Gap Analysis of barriers to general practice accreditation

Final Report

15 January 2024

ALLEN + CLARKE CONSULTING

Acknowledgements

Allen + Clarke Consulting would like to thank all the stakeholders who contributed to the Gap Analysis of barriers to general practice accreditation.

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Glossary and acronyms

Term	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
ACSQHC	Australian Commission on Safety and Quality in Health Care
GP	General Practitioner
IT	Information Technology
NGPA	National General Practice Accreditation
PHN	Primary Health Network
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
WIP	Workforce Incentive Program

About this report

This report is divided into eight sections and an appendix. Section 1 consists of an Executive Summary and includes a summary of 12 key recommendations. Section 2 outlines the methodology of the Gap Analysis. Section 3 explores the characteristics of unaccredited general practices, and Section 4 describes the barriers to achieving accreditation experienced by general practices. Section 5 outlines accreditation motivators and enablers, while Section 6 explores views on the roles played by accreditation agencies in the accreditation process. Section 7 consists of a Conclusion, and is followed by an Appendix which contains three case studies of unaccredited general practices.

1.0 EXECUTIVE SUMMARY

Background

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has coordinated the National General Practice Accreditation (NGPA) Scheme since 1 January 2017. The NGPA Scheme supports the accreditation of Australian general practices to the RACGP Standards for general practices**.** Accreditation is voluntary and is designed to review a practice's systems for managing risks and improve the quality and safety of patient care.

General practices must meet the RACGP definition of general practice for the purposes of accreditation to be considered eligible for accreditation under the NGPA Scheme. While accreditation is voluntary, achieving and maintaining accreditation is a requirement for access to the Government's MyMedicare, Practice Incentives Program (PIP) and the Workforce Incentive Program (WIP) – Practice Stream. To further support general practices and Aboriginal Community Controlled Health Organisations (ACCHOs), the Australian Government is also investing $220 million through the Strengthening Medicare – GP Grants Program, over the 2022-23 and 2023-24 financial years. One of the three investment streams of this grant program is targeted at maintaining or achieving accreditation against the Standards. A one-off grant between $25,000 and $50,000 is available to each participating general practice and eligible ACCHO.

In May 2021, the Department of Health and Aged Care commissioned the Review of general practice accreditation arrangements (the 2021 Review)**.** The aim of the Review was to address concerns in the sector relating to the NGPA Scheme, and to seek stakeholder feedback on the strengths and limitations of general practice accreditation. The Review found that while approximately 84% of general practices in Australia are accredited, there remained scope for improvement. Recommendation 2 of the Review highlighted the need to increase accreditation levels by providing more support for practices to undertake the accreditation process, and by addressing the accreditation barriers facing general practices in rural and regional parts of Australia.

In August 2023, the Department of Health and Aged Care commissioned *Allen + Clarke Consulting* to undertake a Gap Analysis of the barriers faced by unaccredited general practices in seeking and achieving accreditation under the National General Practice Accreditation (NGPA) Scheme. This Gap Analysis supports the implementation of the 2021 Accreditation Review recommendations by improving understanding of the barriers for unaccredited general practices to seek and attain general practice accreditation, and the factors that would incentivise or aid unaccredited practices to seek out and attain accreditation, with the ultimate aim of providing targeted support for these practices.

Key findings

The Gap Analysis found that some general practices still face significant barriers and challenges associated with accreditation. These barriers are experienced disproportionately by particular cohorts of unaccredited practices, with characteristics like geography and practice size presenting barriers to accreditation. While there are a range of incentives and benefits associated with general practice accreditation, there is significant potential for further action by key accreditation stakeholders to improve data, increase motivation and incentives,

and more effectively communicate accreditation benefits to general practices and the general public.

A key finding of the Gap Analysis is that there is limited national-level data about unaccredited general practices. This data limitation poses challenges to presenting generalised findings about the profile of unaccredited general practices in Australia. However, the Gap Analysis has found that unaccredited practices typically fall within one or more categories. Small practices, newer practices, and practices with uncommon operating models that do not fit the RACGP definition of a general practice for the purposes of accreditation, are disproportionately unaccredited. Geography and population demographics influence accreditation status, with socio-economic status, prevalence of languages other than English, and level of regionality and rurality giving rise to particular barriers.

The accreditation Standards are widely considered to be overly complex and long, and include too many requirements that are not considered sufficiently relevant to quality and safety. The accreditation process and surveyor visits create further barriers to accreditation, while financial and staff costs associated with accreditation are a significant impediment for some practices. The impact of these barriers is felt most acutely by general practices with one or a small number of general practitioners (GPs), and few or no support staff. There remains considerable scope for actions by accreditation stakeholders to address each of these barriers, thereby improving efficiency and quality of accreditation processes, increasing the accessibility of accreditation and ultimately increasing levels of accreditation.

The Gap Analysis also found that while quality and safety is an important motivator of general practice accreditation, for many stakeholders, financial incentives are a more compelling driver. In particular, the PIP and WIP Practice Stream are strong motivators and perceived benefits of accreditation. While MyMedicare is a relatively new model, the Gap Analysis found that it holds promise as a motivator and benefit of accreditation, though understanding of the benefits of MyMedicare for practices is uneven and there is scope to improve communications.

Support from Primary Health Networks (PHNs) is widely viewed as the most significant source of support available for general practice accreditation, with many PHNs providing a range of different types of advice and support to general practices. There is an opportunity to further strengthen the role of PHNs in supporting accreditation, and drive a more consistent approach to PHN engagement with general practices on accreditation matters, while still ensuring that support can be tailored to the specific contexts and needs of practices. Clear direction and adequate funding from Government will be integral to harnessing the potential role of PHNs, noting some initial support is provided in the Strengthening Medicare 2023-24 Budget.

For some unaccredited practices, however, the incentives and support available are not sufficient to foster an intention to seek accreditation, with the barriers to accreditation viewed as overwhelming, or factors such as a GP nearing retirement reducing the appeal of available incentives. In some cases, unaccredited practices are generally disengaged from Government processes and PHNs. Broader system level changes may be needed to enable this cohort to move towards accreditation. This should include consideration of a tiered or tailored approach to accreditation that reflects the diversity of general practices and population health needs and takes into account the financial and human resource burden the current accreditation scheme poses to some practices.

Recommendations

There are 12 key recommendations arising from the Gap Analysis (see **Table 1** below).

Table 1 Summary of recommendations

Profile	
1	Develop stronger data on the demographic and geographic profile of unaccredited general practices. PHNs should be tasked with annually compiling practice profiles in their region, including accreditation status, to share with the Department of Health and Aged Care.
Barriers	
2	Revise the definition of a general practice. The Department of Health and Aged Care and the ACSQHC should work with the RACGP to revise the definition of a general practice for the purposes of accreditation to broaden the scope of eligible practices. Addressing community health needs should be at the centre of this process, and the revised definition should allow for innovative models of primary care service delivery.
3	Revise Standards to increase accreditation levels. The Department of Health and Aged Care should work with the RACGP to revise the Standards and indicators to focus more strongly on patient quality and safety, and to remove barriers associated with length, complexity and clarity.
4	Remove barriers and burden associated with the accreditation process. ACSQHC and RACGP should continue to refine the accreditation process and surveyors' visit, and the Department of Health and Aged Care should clearly define and appropriately fund PHNs to support practice accreditation. These actions would reduce the time and cost burden of the accreditation process and visit and ensure the requirements of accreditation do not negatively impact the amount or quality of care provided by general practices.
5	Provide ACCHOs with flexibility to be accredited against one set of standards. The Department of Health and Aged Care should simplify ACCHO accreditation requirements to remove the burden and expense of accreditation, and to ensure requirements are relevant for this cohort.
Motivators and enablers	
6	Increase public awareness of general practice accreditation. The Department of Health and Aged Care and the ACSQHC should develop public-facing resources, that can be utilised by stakeholders including PHNs to raise awareness about the benefits of general practice accreditation. Developing and sharing these resources will support increased public awareness about accreditation and will inform decision making by consumers about the benefits of receiving care at an accredited practice.
7	Communicate the benefits of MyMedicare. The Department of Health and Aged Care should communicate the immediate and longer-term benefits of MyMedicare

	more effectively to general practices. This will address uncertainty in the sector, and help maximise the potential for MyMedicare to foster increased accreditation levels.
8	Review the GP Grants program. The Department of Health and Aged Care should review the GP Grants program to understand the impact it has had on general practice accreditation, and to inform future investment decisions.
9	Improve availability and accessibility of accreditation material. Make the Standards, indicators and other materials relating to general practice accreditation available in key languages other than English. This should include materials provided by accreditation agencies, RACGP and other stakeholders.
10	Provide greater flexibility in accreditation to improve accessibility of accreditation to a broader range of practices. This should include the development of a 'tiered' approach that enables accreditation costs and requirements to be scaled up or down depending on practice size and level of patient care provided. Developing a tiered approach could also incentivise excellence in care.
11	Tailor support and incentives to the needs of cohorts of general practices with low levels of accreditation. The Department of Health and Aged Care should recalibrate existing support to establish a specific GP grants scheme for small practices, or practices in underserved communities and rural/remote areas.
12	Improve consistency of accreditation assessments. ACSQHC should drive consistent high quality accreditation assessments by accreditation agencies. A voluntary code of conduct should be explored as a mechanism for driving consistent industry practices.

