IMPACT ANALYSIS - VOLUNTARY PATIENT REGISTRATION

Primary Health Care Reform

Impact Analysis - (OBPR22-03028)

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This Impact Analysis has been developed to inform the ongoing consideration of issues by Government and was formally assessed by Office of Impact Analysis (OIA) before the announcement of Government policy.

1. Background

Australia's Primary Care System

Primary care provides the foundation for universal health care, working hard to keep all Australians healthy and well in the community, and to deliver care that meets the needs of people and communities at all stages of life, no matter where they live. It is generally the first contact a person has with Australia's health system, and relates to a broad range of care provided in the community by general practitioners (GPs), nurses (such as general practice nurses, community nurses and nurse practitioners), midwives, allied health professionals, dentists, pharmacists and Aboriginal health workers and practitioners. Types of services delivered under primary care include prevention and screening, early intervention, treatment, management, and health promotion.

Primary care can be provided in home or community-based settings such as general practices, other private medical and allied health practices, community health centres, local government settings, and non-government service settings such as Aboriginal Community Controlled Health Services (ACCHS).

The need for reform

The Medicare system has underpinned Australia's safe, affordable, fair health care system for the last 40 years. However, Medicare has struggled to keep pace with the evolving needs of Australians in the context of an ageing population and increasing rates of chronic disease. Public hospitals are strained and the cost of delivering primary care is increasing. For patients, seeing a GP and receiving primary care services is now harder and more expensive than at any time since the introduction of Medicare.

In 2022, in response to the challenges outlined above, the Minister for Health and Aged Care brought together a group of health leaders to form the Strengthening Medicare Taskforce (the Taskforce). The Taskforce was charged with identifying the most pressing investments in primary care, building on the direction outlined in Australia's Primary Health Care 10 Year Plan (the 10 Year Plan) and previous national policy work on primary health care reform (see Appendix 1).

In February 2023, the Government released the Strengthening Medicare Taskforce Report, which outlined a vision for Australia's primary care system of the future. The Taskforce recommended the introduction of Voluntary Patient Registration (VPR) to 'support better continuity of care, a strengthened relationship between the patient and their care team, and

more integrated, person-centred care' (see Strengthening Medicare Taskforce Report | Australian Government Department of Health and Aged Care).

By way of definition, VPR is a proposed new model of general practice care that formalises the relationship between patient, provider and practice. The proposed implementation of VPR provides a registration process via a digital platform that is designed to support future funding reform, and improvements in digital health and data infrastructure.

This Taskforce recommendation builds upon several years of national primary health care reform policy and consultation (see Section 6 for further detail on consultation).

2. Problem Definition

The primary care system in Australia lacks a mechanism to formally link patients to care providers and practices. This reduces Australian patients' ability to experience continuity of care, and exacerbates negative impacts from fragmentation of care.

Not all Australians experience continuity of care, resulting in worse health outcomes

Australia enjoys access to a world class health system with primary care at its centre (Schneider, 2021). This is a strong basis to build on, but more needs to be done to improve patient access to continuity of care.

There is strong evidence that improved continuity of care leads to higher quality care, improvements in preventative health, increased patient satisfaction, decreased emergency department attendances and hospitalisations, and reductions in mortality. Evidence suggests that continuity of care is best achieved through three core components (Haggerty, 2003):

- relational continuity (preferred provider)
- management continuity (coordination across care team)
- informational continuity (exchange of relevant information)

However, data indicates that these core components are not being delivered and continuity of care is limited for many Australians. While 79% of Australians self-report having a preferred general practitioner (GP), service data indicates that 50% of patients visit three or more practices in a three-year period and 79% of patients see three or more GPs in this same period (Department of Health and Aged Care, 2022). Currently, there is also limited system infrastructure for multiple providers to coordinate across a patient's care team and exchange or access relevant patient information.

The dominant fee-for-service Medicare Benefits Schedule (MBS) funding mechanism comprises 90% of general practice funding in Australia. This mechanism incentivises volume-based care over integrated, team-based and longitudinal care models, as it allows higher remuneration for providers if they see more patients, which may encourage providers to shorten consultation times to increase the volume of patients they are able to see. This results in ad-hoc care where GPs and general practices may treat more patients, yet have limited visibility of what services their regular patients are receiving, leading to worse health outcomes.

In recognition of these interconnected challenges in increasing continuity of care, the Taskforce recommended the development of VPR and new funding models, alongside fee-

for-service. A shift towards blended funding would reward providers for working in a team to provide continuous person-centred care. The Taskforce noted that VPR would be a key enabler to shifting to these more blended funding models, and provide the system infrastructure required for providers to deliver continuity of care.

Inadequate oversight leads to fragmented service delivery and poor patient outcomes

Fragmented health care occurs when providers work in isolation, often leading to duplication of effort or miscommunication across the care team. This is exacerbated by poor data management and information sharing.

In Australia, patients access care from a range of providers funded from various sources, either in community or in hospital settings. This can lead to providers operating in silos, with their scope of service determined by the programs and incentives their practice applies for, the scope of practice of the health care professional and organisational priorities, resulting in some patient's care not being holistic or cohesive. This fragmented service delivery can negatively impact the quality of care provided to patients, leading to worse health outcomes and system inefficiencies. For example people with chronic disease who don't have a regular GP are more likely receive more hospital care than those with a regular GP, with 22% more likely to present at an emergency department and 33% more likely to have a non-elective hospital admission (Glazier et al 2008).

