

## The new “Indigenous health” incentive payment: issues and challenges

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**TO THE EDITOR:** In their article, Couzos and Delaney Thiele raise many good points with respect to Medicare Australia’s Practice Incentives Program (PIP) Indigenous health incentive.<sup>1</sup>

The funds in question are part of the “closing the gap” spending by the Rudd government. However, the central question is whether spending many millions of dollars of this allocation to add to the income of general practitioners (through a patient enrolment program and the generation of “care plans”) will in fact convert into greater access to, and greater utilisation of, health services by the Aboriginal and Torres Strait Islander population (hereafter referred to as the “Aboriginal” population). The authors correctly point out that most practices in Australia do not treat Aboriginal patients, and that the uptake of targeted, extended-primary-care items by Aboriginal people is much lower than in the general population.<sup>1</sup>

In most areas, apart from the most remote, the problem is not a lack of services, but the red tape that blocks Aboriginal patients from taking advantage of health services. Adding further layers of red tape, such as patient enrolment, care plans, and health assessments, will only make it harder for Aboriginal patients to access extra health care. For example, an allied health service, normally accessed by walking in off the street, requires a care plan plus a team care plan. Such red tape only adds to the burden of compliance — the problem that lies at the heart of the reason why so many Aboriginal patients fail to meet basic health outcomes.

From an economic viewpoint, one needs to ask what could be done with the money that will go to the health provider for administration, rather than for actual clinical care. For example, paying a GP \$500 to enrol a patient could instead pay for a significant amount of dental work, speech pathology, diabetes education or physiotherapy.

The Department of Veterans’ Affairs (DVA) Gold Card offers an efficient, simple and highly efficacious model that would serve the Aboriginal population a lot better.<sup>2</sup> Under the DVA model, doctors are paid a modestly higher rebate for treating veterans (or their families). However, the real benefit for DVA Gold Card holders lies

in their ability to access an expanded pharmaceuticals scheme, a comprehensive range of allied health and medical equipment, free patient transport, and private hospital care. Under the DVA, such benefits are accessed with minimal paperwork for the referring doctors and patients. Therefore, the DVA model, in contrast to the PIP Indigenous health incentive model, better targets funds towards service delivery.

It is time for politicians and the Department of Health and Ageing to adopt a DVA-style model for the Aboriginal population.

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1 Couzos S, Delaney Thiele D. The new “Indigenous health” incentive payment: issues and challenges. *Med J Aust* 2010; 192: 154-157.

2 Australian Government Department of Veterans’ Affairs. What GPs need to know about gold cards. [http://www.dva.gov.au/service\\_providers/treatment\\_cards/Gold\\_card/Pages/gold.aspx](http://www.dva.gov.au/service_providers/treatment_cards/Gold_card/Pages/gold.aspx) (accessed Feb 2010). □