2.0 GAP ANALYSIS METHODOLOGY

The Gap Analysis sought to answer the key questions outlined in **Figure 1**.

Figure 1 – Gap Analysis key questions

Profile

1. What are the characteristics (including location, types of business model, demographic market served) of unaccredited practices?

Barriers

2. What are the perceived barriers / impediments to accreditation?
3. What are the perceived costs in relation to accreditation?
4. Are these barriers internal (practitioner side) or external (systemic)?
5. Do the demographic characteristics of the practices and owners influence the types of barriers to accreditation that are experienced?

Motivators and enablers

6. To what extent do currently unaccredited practices intend to become accredited?
7. What factors motivate practices to want to become accredited?
8. What are the perceived benefits of accreditation?
9. What motivated providers to apply for accreditation funding through the GP Grants Program?
10. What is the impact of the GP Grants Program in supporting accreditation?
11. What supports have general practices received from PHNs or other sources that have encouraged or supported practices to become accredited?
12. Are there any other factors that would motivate general practices to apply for accreditation?

2.1 Analytical approach

The Gap Analysis employed a comprehensive mixed-method approach to data collection and analysis (see **Figure 2**). A total of 20 documents were reviewed, and 46 interviews were held with stakeholders including PHNs, unaccredited general practices, the RACGP, the ACSQHC, accreditation agencies and a researcher with expertise on ACCHO accreditation issues.

350 unaccredited general practices were invited to participate in an interview or complete the survey. Contact details for these practices was provided by PHNs. Thirteen practices chose to participate in an interview, and 31 responded to the online survey. Nine practices completed both an interview and a survey.

The online survey consisted of 30 questions. It included introductory questions relating to the location of the practice, the types of services provided by the practice, the practice's ownership model, the demographics of the survey respondent, and the nature of respondent's role. The survey questions then focused on generating insights in relation to the Gap Analysis questions provided at **Figure 1**.

Figure 2: Data sources informing the Gap Analysis

Review information sources	
	**Desktop Analysis** 20 documents were reviewed including relevant NGPA, RACGP ACSQHC documents, reference materials for the Incentives Programs and General Practice Grants, the 2021 Review of general practice accreditation arrangements and associated Consultation Paper, and materials available on the websites of the four accreditation agencies.
	**Unaccredited general practice data** Data was received from the Department of Health and Aged Care and some PHNs, detailing the names and locations of unaccredited general practices.
	**Stakeholder Consultation** 46 interviews were held with PHNs (27), unaccredited general practices (13), three accreditation agencies, ACSQHC, RACGP and other stakeholders.
	**Online Survey** 31 unaccredited general practices responded to an online survey.

2.1.1 Gap Analysis limitations

There are some limitations to the data available for the Gap Analysis. Low survey participation and incomplete national data on unaccredited practices limited the level of quantitative analysis that could be undertaken, although where possible data from these sources was triangulated with qualitative data to support findings and recommendations. Limitations include:

- Despite efforts to engage with unaccredited general practices (directly, and through PHNs), limited input was received. Self-selection bias and representativeness of the sample are potential limitations.
- Limited available data on the profile of unaccredited general practices at a national level, and their contact details. This limitation was reduced to some extent by PHNs providing information about unaccredited practices in their regions when they had data available and were prepared to share it for the Gap Analysis.

The 2021 Review also received a relatively small number of responses (n=39) to the online survey, though it is unclear what proportion of the participants were from unaccredited general practices. The small numbers of survey respondents to the 2021 Review suggests a low level of engagement among unaccredited general practices over time, which also correlates with barriers discussed in Section 4.

3.0 WHAT ARE THE CHARACTERISTICS OF UNACCREDITED PRACTICES?

This section discusses findings in relation to the profile and key characteristics of unaccredited general practices. The Gap Analysis builds on the 2021 Review by identifying new demographic information about unaccredited general practices.

There remains uncertainty about the precise number of unaccredited practices operating in Australia. There is no single dataset that captures details of unaccredited practices with a high degree of accuracy, and any estimate of overall numbers would be strictly point in time and subject to data limitations.

3.1 Main types of unaccredited general practices

The Gap Analysis found that unaccredited general practices typically fall within one or more of the following categories:

- Practices with a small number of GPs and limited or no support staff
- New practices
- Alternative practice model
- Practices in lower socio-economic areas, areas with lower levels of English as a first language, and regional and remote areas.

Small practices

The Gap Analysis found that small practices, often with a solo GP, are more likely to be unaccredited. The GPs in these practices often feel they do not have the time to manage accreditation, and the available incentives are either not understood or are regarded as inadequate to warrant the time and expense required to undertake accreditation. These practices frequently do not employ other staff (including for instance a practice manager, administration staff or a nurse) who would be able to support/manage the accreditation process.

The Gap Analysis found that GPs working at these general practices are often older and may be close to retirement. Some practices among this cohort still operate paper-based business systems, which may mean they would not meet accreditation requirements.

Newer general practices

Some unaccredited practices are new practices who are likely to become accredited, but have lacked the time, capability or motivation. Feedback from several newly opened general practices indicated that they understood the financial and quality and safety benefits of accreditation and intended to become accredited, though had deprioritised accreditation to focus more on immediate priorities – like hiring staff and establishing a patient base.

Niche general practices

The Gap Analysis found that there are a range of practices across Australia that service particular populations, provide targeted or niche healthcare services, or have uncommon operating models. These practices may not fit the established RACGP definition of a general practice for the purpose of accreditation, or may be uncertain about whether they would meet the definition.

Geographic and demographic considerations

The Gap Analysis found that geography and demographics influence the ability of general practices to become accredited. Levels of accreditation are lower in some rural and remote areas, despite the fact that accreditation would enable access to rural incentives. Rates of accreditation are also lower in some socioeconomically disadvantaged outer suburban areas. The Gap Analysis found that areas with large overseas-born populations, or where English is not the primary language spoken, tend to have lower levels of practice accreditation.

Recommendation 1

Develop stronger data on the demographic and geographic profile of unaccredited general practices. PHNs should be tasked with annually compiling practice profiles in their region, including accreditation status, to share with the Department of Health and Aged Care.

4.0 ACCREDITATION BARRIERS

4.1 What are the perceived barriers / impediments to accreditation? Are these barriers internal (practitioner side) or external (systemic)?

This section explores the barriers or disincentives to seeking accreditation experienced by unaccredited practices, and the costs of accreditation.

The perceived barriers and impediments to accreditation consist of both **practitioner side** and **systemic factors**. The Gap Analysis found that practitioner side factors often influence the impact of systemic barriers. For instance, a practice's internal staff capacity may impact its ability to effectively engage with complex accreditation Standards. Practitioner and systemic factors can also overlap – for instance, a practice's inability to recruit staff may be reflective of a broader health system challenge.

4.2 RACGP definition of general practice for the purposes of accreditation

The Gap Analysis found that the narrow RACGP definition of a general practice is a barrier to accreditation for some practices. The 2021 Review explored the definition of general practice, and reported the definition was '*currently under review*'. At the time of the Gap Analysis, the existing RACGP definition was still in place, with progress having been made on updating this definition since the 2021 Review. The Gap Analysis builds upon the 2021 Review by presenting further information and insights relating to definitional barriers. While a range of barriers are described below, a key theme throughout the Gap Analysis was the need to consider community need in defining general practices for the purposes of accreditation.

A range of examples were provided of practices with models of care that do not meet the RACGP definition of general practice. Some practices said they would like the opportunity to become accredited. Examples of non-traditional practices include:

- Mobile clinics providing outreach services (for instance, for people experiencing homelessness)
- GPs operating aged care services
- clinics that do not have all of the required infrastructure
- practices that do not provide the full range of services that RACGP require for a general practice, rather focusing on a particular disease or condition (for instance, diabetes).

Some chronic disease focused practices have a small number of general practitioners who work in collaboration with other health practitioners including psychologists, naturopaths, chiropractors, and nutritionists. To receive access to Commonwealth funded programs the health service must meet the definition of general practice as described by the RACGP. In this scenario these practices would not be eligible and therefore there is little incentive for these practices to become accredited.

A GP who works in a mobile outreach clinic suggested they '*provide almost everything that you would expect in a bricks and mortar practice without the bricks and mortar*.' For this outreach clinic, which employs three general practitioners and bulk bills, being ineligible for accreditation created challenges, including not being able to access PIP payments or additional funding for First Nations patients.

> *Last time we enquired they were very inflexible. It should be more about the community needs, at a time and place that works for them.*
>
> − Unaccredited general practice representative

The Gap Analysis heard examples of GPs operating a practice from their home. These practices do not meet accreditation requirements – for instance, because they do not have reception staff, have no or limited ability to provide vaccinations, or have limited access to a sink. The Gap Analysis also found that some unaccredited practices consist of a GP who rents a consulting space within another (accredited) practice, a practice model that is not eligible for accreditation.

