First Annual Report on Quality Improvement Measures in General Practice released by the Australian Institute of Health and Wellbeing (AHIW).

General practitioners (GPs) are the first point of contact for most Australians seeking health care[1], with 83.2% of the population seeing a GP in the previous 12 months[2]. In 2018-19, nationally there were 158 million GP attendances, or 6.3 per person up from 5.3 per person (113 million) in 2008-09 (claimed through Medicare) (AIHW 2020).

The Practice Incentives Program (PIP) Quality Improvement (QI) Incentive is a payment to general practices for activities that support continuous data driven quality improvement in patient outcomes and the delivery of best practice care.

The first annual report on the 10 PIPQI measures shows data (2020-2021), shared at the community level, and collected through the PIPQI Incentive, has the potential to inform primary health providers how to improve care and services to clients and within a population.

For example, this report may be used to assist the understanding of what proportion of a population within a region may benefit from preventative measures to ensure effective management of a specified chronic disease, such as diabetes and cardiovascular disease as well as immunisation and cervical screening. This can help delay progression of the condition, improve quality of life, increase life expectancy, and decrease the need for high-cost interventions.

Findings included:

Nationally, 59% of regular clients who had a recorded diagnosis of **Type 1 diabetes had an HbA1c result recorded within the previous 12 months in their GP record.** This varied from 49.0% to 69.4% across PHNs.
WAPHA PHN North had this information recorded for 56.1% of clients.
WAPHA PHN South had this information recorded for 51.8% of clients
WAPHA PHN Country had this information recorded for 57.1% of clients

Nationally, 73.4% of regular clients who had a recorded diagnosis of **Type 2 diabetes had an HbA1c result recorded within the previous 12 months in their GP record.** This varied from 66.5% to 82.1% across PHNs.
WAPHA PHN North had this information recorded for 75.3% of clients.
WAPHA PHN South had this information recorded for 73.9% of clients
WAPHA PHN Country had this information recorded for 71.4% of clients

[1] https://www.aihw.gov.au/reports/primary-health-care/pipqi-measures-national-report-2020-21/contents/about

[2] https://www.aihw.gov.au/reports/primary-health-care/pipqi-measures-national-report-2020-21/contents/about

Nationally, 64.2% of regular clients aged 65 years and over had an **influenza immunisation status recorded in their GP record in the previous 15 months.** This varied from 47.3% to 73.5% across PHNs.
WAPHA PHN North had this information recorded for 59.1% of clients.
WAPHA PHN South had this information recorded for 59.9% of clients
WAPHA PHN Country had this information recorded for 59.2% of clients

Nationally, 58.6% of regular clients with diabetes had their blood pressure recorded in the GP within the previous 6 months, all ages. This varied from 51.4% to 64.5% across PHNs.
WAPHA PHN North had this information recorded for 55.1% of clients.
WAPHA PHN South had this information recorded for 58.2% of clients
WAPHA PHN Country had this information recorded for 60.0% of clients

Nationally, 48.5% of regular clients with a record of the necessary risk factors in their GP record for CVD risk assessment, 45-74 age was 48.5%. This varied from 36% to 69% across PHNs.
WAPHA PHN North had this information recorded for 52.2% of clients.
WAPHA PHN South had this information recorded for 58.0% of clients
WAPHA PHN Country had this information recorded for 57.8% of clients

View the full report and data

Frequently Asked Questions

Are there set targets for each general practice?

The improvement measures are intended to support a regional and national understanding of chronic disease management in areas of high need and are not designed to assess individual general practices or general practitioner performance. There are no set targets for the improvement measures.

Which patients are included in the data set?

PIPQI data submitted by PHNs only includes 'active' or 'regular' clients – an individual who has visited a practice 3 or more times in the 2 years prior to the date of data extraction, when those service events were eligible for a MBS rebate. This is consistent with the RACGP definition of an active patient/client (RACGP 2010). Therefore, clients who visited a GP less than this amount are not included in this report. Note, that those 3 visits could be at any time during the 2 years and do not necessarily mean that attendance at a practice has been recent.

Is the information de-identified?

General practices enrolled in the PIPQI Incentive commit to implementing continuous quality improvement activities that support them in their role of managing their patients' health. They also commit to submitting nationally consistent, de-identified general practice data, against ten key Improvement Measures that contribute to local, regional, and national health outcomes (Department of Health 2019b).

How do PHNs utilise the PIP Eligible Data Set?

PHNs enhance and connect primary healthcare within their region to achieve better health outcomes. Through their already established trust and working relationship with general practices, PHNs utilise the PIP Eligible Data Set to:

- work in partnership with local general practices to support quality improvement initiatives through reporting and feedback on managing general practice patient population and
- perform needs assessments and plan service delivery at different levels, including PHN boundaries, local health districts, jurisdictional boundaries and at national level.

How do I find out more about the PIP incentive payments?

Practice Assist has a comprehensive PIP tool kit available for general practice and can assist with registration.