiency (unnecessary burden, complexity) and overall efficiency of the incentive.
 - The administration of incentives is too burdensome, and practices noted a conflict between incentive requirements and desired outcomes.
 4. Sustainability – the sustainability of the incentive itself and the consumer health outcomes it drives.
 - Practices rely on incentives to drive financial sustainability, not behavioural change. Stakeholders expressed concern over other government initiatives that are in conflict with incentive outcomes in the mid- to long term.

Stakeholder consultation

- KPMG consulted stakeholders through direct consultation, focus groups, a public survey and written submissions.
 1. 16 Primary Health Networks (PHNs), 2 Aboriginal Community Controlled Health Organisations (ACCHOs) and 21 Primary Care peak bodies were consulted directly and through focus groups.
 2. A public consultation, seeking survey responses and written submissions, was open from 17 November 2023 to 22 December 2023.
 - 190 completed surveys and 35 written submissions were received.
 3. KPMG held a validation workshop with the department on 21 February 2024.

Final report — key findings

Program	Findings
Overall – PIP and WIP	<ul style="list-style-type: none">• Lack of coherent strategy and alignment between the individual incentives and other government policy.• Lack of clear linkage between incentives and patient health outcomes.• Incentives aren't evolving in response to current healthcare challenges; for example, workforce shortages, operational costs and the increasing size of general practices.• Complex administrative requirements reduce incentive uptake, which disproportionately affects smaller and/or rural and remote practices.• Many practices rely on incentive payments for practice sustainability, rather than using them to support behavioral change.

Program	Findings
PIP After Hours	<ul style="list-style-type: none"> The current payment amount does not adequately cover the costs of after-hours care delivery. Practices are facing increased competition from other bodies, such as PHNs and UCCs, which the incentive has not adapted to.
PIP Aged Care Access Incentive	<ul style="list-style-type: none"> The incentive needs more tailored support for mid-range providers. The incentive has not adapted to the changing health landscape, including the broad adoption of telehealth. <p>Note: This incentive will be discontinued and replaced with the new General Practice Aged Care Incentive.</p>
PIP eHealth	<ul style="list-style-type: none"> Practices require improved support, communication and education around digital health literacy. Practices need more transparency and accessibility of their ePIP data. Introducing more flexibility targeting would allow for more realistic goal setting and recognise the diverse needs of different populations.
PIP Indigenous Health Incentive	<ul style="list-style-type: none"> There is a need to redefine and enhance culturally safe care. Improve stakeholder communication, training and awareness. There is a poor correlation between payments and provision of care. There is significant support from the sector to continue and increase funding for the incentive.
PIP Procedural GP Payment	<ul style="list-style-type: none"> Improve support for upskilling and placements of rural generalists. Eligible services do not align with rural and remote community needs. A lack of stakeholder understanding and awareness reduces incentive uptake.
PIP Quality Improvement	<ul style="list-style-type: none"> Current QIMs have little influence on improving the management of complex chronic conditions. There is poor integration and compatibility between Clinical Information systems and PHN systems. Practices are primarily incentivised to simply provide data, not engage in QI activities.
PIP Rural Loading	<ul style="list-style-type: none"> The use of RRMA is outdated and burdensome, as most programs use MMM. The payment amounts do not adequately cover the cost of providing care in the most remote regions (MM 6–7).
PIP Teaching Payment	<ul style="list-style-type: none"> The scope should be broadened to allow nurses, NPs and midwives to supervise medical students. The payment amounts do not cover the opportunity cost of taking on students.
WIP Doctor Stream	<ul style="list-style-type: none"> Payment does little to attract new GPs to rural and remote areas, only helping improve retention. Year-level payment tiers don't encourage retention of doctors in specific communities, only MMM regions. Payment does not adequately support the needs of rural/remote areas given its focus solely on GPs.
WIP Practice Stream	<ul style="list-style-type: none"> Non-nursing professions rarely benefit from the payment. Poor visibility of the number and type of professionals using the payment. The payment cap is too low, leaving larger practices unable to fully use the program.