Some practices indicated objections to the requirements of the general practice definition to have certain items in their practice for the purpose of achieving accreditation. For instance, one unaccredited general practice representative indicated an unwillingness to have oxygen in the practice, due to safety concerns and because of the availability of oxygen in metropolitan settings, including delivery through an ambulance. Several practices also objected to the requirement of having a vaccine fridge, as they do not provide vaccines to patients, feel they cannot afford the extra cost of a vaccine fridge, or use an ordinary household fridge for storing vaccines.

Stakeholders suggested that consideration should be given to broadening accreditation eligibility to alternative primary care models beyond the traditional general practice model, in order to meet the needs of the community. The National Safety and Quality Primary and Community Healthcare Standards were identified as providing a potentially more appropriate or accessible form of accreditation for some general practices. The Primary and Community Healthcare Standards were launched in October 2021 and '*aim to protect the public from harm and improve the quality of health care delivered by describing a nationally consistent framework, which all primary and community healthcare services can apply when delivering health care*.'[1]

[1] https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare

> *The way primary healthcare is delivered needs to change. The system is broken. I'm strongly advocating for increased pathways of primary health clinicians. More accredited practitioners, look at alternative models that don't require so many seats, brochures in waiting rooms, there are a whole list of things that don't impact on patient care. It should be more about community needs, at a time and place that works for them.*
>
> Unaccredited general practice representative

Recommendation 2

Revise the definition of a general practice. The Department of Health and Aged Care and the ACSQHC should work with the RACGP to revise the definition of a general practice for the purposes of accreditation to broaden the scope of eligible practices. Addressing community health needs should be at the centre of this process, and the revised definition should allow for innovative models of primary care service delivery.

4.2.1 Complexity of Accreditation Standards and Indicators

The Gap Analysis found that the RACGP Standards and large number of indicators are a barrier to accreditation for some practices. Some stakeholders have strongly held views in relation to the complexity, size, appropriateness and prescriptiveness of the Standards and indicators.

Several stakeholders interviewed during the Gap Analysis regularly described them as '*overwhelming*', while a PHN described the process and requirements for general practices as '*absolutely over-cooked*'. The Standards and indicators can be challenging to understand for some practices, and some practices view some indicators as non-essential to the delivery of safe and quality health care. The large number of indicators contributes to the overwhelming nature of the Standards for some practices, with the number of indicators contrasted with the more streamlined and targeted approach adopted in other standards in the Australian health sector such as the National Safety and Quality Health Service Standards.[2]

One sector stakeholder suggested that:

> *That's an awful lot of indicators. It is overwhelming. There's just so many indicators it's like you can't even bite off the first bite to chew it, because it just feels like you'd be there forever.*
>
> − Sector stakeholder

[2] https://www.safetyandquality.gov.au/standards/nsqhs-standards

However, some stakeholders acknowledged that the Standards should not be simplified too much, given the important role they play in quality and safety. A PHN considered that:

> *accreditation is only about the minimum safe level of care, not best practice. Some complexity is warranted to incentivise formal recognition and signal that they're meeting this minimum standard.*
>
> − PHN representative

An accreditation agency described that to date the RACGP standards have been fit for purpose for the majority of general practices, but suggested:

> *As we embark on different innovative models of care in primary care, there will be a requirement for us to consider what standards would meet the needs of the different types of practices or services that are available.*
>
> − Accreditation agency

One consequence of the complexity of the Standards and the large amount of effort required to establish practice policies and procedures has been that some general practices feel they need to use the services of lawyers and consultants to support the accreditation processes. One PHN described that the industry is '*leveraging fear*' and *'taking advantage of GPs out of fear – this is going against the intent of accreditation*'. Another PHN advised of instances where consultancy firms had approached them for advice and resources about accreditation which they could then pass onto a general practice they were providing accreditation services to, indicating that there should not be an expectation that PHNs would provide support to consultancy firms, and that they needed to develop a clear process for managing such requests.

The RACGP acknowledged in the 2021 Review that there is a need to review the Standards to '*streamline the effort required by practices to meet the Standards*' and continuously improve the Standards to respond to changes in the primary care landscape. While the limitations around the Standards identified in the 2021 Review appear to remain relevant in 2023, the RACGP advised the Gap Analysis that it is responding to the recommendations of the Review and has work underway to strengthen general practice accreditation and make it more accessible. This includes updating the definition of general practice for the purposes of accreditation to be more inclusive; preliminary work on the 6th Edition of the Standards, including potentially reducing the number of indicators; and consideration of ways to reduce the burden of accreditation visits.

Recommendation 3

Revise Standards to increase accreditation levels. The Department of Health and Aged Care should work with the RACGP to revise the Standards and indicators to focus more strongly on patient quality and safety, and to remove barriers associated with length, complexity and clarity.

4.2.2 Accreditation process and visit

The Gap Analysis has found a range of barriers to accreditation relating to the accreditation process. The 2021 Review found a '*lack of confidence in key elements of the NGPA scheme*' and in the accreditation process, with four of the Review's recommendations directly relating to the accreditation process or visit. The Gap Analysis has identified a range of barriers in the accreditation process, indicating little visible change within the sector since the 2021 Review.

During the Gap Analysis, many stakeholders raised the significant time and staff effort involved in the accreditation process throughout the accreditation cycle, but particularly in the months leading up to the accreditation surveyors' visit and then during the visit itself. In some practices, the accreditation process places significant pressure on practice staff. The significant time involved in updating policies and processes was raised by several stakeholders and was described as '*incredibly onerous*' and a disincentive to become accredited for some practices.

The stressful nature of the accreditation visit, and the preparation required for the visit were raised by several stakeholders. A sector stakeholder remarked that '*the sooner we remove the event component of it, the sooner it will improve*' while several stakeholders raised concerns about the actions and behaviours of surveyors during the accreditation visit. A GP advised that a negative experience with a surveyor resulted in the practice not seeking re-accreditation. This GP indicated that the experience of the accreditation visit outweighed any potential benefit the practice might receive from the PIP (see case study 2).

Other stakeholders suggested there is a large discrepancy in the way accreditation surveyors interpret the Standards and indicators, and that requirements appear to change without being explained to practices. A general practice representative indicated that '*the accreditors seem to have a preoccupation with trying to justify their role with telling us all the things we're doing wrong. Every new assessor then seems to pick apart something new or previous things that were OK*.'

The Gap Analysis found evidence of disruption to patient care in general practices resulting from the accreditation process. Several practices and PHNs described occasions when the '*burden*' of the accreditation visit had resulted in reduced delivery of patient care during and in the lead up to the visit, with a PHN suggesting that the accreditation visit '*reduces the hours that practices can open because practitioners are instead preparing for accreditation*.' Another PHN described '*the large toll on personnel prior to inspections, and indicated that two practice principals and a nurse usually need to take a day off from seeing patients to be available to the inspectors over a day or two*.' This finding is important to consider in the context of the stated objective of accreditation to enhance quality and safety, and should be a consideration in future efforts to increase rates of general practice accreditation.

The burden of accreditation and the accreditation visit is particularly significant for smaller practices who may lack the staff resources to effectively manage accreditation while maintaining patient appointments. One PHN said the accreditation visit is seen by general practices as a '*necessary evil*' that can be absorbed in larger practices but which in smaller practices takes up enormous time and impacts on seeing patients.

Recommendation 4

Remove barriers and burden associated with the accreditation process. ACSQHC and RACGP should continue to refine the accreditation process and surveyors' visit, and the Department of Health and Aged Care should clearly define and appropriately fund PHNs to support practice accreditation. These actions would reduce the time and cost burden of the accreditation process and visit and ensure the requirements of accreditation do not negatively impact the amount or quality of care provided by general practices.

4.2.3 Workforce challenges

The need for practice support staff (particularly a practice manager) to manage the administrative requirements of accreditation has been highlighted throughout this section on barriers. However, securing and retaining such workforce was also raised as an issue in this Gap Analysis, with workforce shortages, high staff turnover, and staff capability and capacity raised by many stakeholders as posing barriers to accreditation.

One PHN pointed out that many practices have experienced high turnover of staff in the last three years, with stakeholders suggesting that staff turnover has been particularly pronounced since COVID-19 commenced. This has led to a loss of corporate knowledge and skills in relation to accreditation. In some regions, it is common for the spouses of GPs to work as practice managers or in administrative support roles, or for the local shop assistant to also work as the practice manager. One rural general practice representative reflected that '*there aren't many people in our small town who have the experience necessary to be receptionist in the practice*'. In some practices, administrative staff receive limited support and training – '*the practice manager just gets thrown in and learns through experience and there's a lot of burnout because there is no training and support*'. The Gap Analysis has also found that the size and complexity of the workload of practice managers contributes to staff turnover, with some stakeholders suggesting that the burden of the accreditation process itself can be a contributor to staff turnover.

The Gap Analysis was informed that staff turnover (among nurses and receptionists for instance) was higher in lower socio-economic areas, and that this could be a contributor to lower rates of accreditation in those areas (see Section 4.4)

As detailed in the RACGP's Heath of the Nation 2023 report, rural and remote areas (MMM 5-7) have significantly fewer GPs per 100,000 people than MMM1-4 areas, and this imbalance has an impact on access to healthcare.[3] A priority for the Australian Government should be to ensure that barriers to accreditation are addressed in rural and remote areas, and that efforts to strengthen general practice accreditation requirements and processes do not inadvertently

[3] RACGP, *Health of the Nation 2023*, 34-35.

create new barriers to operating a general practice or achieving accreditation in already underserved communities.

4.3 What are the perceived costs in relation to accreditation?

Cost is a significant barrier to accreditation for some general practices. Accreditation costs can include those associated with achieving and maintaining accreditation requirements, the cost of using accreditation agencies, costs associated with contracting extra staff to assist with accreditation or backfilling practice managers while they prepare for accreditation, and for some practices the costs associated with receiving accreditation support and advice from lawyers and consultants. Further considerations include the opportunity cost of lost revenue for GPs required to manage the accreditation visit instead of providing patient care.

Many of the findings of the Gap Analysis regarding cost aligned with the 2021 Review that reported on direct and indirect costs of accreditation and recommended that the costs of accreditation to general practice should be reduced. The Gap Analysis has also found that the costs of general practice accreditation are likely to disproportionately impact practices in regional, rural and remote locations.

Stakeholders provided varying estimates of financial costs. Financial costs raised by stakeholders included staff time to complete the paperwork, upskilling staff, and infrastructure required for accreditation, including vaccination fridges, generators for fridges, and IT infrastructure. One PHN suggested that accreditation processes cost approximately $10,000, in addition to approximately $5,000 to pay the accreditation agency. Another noted that they '*hear all the time that it costs $75,000 annually to do accreditation*', estimating that this figure is the cost of staff in addition to approximately $40,000 in other costs. This PHN described the costs as '*particularly visceral for GPs that are making just 5% profits, which is common for many practices in Australia*.'

As described in Section 4.2.2, managing the accreditation process and visit results in reduced time available to see patients. The potential for indirect negative patient health outcomes to occur if patients are unable to access timely healthcare if fewer patient appointments are available on day of visit is of concern. This may be a greater consideration in the small and solo clinics, and may disproportionately affect patients in regional, rural and remote areas with already limited primary healthcare availability and significant health disparities.

4.4 Do the demographic characteristics of practices and owners influence the types of barriers to accreditation that are experienced?

The Gap Analysis found that the demographic characteristics of practices and owners strongly influence the types of barriers to accreditation they experience. This section details barriers experienced by several key demographic groups. In terms of ownership models: 15 survey respondents identified that their general practice was owned by a single GP, five were owned by multiple GPs, while three were owned by a practice manager. Two respondents indicated their practice had a not-for-profit model, and two respondents indicated that their practice had a corporate operating model. The remaining four respondents had ownership models including being owned by a State Health Department, owned jointly by a husband and wife, and owned jointly by a GP and a practice manager.

Small and paper-based practices, older GPs

Most stakeholders interviewed stated that unaccredited practices were more likely to be those with one or a small number of GPs, and few or no support staff. These practices often have no practice manager to manage the accreditation process. While this finding cannot be verified from the available quantitative data, all unaccredited general practices that participated in interviews for the Gap Analysis were small practices, often with only one GP.

Being an older GP nearing retirement and '*not being interested in accreditation*' was identified by many stakeholders as another demographic factor that influenced intention to become accredited or maintain accreditation.

Using paper-based records and having limited information technology (IT) infrastructure or practice management software were regularly identified by stakeholders as posing a barrier to accreditation. Older GPs are the cohort most likely to have paper-based administration and records. One PHN noted that there are 18 practices in their region that are solely paper-based. A lack of IT connectivity may prevent some general practices from being able to undertake the online accreditation self-assessment tool. Some stakeholders suggested that the costs associated with IT and the necessary information security can be significant. Some unaccredited general practice representatives indicated concerns about the security of digital records and vulnerability to cybercrime.

> *My current system works perfectly well, and has for the last several decades. Without having to pay any software licence fee and constant updates, and my records will be able to be read in a thousand years, unlike with a computerised record.*
>
> - Unaccredited general practice representative

Low return on investment for small general practices was a common theme raised during the Gap Analysis, particularly for small practices and older GPs.

> *Solo or very small practices tend to see accreditation as a burden, with little or no return on investment. The effort required to compile evidence etc is often a distraction to the core services. They don't have the capacity to run the business, make it financially sustainable and viable, and also meet the requirements, particularly the evidentiary requirements.*

- PHN representative

Geographic and demographic barriers

The Gap Analysis found that geography and demographics influence the ability of practices to become accredited. Levels of accreditation are lower in some rural and remote areas, with Queensland particularly affected. For some rural and remote practices, the logistics and '*tyranny of distance*' associated with their location created barriers to becoming accredited, including challenges associated with being unable to recruit quality staff and receive effective support from their PHN.

The available data suggests that some lower socioeconomic and/or outer suburban areas have a disproportionately high number of unaccredited practices. Relevant factors may include socio-economic status, and the use of languages other than English by general practice staff.

One sector stakeholder highlighted that practices in poorer areas experience challenges including a significant portion of patients who cannot afford co-payments, which places financial pressure on practices. A PHN observed that there are more unaccredited practices '*in the south of our region, which is lower socioeconomic status*' and that these practices tend to share other structural characteristics including lack of digitisation and a lack of practice managers and nurses.

4.5 The accreditation experiences of ACCHOs

The Gap Analysis has found that ACCHOs deliver a broader range of services than mainstream general practices ('*everything from pre-birth programs to aged care*'), and that this leads to a disproportionate accreditation burden. An ACCHO-affiliated researcher indicated that on average ACCHOs manage an average of seven accreditation standards, and that some manage up to 11 standards. It was estimated that the average direct cost to an ACCHO of complying with one standard is $20,000 per year, plus staff time and costs associated with purchasing electronic systems to manage accreditation processes. Stakeholders suggested that accreditation should be streamlined by recognising the ISO 9001 2025 Quality Management System standard for ACCHOs, and making PIP and WIP funding available for ACCHOs accredited against this standard.

Recommendation 5

Provide ACCHOs with flexibility to be accredited against one set of standards. The Department of Health and Aged Care should simplify ACCHO accreditation requirements to remove the burden and expense of accreditation, and to ensure requirements are relevant for this cohort.

5.0 ACCREDITATION MOTIVATORS AND ENABLERS

This section explores the extent to which unaccredited general practices intent to seek accreditation, and the perceived motivators and enablers of accreditation.

5.1 To what extent do currently unaccredited practices intend to become accredited?

The Gap Analysis found that the intention of unaccredited practices to become accredited appears to be generally high, as would be expected from the high level of accreditation in Australia. However, intention to become accredited is strongly influenced by the characteristics of the general practices identified in Section 3, and some types of general practices have a lower level of intention to become accredited.

Small practices

Interviews undertaken during the Gap Analysis suggested that this cohort of unaccredited practices typically have low levels of intention to become accredited. This cohort experience significant barriers that negatively influence intention, and incentives in place are not strong enough or sufficiently targeted to increase levels of intention.

Newer general practices

Feedback from several newly opened (within 18 months) general practices indicated that they understood the financial and quality and safety benefits of accreditation and intended to become accredited, though most had deprioritised accreditation to focus on more immediate priorities – like hiring staff and establishing a patient base. One GP from a practice that opened in August 2022 indicated that they had '*wanted to become accredited since day one, but were too busy. Patients are the priority*.' This practice was advised by other general practices to wait for six months after opening their practice before seeking accreditation.

Niche general practices

Given the range of different characteristics of niche general practices, there is no clear trend in their intention to become accredited. Some of these practices wish to become accredited but are unsure of their eligibility and pathways, while others believe they do not meet the definition and accordingly do not intend to seek accreditation. Others indicated they did not feel that there were sufficient incentives for their model of practice to warrant the effort required to become accredited.

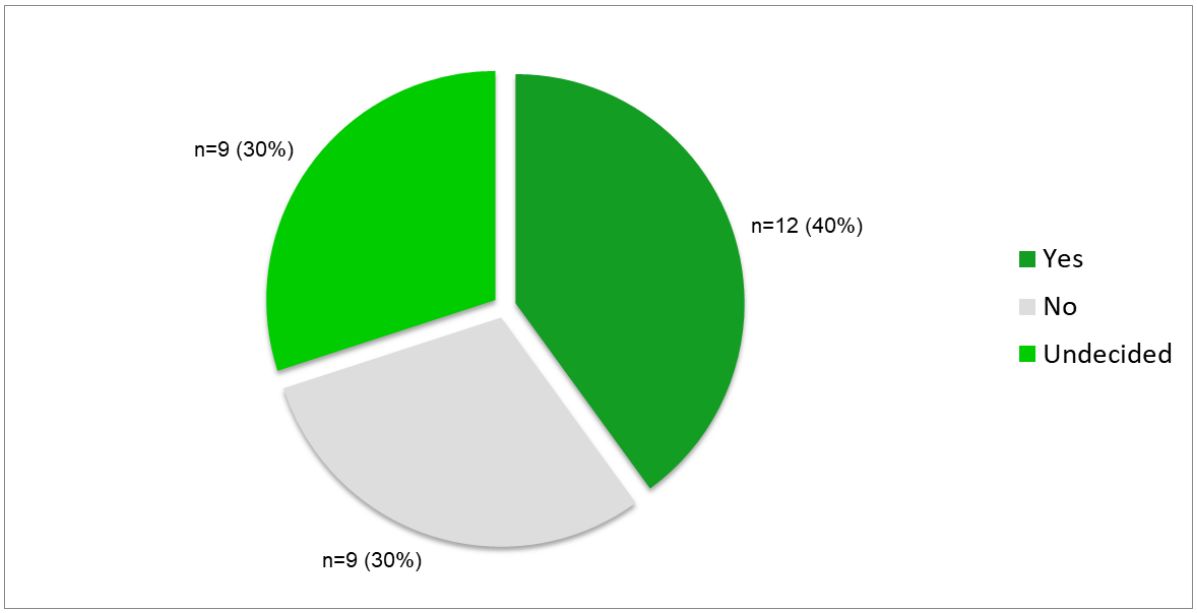
Geographic and demographic considerations

While practices in this cohort generally share some geographic and demographic characteristics (rural/regional, linguistic, socio-economic), this is a diverse group and it is challenging to generalise levels of intent to become accredited. However, the Gap Analysis was presented with examples of general practices in these cohorts that wished to become accredited but were faced with significant linguistic or geographic barriers.