Final report – Key incentive program statistics

Program	Total practice uptake (2023)	Funding in \$m (2023)
Practice Incentives Program	6,375	\$467.6
PIP After Hours	6,073	\$88.7
PIP Aged Care Access Incentive	2,351	\$38.8
PIP eHealth	6,066	\$111.3
PIP Indigenous Health Incentive	3,576	\$41.6
PIP Procedural GP Payment	246	\$5.9
PIP Quality Improvement	6,138	\$94.2
PIP Rural Loading	1,969	\$41.7
PIP Teaching Payment	1,944	\$45.1
Workforce Incentive Program	n/a	\$518.2
WIP Doctor Stream	n/a	\$124.6
WIP Practice Stream	5,480	\$393.6

Appendix 7 – National and international literature and evidence review: Summary

Aim of the review

The department commissioned the Centre for Future Health Systems and the Centre for Primary Health Care and Equity at the University of New South Wales (UNSW Sydney) to undertake an international literature and evidence review to determine how blended funding models drive access and quality of care and how they promote multidisciplinary team care arrangements across providers in countries around the world.

The review found that, while blended payment models show promise, evidence on the cost-effectiveness of pay-for-performance or capitation models is lacking, and that a cost-benefit analysis should be considered before implementing specific incentives.

Key findings

Key findings on evidence from the literature on the impact of blended funding models on quality outcomes in multidisciplinary settings:

1. There is sufficient evidence that blended payments, which included pay for performance, improved the quality of care in multidisciplinary primary care settings. There was more evidence of change in processes than in outcome measures of quality of care.
2. There is insufficient evidence that capitation payments improve quality of care.
3. The effects of payments on quality of care may be enhanced by providing incentives at both the individual and team level or linking incentives to other activities such as training and quality improvement.
4. There is insufficient evidence for or against the impacts of pay for performance or capitation on health equity.
5. Evidence from qualitative research suggests that pay for performance and capitation may improve teamwork if funding is pooled at team level.

Key findings on the evidence from the literature on the effectiveness of different payment models on preventive care for people with complex chronic disease:

1. Insufficient evidence was found regarding the impact of pay-for-performance or financial incentives in general practices on primary health outcomes (e.g. mortality rates), particularly among patients with complex chronic diseases.
2. Insufficient evidence was attributed to the scarcity of research focusing on primary health outcome measures, possibly due to many pay-for-performance programs emphasising other quality indicators.
3. Some studies indicated the positive effects of pay-for-performance or financial incentives, preventative care activities, process measures and intermediate health outcomes, particularly in patients with diabetes; however, these findings varied widely across studies, disease types, outcome measures and program designs.
4. Positive impacts, where present, tended to be small, and improvements were mostly confined to incentivised activities, sometimes negatively affecting non-incentivised areas.
5. There was an observed ceiling effect in improvements, plateauing after reaching the maximum thresholds set for financial incentives in program implementation.

Key findings on the benefits of funding primary care using different payment models:

1. There was insufficient evidence due to the limited number of relevant studies in this area.
2. Switching from fee for service only to blended models might lead to general practices or clinicians self-selecting these models.

3. Even in blended models, general practices and physicians focused more on the fee-for-service component, which could potentially increase services related to this payment structure. Any pay-for-performance incentives offered under fee for service might be more successful in meeting physician objectives.
4. Capitation payment models were related to lower service usage and could reduce unnecessary services for low-complexity patients.
5. An economic evaluation of pay-for-performance services is crucial.
6. Not all pay-for-performance programs were cost-effective. An indicator-level cost-effectiveness analysis is recommended.
7. The implementation of blended models could prove very costly for the funder. Thus, an analysis of the overall benefits of such a model will be critical before implementation.

Key findings on the evidence from the literature on what drives behavioural change in primary care providers:

1. There is insufficient evidence of blended funding's impact on behaviour change. Blended funding models showed insufficient evidence of affecting primary healthcare provider behaviour regarding patient-centred care and improved health outcomes. The evidence also generally lacks findings regarding the motivations and factors driving primary care providers towards behaviour change.
2. There is insufficient evidence on the cost-effectiveness of financial incentives used to drive behaviour change. There was insufficient evidence on the cost-effectiveness of financial incentives compared to other behaviour change strategies. Various financial incentives, including pay-for-performance measures and service targets, showed inconsistent impacts on modifying provider behaviours.
3. Importance of interprofessional teams. Studies emphasised the need for role differentiation and co-location in interprofessional care teams to enhance collaborative behaviours, although the evidence supporting this was low quality.
4. The drivers of behavioural change is unclear. There was limited evidence on specific success factors associated with interventions that drove provider behaviour change across all contexts. However, the literature discussed sustaining interventions over time, focusing on influence rather than directing change, and on effective communication.