Intention to become accredited – survey data

The survey of unaccredited general practices explored intent to undertake accreditation. The majority of respondents either intend to become accredited (40%) or are undecided (30%) (**Figure 3**).[4] The low survey numbers limit the ability to undertake deeper analysis of accreditation intention by practice characteristics.

Figure 3: Intention of unaccredited general practices to become accredited



[4] Thirty of 31 survey respondents answered this question.

5.2 What factors motivate practices to want to become accredited? What are the perceived benefits of accreditation?

This section explores factors that motivate practices to want to become accredited, and the perceived benefits of accreditation. There is some overlap between the perceived motivators and benefits.

5.2.1 Quality and safety

While the purpose of the RACGP's Standards for General Practices (5th edition) is to protect patients from harm by improving the quality and safety of health standards[5], the Gap Analysis found that views on the role quality and safety considerations play in motivating general practice accreditation varies widely, and quality and safety is often not considered a key motivator of accreditation.

Some unaccredited general practices, PHNs and other stakeholders see quality and safety as important drivers of accreditation. Some stakeholders believe that accreditation provides an important opportunity to reflect on how a practice is run, and potential areas for improvement. While being unaccredited does not mean that a practice is not providing quality and safe care, it might suggest they are not necessarily developing or using processes for improving their safety and quality.

> *Being accredited means that you reach a standard that says you are performing at a best practice level, that's why a lot of GPs go down the accreditation pathway.*
>
> - PHN representative

Supporting quality and safety is a stated priority of general practice accreditation agencies. One agency stated that '*a lot of the work we do with our clients is to support them, to improve quality and patient safety. We are very much committed to that journey and work we've done in the accreditation field has been in line with that vision*.' This agency advised that they aim to ensure that practices have a good understanding of continuous quality improvement principles, and how accreditation fits within that cycle of work.

On the other hand, stakeholders often indicated during consultations that quality and safety are not the most significant driver of accreditation, and that accreditation is often a '*tick box exercise*.' One unaccredited practice reflected that '*just because you can tick the box as a general practice does not infer that you've got quality*.' Another indicated that '*many indicators aren't about safe, quality service but are simply reflective of bureaucracy…generally they don't improve quality and safety*.'

[5] https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed/introduction-to-the-standards-for-general-practice/

The Gap Analysis found that accreditation processes and the accreditation visit often take place without input from or engagement with clinical staff, and that it can become a purely bureaucratic process with little real engagement with quality and safety considerations. A sector stakeholder suggested that '*if you write Standards that are meaningful to GPs, they will engage with them*.'

Some unaccredited practices indicated that they provide high quality care and that becoming accredited would have no impact on the quality of care they provide. One GP working in an unaccredited practice said that while their practice is not accredited, the small size of their practice means they can '*fill gaps and fix problems as needed because their small size makes them nimble and adaptable*.' Another unaccredited practice representative suggested that '*we feel that we are operating properly and efficiently, and we don't need to tick a box*.'

5.2.2 Workforce strengthening

Stakeholders advised that an important motivator and benefit of accreditation is that it supports practices to attract high quality, experienced clinical and non-clinical staff. Some PHNs, unaccredited practices and sector stakeholders also indicated that being able to access and train registrars is an important motivator of accreditation, particularly for smaller practices with limited staff. One practice manager from a solo-GP general practice in a small town indicated that a significant benefit of accreditation for them would be the ability to employ a registrar – particularly if the registrar was female, as the GP is male and some patients might not want to see a female doctor.

Some unaccredited general practice representatives suggested that accreditation provides more benefits for big practices with regular staff turnover, and junior doctors who are new to the job. For these practices, accreditation provides useful frameworks that newer and younger members of staff can draw on as a guide to quality and safety.

5.2.3 Public perception

Stakeholders suggested that healthcare consumers have little or no understanding of and interest in whether a practice is accredited, or what general practice accreditation entails. Generally, there is a perception that there is little value for practices in being able to market their accreditation, as it does not inform consumers' choice of practice.

One GP, who had a career in medicine spanning 30 years and has worked as a solo practitioner in an unaccredited practice for the past seven years, advised that in those seven years they have never been asked whether the practice is accredited. Others commented that '*I really don't think the message is getting out there that it's a good thing and getting the public on side*' and '*someone will rock up to a practice and don't even know that it's accredited or not*.'

> *There is an expectation by clinicians to work in a practice that meets a certain level or certain standards…accredited practices that are recruiting can use that as a lever. I think it's less of a driver for patients.*
>
> - PHN representative

The 2021 Review recommended enhancing patient engagement to inform continuous improvement of general practice. The findings of the Gap Analysis regarding patient perception of accreditation indicates little visible change in the sector last two years.

Recommendation 6

Increase public awareness of general practice accreditation. The Department of Health and Aged Care and the ACSQHC should develop public-facing resources, that can be utilised by stakeholders including PHNs to raise awareness about the benefits of general practice accreditation. Developing and sharing these resources will support increased public awareness about accreditation and will inform decision making by consumers about the benefits of receiving care at an accredited practice.

5.2.4 Incentives programs

The PIP and WIP are among the most significant motivators and perceived financial benefits of general practice accreditation. This builds upon the 2021 Review which, while providing an overview of the incentives payments program and the role of accreditation in enabling access, did not explore the role of the incentive payments as a motivator of accreditation.

PHNs reported that the incentives programs play an important role in business sustainability and support provision of quality clinical care. A GP who works in both an accredited and unaccredited practice observed that the accredited practice would not survive without the PIP and the WIP. Financial incentives were described as a bigger motivator for practice owners than for practice managers, on account of their focus on business sustainability and profitability. An accreditation agency representative claimed that '*it's not uncommon to find people who don't understand the quality process and they're only there for the PIP incentive*,' while an unaccredited general practice representative speculated that '*a lot of medical centres would only do it for the funding*.'

Several stakeholders suggested that practices that solely privately bill do not benefit from the PIP and the WIP, and the incentives are not a motivator of accreditation for these practices. A GP from an unaccredited practice suggested that '*we run our practice quite profitably without extra money from the government*', and indicated that for their practice, quality and safety was a more important motivator.

Stakeholders suggested that there may be inequity in access to PIP and WIP payments. Several PHNs advised that small general practices, particularly in small towns, may not have access to support staff who could help to understand the potential benefits of the incentives payments.

The incentives payments also do not appear to be a strong motivator for older, solo GPs who are nearing retirement, with the costs and effort required considered to outweigh the incentives, and a view that it takes a while for the incentives to build up to a point where they provide significant value. There is also a perceived lack of financial incentive to become accredited for some untraditional practice models, particularly those offering longer appointments, coordinated care and those focused on chronic conditions. More tailored incentives for those practices may encourage greater levels of accreditation.

5.2.5 MyMedicare

There are mixed views on whether MyMedicare is motivating accreditation among unaccredited general practices, and in relation to the benefits MyMedicare is having or will have for participating general practices. As this is a new reform, it is not unexpected that the Gap Analysis has not found a clear signal from the primary care sector.

PHNs have generally been active in promoting MyMedicare, following up with practices and providing administrative support, and the Gap Analysis heard that this promotion has contributed to achieving high levels of uptake in their regions. Sector stakeholders advised that they have observed increased interest in accreditation among unaccredited general practices since the rollout of MyMedicare commenced.

The Gap Analysis found that some PHNs and unaccredited practices believe the rollout of MyMedicare had been hurried, and there has been insufficient information available about the immediate and longer-term benefits for general practices participating in MyMedicare. Some general practices and PHNs expressed uncertainty and concerns about the impacts of MyMedicare on payroll tax, and suggested this may impact intention to become accredited.

One accreditation agency representative reflected that MyMedicare had never arisen in discussion with general practices and considers that '*it will be irrelevant for some clinics but a driver for others*.'

> *About 90% of practices in our region took this up. Our PHN did a lot of work to alleviate the administrative steps to access it. The last-minute rollout of government initiatives like MyMedicare has led to some anxiety amongst practices as they've been unsure of what the changes mean for them.*
>
> - PHN representative

Recommendation 7

Communicate the benefits of MyMedicare. The Department of Health and Aged Care should communicate the immediate and longer-term benefits of MyMedicare more effectively to general practices. This will address uncertainty in the sector, and help maximise the potential for MyMedicare to foster increased accreditation levels.

5.3 What motivated providers to apply for accreditation funding through the GP Grants Program? What is the impact of the GP Grants Program in supporting accreditation?

This section explores the role of the Strengthening Medicare GP Grants Program in providing financial support to practices to seek or maintain accreditation, and the impact of the program in supporting accreditation. This analysis is limited by the absence of data in relation to general practices that received grant funding for the purposes of accreditation.

Interviewed stakeholders suggested that the GP Grants Program appears to have been widely used by general practices to support accreditation, though the level of overall uptake and the portion of grants used for accreditation purposes appears to vary across PHN regions.

Several PHNs indicated that unaccredited practices had applied for a GP grant for the purpose of gaining accreditation. One PHN identified that of nine unaccredited practices in their region, seven had applied for a grant and four of those had ticked the accreditation option. This PHN indicated that these practices were new practices who would have likely undertaken accreditation irrespective of whether there was grant funding available.

On the other hand, some PHNs suggested the GP grants were not a driver of accreditation. One suggested that '*a lot of practices were interested in the GP grants but the majority (98%) were not interested in accreditation*' while another advised that grants had primarily been used for infection control and IT, not accreditation.

There is scope for improved calibration of the GP Grants program in future implementation. Unaccredited practices are small and received less funding to progress accreditation than larger practices, while the costs of accreditation are fixed.

Recommendation 8

Review the GP Grants program. The Department of Health and Aged Care should review the GP Grants program to understand the impact it has had on general practice accreditation, and to inform future investment decisions.

5.4 What supports have general practices received from PHNs or other sources that have encouraged or supported practices to become accredited?

PHNs are an important source of accreditation support and advice for many general practices. The 2021 Review reported PHNs '*can play an enhanced role in supporting general practices in matters related to accreditation*', while noting PHNs are funded to undertake a range of activities to support general practices with accreditation-related matters. The Review recommended that PHNs provide targeted support and mentoring for unaccredited practices to implement standards and achieve accreditation.

Stakeholders described a diverse range of levels and types of support that PHNs offer to general practices to support accreditation. An accreditation agency observed that '*PHN commitment to giving support and being open to knowing what support is needed by practices varies a lot by regions*.' Some PHNs provide a 'light touch' approach or minimal support for accreditation, and said they do not view supporting accreditation as a core part of their work. One PHN indicated that '*we support some of the work, but it's not core business of PHN, my team would be spending months out there if it was*.' However, most PHNs outlined a range of different types of support they provide, and said they view accreditation as an important part of their work and an integrated component of their work supporting general practice quality and safety.

PHNs advised that the types of support they provide to general practices includes:

- Site visits to provide support to general practices in understanding accreditation requirements, and developing necessary processes and systems
- Phone and email support and advice
- Advice in relation to choosing and engaging with accreditation providers
- Facilitating email-based communities of practice focused on accreditation, particularly for practice managers
- Mock accreditation visits to identify gaps and issues, and provide '*another set of eyes over the practice*'
- Virtual and face-to-face workshops for general practice representatives. These can be generally focused on accreditation, or cover specific themes like infection control, cold chain and governance. Workshops are held regularly (monthly, quarterly) or on an ad hoc basis.

A PHN representative explained that a large part of their role is educating practices about the benefits of accreditation. They explained that a lot of the time practices think it is a '*waste of time*' but that after receiving guidance and progressing accreditation '*they feel like they've achieved something*.'

A health sector stakeholder indicated that when Medicare Locals were in place, some of their support officers focused on the PIP incentive and '*would go out and have a look into the database of each of the practices and actually give them an estimate of what the PIP might be worth*.' The Gap Analysis did not hear evidence of this level of targeted support being provided to general practices by PHNs.

General practices provided positive feedback about the value PHNs play in the accreditation process, and more broadly in quality and safety matters. Practices highlighted the role of PHNs in hosting webinars, visiting practices, providing advice on being insured correctly, vaccination protocols, immunisation, and advice on the incentive programs. On the other hand, one GP reported that they had not taken up their PHN's offer of support because '*it is our responsibility to look after the quality of our practice*.'

> *The PHN approached the practice by respectfully offering to help become accredited and promote accreditation, without putting pressure on the doctor to apply.*
>
> - Practice manager

Some PHNs have a detailed understanding of the unaccredited general practices in their regions. One PHN said they have a strong understanding of the capabilities and needs of accredited and unaccredited practices across their region, and tailor engagement on a continuum from '*light touch to business and clinical optimisation and transformation*.' Another PHN described that they '*try to find what drives them and link that to accreditation, looking at every specific practice in how they work and what's the best for them moving forward*.' Several PHNs suggested they have at least one staff member who is considered to be an in-house expert on the accreditation Standards and process.

Some PHNs noted that their staff working in quality and safety, and providing accreditation support, have significant experience and that in some cases these staff have previously worked as practice managers and managed accreditation processes directly in general practice settings. One PHN staff member described that supporting general practice accreditation had been '*my whole work over the past 17 years*.'

> *Every quarter we run accredited training and workshops on CPR, cold chain, telephone techniques, difficult patients, foundational elements of accreditation. We did a receptionist course to upskill receptionists and a nursing education program that involves clinical aspects and management, run monthly.*
>
> - PHN representative

> *Relationship building is really important, having a consistent person that you can go to within the PHN that understands your practice, the way that your practice operates, knowing the different nuances across the practices.*
>
> - PHN representative

A range of stakeholders suggested a more nationally consistent role for PHNs in supporting accreditation may increase levels of accreditation, improve the accreditation experiences of general practices, and more generally improve quality and safety. Several PHNs recommended broad rollout of a process in which PHNs would provide targeted support to individual practices in particular areas at regular intervals across the three-year accreditation cycle, and then providing evidence to the relevant accreditation agency of the standard the practice is at and what processes/policies are in place. This more structured involvement by PHNs and engagement with accreditation agencies may assist with reducing the burden of the accreditation processes, and may lead to improved quality and safety.

5.5 Are there any other factors that would motivate general practices to apply for accreditation?

5.5.1 Practical resources to support accreditation

Stakeholders regularly highlighted the need for practical resources and tools to make the accreditation process easier to understand and navigate. Examples given included guides or manuals explaining the whole accreditation process, or particular aspects of the process; online resources; flow charts; checklists, and lists and templates of necessary internal policies. Some general practices indicated they were not aware of materials available through the RACGP, or that might be available through their PHN. One practice manager was advised that in a previous role in an accredited practice, she had only been made aware by the accreditation agency of the accreditation templates they had available after the accreditation process had finished.

As detailed in Section 3, the Gap Analysis has found that the Standards, accreditation guidance materials and websites are not available in languages other than English. Representatives from one PHN, in whose region 37 percent of people speak a language other than English at home, highlighted the benefit that would be associated with having accreditation Standards and materials in other languages. A GP whose second language is English commented that opportunities are missed because of language limitations, though suggested that '*just making it more user friendly*' would suffice instead of translation into other languages. The Gap Analysis also found that translation into plain English would increase accessibility for Aboriginal and Torres Strait Islander medical practitioners.

Development or updates of guidance materials should consider translation into key languages to increase accessibility to general practices whose staff have limited English language capacity.

> *It would be really great if generic RACGP guides/manuals were provided to practices that set out what policies and practices are required in practices. A standard manual would save each practice having to compile one.*
>
> - PHN representative

The Fifth Map

Several PHNs identified the Fifth Map resource as a valuable tool available to general practices to help visualise the scope and context of the RACGP Standards, and that there had been high levels of uptake of the tool in their regions. The Fifth Map can be posted on a wall and viewed by practice staff involved in the accreditation process. One PHN advised that general practices find the Fifth Map useful '*because it clarifies the steps that practice managers in particular need to go through in a visual and logical process*.' According to the Fifth Map website, '*the high-resolution maps are formally and exclusively licensed by RACGP as an accepted resource to understand the Standards for the 1000 days between accreditations and to prepare and manage pre-accreditation activities. The 5th Map is in use in 480+ practices*.'[6]

Recommendation 9

Improve availability and accessibility of accreditation material. Make the Standards, indicators and other materials relating to general practice accreditation available in key languages other than English. This should include materials provided by accreditation agencies, RACGP and other stakeholders.

5.5.2 Potential for a tiered approach to accreditation

The Gap Analysis found that the development of a 'tiered approach' to accreditation may serve to increase accreditation accessibility and attractiveness, particularly among small practices. Stakeholders described that introducing a tiered approach based on size or type of practice may improve accreditation levels, with costs and administration suggested as potential options for tiering. There is also a view that current indicators are designed for big practices with larger numbers of staff, and that different indicators should be developed for small practices. A PHN suggested that accreditation should be reformed to be a '*ladder of opportunity*' which provides different tiers and steps to support engagement and quality improvement, unlike the '*take it or leave it approach*'. This approach could also involve a package of funding options for PHNs to provide tailored stepwise support.

> *If the department are really looking at how you get those practices that are not accredited to become accredited they should see if there's a way of tiering the accreditation process depending on the size or type of your practice, and so whether there is some type of tiered mechanism that reduces the administration.*
>
> - PHN representative

[6] https://www.5thmap.com.au

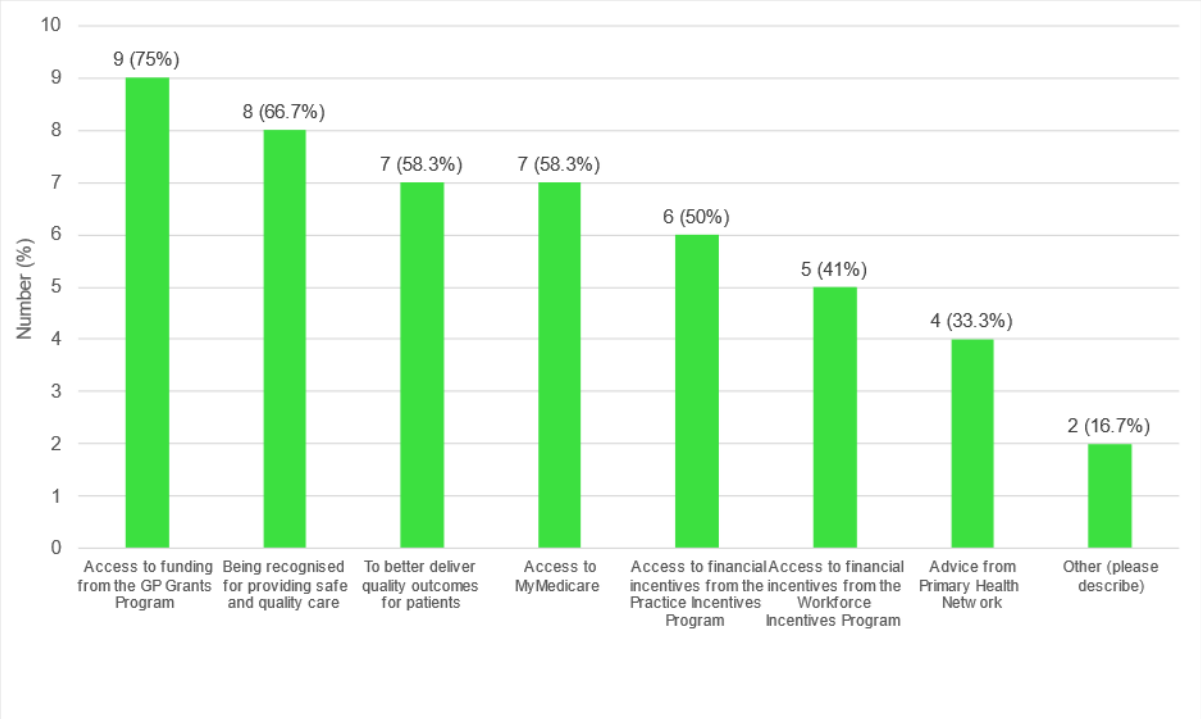
A lower accreditation tier is required for smaller GP run, non-corporate practices. The current requirements are too administratively heavy, which will result in poorer service delivery to patients (despite the financial incentives on offer).

- Unaccredited general practice representative

Findings from the survey of unaccredited practices

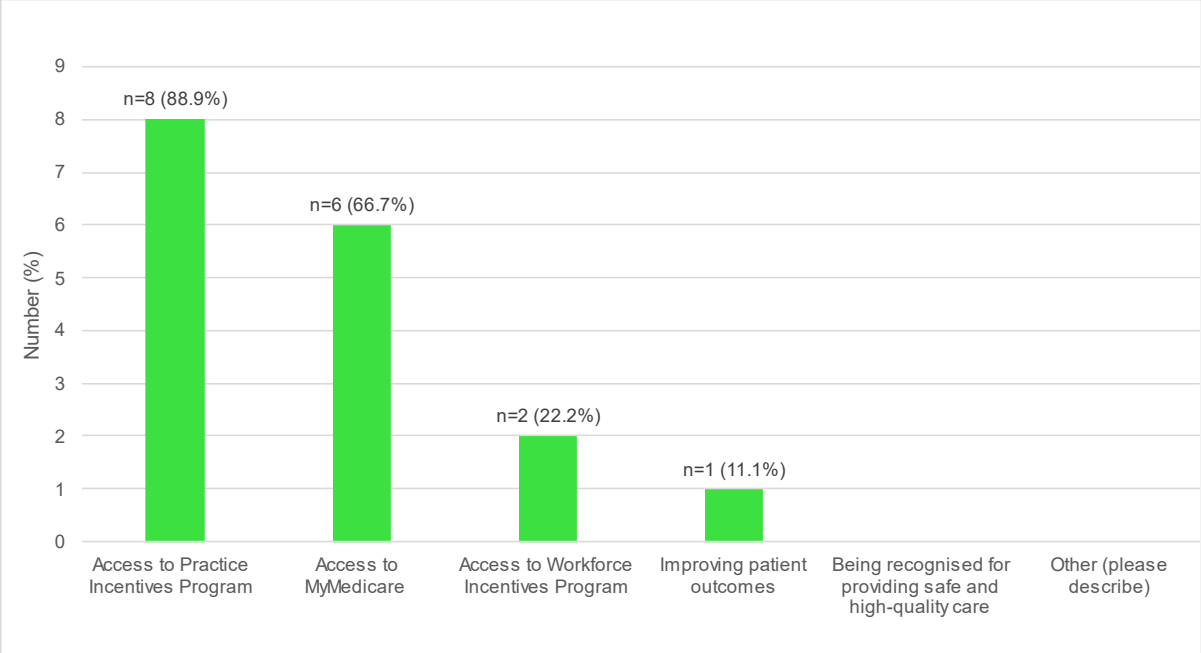
As described in Section 2, the small number of responses to the survey of unaccredited practices limits the generalisability of its results. However, some observations can be made about perceived motivations and benefits which support qualitative evidence generated through the Gap Analysis process. **Figure 4 and Figure 5** outline survey responses in relation to motivations and benefits.

Figure 4: Motivators of intention to become accredited[7]



[7] Of respondents who indicated an intention to become accredited. Respondents could select more than one motivator.

Figure 5: Perceived benefits of accreditation



The survey data suggests that access to funding and quality and safety considerations are both strong motivators, while the strongest perceived benefits of accreditation are financial.

The GP Grants Program was the most commonly identified motivator of general practice accreditation, with nine responses. While it is unclear whether access to funding is a 'motivator' as such or an 'enabler,' this response rate does highlight the important role of the Grants program in encouraging and supporting accreditation.

The second most commonly identified motivator of accreditation was 'being recognised for providing safe and quality care' (eight responses), while 'to deliver better quality and safety for patients' was the third most popular response (seven responses). Contrastingly, when asked about perceived benefits of accreditation, only one respondent considered that 'improving patient outcomes' is a benefit, and no respondents indicated that 'being recognised for providing safe and high quality care' is a benefit. This contrast may support the finding that while quality and safety is a motivating factor, accreditation has little practical impact on quality and safety.

Access to financial incentives from the PIP and WIP were the fifth and sixth most significant motivators. When asked though about perceived benefits of accreditation, access to the PIP was considered to be the most significant benefit, with eight responses. This broadly supports the findings in Section 5.

Access to MyMedicare was the fourth highest motivator, and the second highest perceived benefit, with seven and six responses respectively. This suggests MyMedicare is influential in motivating and rewarding general practice accreditation.

Recommendation 10

Provide greater flexibility in accreditation to improve accessibility of accreditation to a broader range of practices. This should include the development of a 'tiered' approach that enables accreditation costs and requirements to be scaled up or down depending on practice size and level of patient care provided. Developing a tiered approach could also incentivise excellence in care.

Recommendation 11

Tailor support and incentives to the needs of cohorts of general practices with low levels of accreditation. The Department of Health and Aged Care should recalibrate existing support to establish a specific GP grants scheme for small practices, or practices in underserved communities and rural/remote areas.

6.0 THE ROLE OF ACCREDITATION AGENCIES

There are a diverse range of views on the roles accreditation agencies play in the accreditation process. Three of the four accreditation providers undertook an interview for the Gap Analysis, and described different approaches to supporting general practices through the accreditation processes. Some stakeholders provided positive feedback about the role of accreditation agencies in supporting accreditation, while others were critical of barriers created by accreditation agencies.

One agency indicated they work closely with practices to provide advice and education on accreditation, and said that '*we pride ourselves on the support that we do provide and over the years listening to the client feedback, the practices we've enhanced what we do and based on their needs*.' This agency talked about the role of client support officers in '*supporting practices through the accreditation process and helping them understand the Standards, intent of the Standards, the explanatory material and helping them understand that it's not something to feel confronted by*.' The agency described a range of webinars and e-learning modules they offer to support understanding of what the accreditation standards are trying to achieve, and that '*education is a is a big thing for our organisation*.'

On the other hand, another accreditation agency indicated that they are '*very strong on our role as an accrediting body, not a consultancy body that works alongside/in-person with practices*.'

PHNs, unaccredited practices and sector stakeholders highlighted the importance of the accreditation agencies, and there was some positive commentary. For instance, one GP who currently practices at an accredited and unaccredited practice described an accreditation agency representative as being '*just wonderful, really personable, super, any question I had she would answer it*.'

However, stakeholders were frequently critical about accreditation agencies. PHNs highlighted the importance of having a relationship with the accreditation agencies. One PHN observed that '*we aren't competing with accreditation companies, we are in the middle*'. While one accreditation agency engaged with the PHN effectively, the other '*still thinks we are competing with them*…' This suggests there may be confusion at accreditation agencies about the roles of PHNs, and opportunities for proactive engagement with accreditation agencies to highlight PHN roles and the potential benefits to accreditation levels and quality and safety that may arise through a more collaborative approach.

Several unaccredited practices expressed frustration with the intrusive nature of visits by surveyors, and there was broad criticism of the level of support and advice provided by accreditation agencies throughout the accreditation cycle. One PHN suggested that general practices feel they '*pay for a service and aren't getting anything for it*', while another suggested that the support provided by accreditation bodies is '*often remote and quite generic*.' A GP from an unaccredited practice suggested there should be a review of how cost-effective accreditation agencies are, how many complaints are made against them and how they are responding to complaints. The Gap Analysis found that in some cases, general practices are

not aware of what support is available from their accreditation provider, so they rely on their PHN.

> *Our first two accreditors were friendly and helpful but the assessor during the third process was obnoxious and too stringent in what they expected to see. This was very different to the other assessments. The doctor and practice manager asked the assessor to leave because it was causing too much stress.*

- Unaccredited general practice

Staff shortages within accreditation agencies can lead to delays in accreditation processes. For instance, one PHN spoke of an example of an accreditation surveyor, who also practices as a GP, needing to postpone an accreditation visit because of demands within their own general practice.

A sector stakeholder expressed concerns with accreditation agencies providing hands-on support to general practices they are assessing, as well as with what they described as a conflict of interest that may arise if accreditation agencies feel obliged to provide accreditation to general practices who do not meet requirements, since they are receiving payment). This stakeholder also suggested that the emergence of new accreditation companies in the Australian market is positive, as it will lead to more options and improved service and support.

Concerns were also raised about accreditation agency surveyors undertaking assessment of practices geographically close to their own practice. In some instances, practices are being assessed by surveyors who may personally know staff at the practice, and whose practice may be in direct competition with that of the surveyor. In some cases, the Gap Analysis found that surveyors may use such assessments as an opportunity to gather business intelligence on the practice.

Recommendation 12

Improve consistency of accreditation assessments. ACSQHC should drive consistent high quality accreditation assessments by accreditation agencies. A voluntary code of conduct should be explored as a mechanism for driving consistent industry practices.

7.0 CONCLUSION

This Gap Analysis has detailed a range of barriers to general practice accreditation in Australia, and identified ways the Department of Health and Aged Care and other key stakeholders can address gaps and drive increases in levels of general practice accreditation.

The Gap Analysis found that there continues to be significant challenges associated with general practice accreditation. These range from barriers created by the length and complexity of the RACGP Standards, the restrictive nature of the RACGP's definition of general practice for the purpose of accreditation, and burdens created by the accreditation process itself. These challenges are experienced disproportionately by particular cohorts of general practices, including those with older GPs, small numbers of GPs and support staff, and those in outer metropolitan and regional/rural settings.

Current government programs show promise for improving accreditation rates, with the GP Grants program and incentives programs appearing to be important enablers and motivators of accreditation. MyMedicare appears to have promise for increasing interest in accreditation, but there is confusion in the primary care sector about the benefits of MyMedicare that should be addressed in order to harness the potential of this program.

For many general practices, their local PHN is the most significant source of support and advice on accreditation matters. Ensuring that PHNs receive appropriate funding and sufficient direction will support a more consistent approach by PHNs in supporting accreditation, and will help maximise their national role in increasing general practice quality and safety.

Despite the available incentives and support, there remains a cohort of general practices for whom accreditation does not seem attractive or relevant. Whether further incentive and support should be provided to this cohort of general practices, or whether effort should instead be focused on those practices who are more engaged and may be more likely to progress towards accreditation, is an important policy decision.

Finally, there remains limited data at a national level in relation to general practice accreditation. Creating and maintaining stronger data will improve understanding of barriers and enablers of general practice accreditation, and will help maximise the effectiveness of policy settings, funding and engagement with general practices.

Appendix A - Case studies

The case studies below were developed based on interviews with representatives from three unaccredited general practices. They illustrate the experiences and views of these GPs and practice managers in relation to general practice accreditation. They include the experiences and views reflect the Gap Analysis' findings in relation to barriers, motivators and enablers of accreditation. The identities of the participants have been anonymised and the locations of their practices are described in a manner that protects their privacy.

Case study 1 – Solo practitioner in an unaccredited general practice in regional Victoria

Dr A has over 40 years' experience as a GP in general practices, and started practicing solo in 2017. At this time, she decided against seeking accreditation of her new practice, and her practice has remained unaccredited since then.

Dr A is not considering seeking accreditation. Based on her career in general practices, Dr A believes that accreditation '*does absolutely zero for the quality of care*', and that it is generally considered to be a '*tick box exercise*' undertaken by a practice manager with little engagement with doctors.

Dr A sees her current solo arrangements as supporting the provision of flexible and personalised patient care. She contrasted this with '*six-minute medicine*', and the 'conveyor belts' operated by larger corporate practices.

Dr A described that in six years as a solo operator, not one patient had asked whether her practice was accredited. Dr A suggested that the average member of the public has no awareness or understanding of general practice accreditation.

Dr A noted that even if she wished to pursue accreditation, the lack of administrative support in her practice would make the accreditation process '*hugely daunting*'.

Dr A advocated for a more tailored approach to accreditation that reflects the diversity of general practice arrangements in Australia, and population health needs. Dr A suggested that the accreditation process could be substantially improved, including by creating a more modular accreditation process that takes the pain out of having one 'event' every three years.

Dr A suggested that PHNs should play a more formal role in supporting practices with achieving accreditation.

Case study 2 – Solo practitioner in previously accredited but now unaccredited general practice in metropolitan Sydney

Dr B has over 40 years' experience as a GP, and his practice was accredited three times. Dr B '*oversees everything in his practice*' and feels certain he delivers quality and safe care. Dr B was motivated to participate in the Gap Analysis because he does not believe the government, the RACGP or accrediting agencies understand the impact the accreditation process has on solo GPs. Dr B would welcome reform and simplification of the process.

The last experience of accreditation left Dr B feeling so '*angry and disillusioned*' he will not seek accreditation again. Dr B indicated that the assessors' style was too rigid, and they were preoccupied with trying to justify their role by '*telling us all the things we're doing wrong*', rather than being helpful and providing practical advice. Dr B considers the assessors should provide more guidance on how to meet the indicators, and support with the accreditation process. Dr B believes the incentive payments linked to accreditation do not make sense for solo GP practices, and that it isn't worth the time and stress.

Dr B considered indicated previous accreditation had supported quality improvement to a limited extent, through useful hints on areas for practice improvement. Dr B considers accreditation a good idea in principle and recognises that the accreditation Standards make sense for large practices. In Dr B's view, the scheme does not account for solo practices; quite a few indicators are geared towards big practices with lots of staff. Dr B considers this highly impractical for his practice and said he would like to see different indicators for small practices.

Dr B also considers that the indicators are written in a way that is too official which makes it hard to understand how to demonstrate compliance with them. Dr B suggested that the Standards should be written in a more practical way, and that a PHN staff member should be present at assessments to help practices understand the practicalities of applying the Standards, and to support effective engagement with accreditation agencies.

Case study 3 – Practice Manager in an unaccredited new general practice in rural Western Australia

Practice Manager C works in a practice at which their spouse is the sole GP.

Practice Manager C is hoping to register for accreditation by the end of 2023, and has spent this year studying the Standards and preparing for accreditation. Practice Manager C indicated that the preparation for accreditation is '*so time-consuming, it's unbelievable, sometimes I spend a whole day reviewing one policy*'.

Practice Manager C considers the cost of accreditation to be very high, and advised that the support they are receiving from a consultancy firm in preparing for accreditation is expensive. Practice Manager C suggested that while the GP Grants are of interest, they understand that as a small practice they would receive the lowest amount of grant funding. She suggested that a more equitable approach to the amount of grant funding available would act to further incentivise accreditation for smaller practices.

Despite these misgivings, Practice Manager C values the transparency and credibility of the Standards in the accreditation scheme. She believes the accreditation process will support credibility, compliance, safety and continual improvement in her practice. Practice Manager C suggested that a further benefit of accreditation will be that it will enable their practice to recruit a registrar and provide more choice of GPs for patients. Practice Manager C indicated she would appreciate being able to ask questions about the accreditation to get practical advice, but was unsure of who the appropriate organisation was to engage with.

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