Currently, without VPR there is a lack of infrastructure to address fragmented health care. For example, My Health Record can currently display a patient's health information including details of medical conditions and treatments, test or scan results. It will not however identify the patient's preferred providers, have the interactive functionality to enable patient registration to a specific provider and practice, provide a practice with visibility of their regular patient population collectively, or link a patient's registration with a provider to MBS payments available to a patient's 'usual provider' or to targeted provider or practice incentives to support patient-centred care. When a patient unexpectedly is treated in a new health care setting, such as through an emergency hospital admission or visit to an urgent care clinic, there is currently no national and patient-controlled record of who can be contacted about their case history and for handover to ongoing treatment. The lack of a link between the patient's health care information available through My Health Record and the registration information regarding their health care team responsible for their primary care creates further fragmentation in health care delivery. Further, while My Health Record can provide a historical picture of care, without voluntary patient registration it does not provide an opportunity for the patient to express their preferences on who they want as their current care team. These limitations in the current infrastructure hinder the ability of Australia's primary care system to address patient activation and consumer-led care and major health challenges, such as an ageing population, the increasing prevalence of chronic conditions, and the increased expectations of patients.

Similarly, without VPR there are limited mechanisms to facilitate the systematic collection of de-identified patient-level primary care data and feedback to practices about quality improvement in care for their regular patient populations. At the provider and practice level, this undermines continuous quality improvement. In the broader primary care system, this inhibits support service planning and health system integration at local, regional, jurisdictional and national levels to allow for population health needs analysis.

3. Objective of Government Action

The Government is committed to ensuring that Australians can access a world class primary care system that is designed and funded to meet the population's increasingly complex health needs (see Section 2). Responding to the recommendations of the Taskforce, the Government will introduce a range of reforms centred on improving patient access to person-centred care, encouraging coordinated multidisciplinary teams, enhancing data and digital technology for value-based care, and supporting the primary care sector to embrace organisational and cultural change.

The option of implementing VPR provides an opportunity to invest in improved continuity of care, which leads to higher quality care, improvements in preventative health, increased patient satisfaction, decreases in emergency department attendance and hospitalisations, and reductions in mortality.

If introduced alongside funding reform, VPR could also enable delivery of a range of reforms, including better targeting of funding to need, improved equity, driving better quality care linked to quality measures and improvements in data collection and sharing. Over time, VPR could be expanded to include additional health and care professionals and new models of care. VPR could provide a mechanism to target incentive payments to improve the quality of care for registered cohorts with more complex needs and at risk of poorer health outcomes. VPR could also allow appropriate monitoring to ensure practices are adequately resourced to provide high quality, multidisciplinary team based care.

In order to achieve this objective, potential barriers need to be considered including the need for infrastructure and supporting data, practice capacity issues (including workforce pressures and an already crowded curriculum), low patient activation and health literacy (among individuals that are not routinely engaged in their health care), and the ability for some individuals to effectively use digital technology (such as Older Australians).

4. Policy Options

Two policy options (implement VPR or not implement VPR) will be considered by Government on the basis of significant consultation with the primary health care sector, and most recently, the recommendation from the Taskforce to introduce VPR. Further detail regarding consultations and Taskforce recommendations are below in Section 6.

Option 1 - Status Quo – Do Nothing

Option Overview

Under this option, VPR will not be implemented. This will signal a government decision to not invest in patient-centred continuous care, particularly following the Taskforce's explicit recommendation to implement VPR. There will be no infrastructure linking a patient with their preferred provider and practice. Providers will not be able to formally identify who their regular patients are without local registration. Not implementing VPR will also limit the effectiveness of associated funding reform proposals and will reduce the capacity to deliver on the broader goal of the primary care reform agenda to improve patient outcomes. For example, without introducing VPR as a way of targeting incentivised quality care packages to registered patients, the effectiveness and efficiency of payment models such as the new

General Practice Aged Care Incentive (GPACI) or the Wrap-around Care for Frequent Hospital Users program will be diminished (see Section 5 for more detail). Without VPR, health providers will not be able to be formally matched with patients and receive payments for quality, continuous care.

Other Department programs and initiatives will be progressed to address issues including inequitable access to primary care, increasing rates of chronic and complex disease, and fragmentation in the health system. These programs and initiatives include workforce distribution strategies, expansion of successful innovative care model trials, expansion and reform of Primary Health Network (PHN)-based programs, and review of existing incentive programs.

Option 2 (Implementation of VPR)

Option 2 Overview

This option supports the introduction of VPR to promote continuity of care, strengthen the relationship between the patient and their care team, and help participating GPs and practices better understand and meet their patients' needs. VPR is a critical starting point to drive reform in primary care.

The proposed approach to implementation is universal and voluntary. This approach was informed by research into the strengths and weaknesses of overseas registration models and the advice of the Taskforce on what approach would be most effective in the Australian context.

A targeted implementation approach, where VPR is only available to defined cohorts, was considered but not recommended on the basis that continuity of care benefits everyone, access to VPR should be available to all Australians, and cohorts can still be effectively targeted through VPR without restricting scope of registration. A targeted approach would also limit the broader population and health system benefits of an ongoing patient relationship with a GP and practice including equitable care provision, population health needs analysis and service planning.

Consideration was also given to whether the VPR model should operate differently in Aboriginal Community Controlled Health Services (ACCHS), rural and remote Australia, and for other priority populations. While a universal registration was considered to be the most equitable approach, the implementation of VPR will be designed to ensure culturally appropriate engagement, accessible communications, and to streamline processes for those patients already connected to an ACCHS.

In considering the option of mandatory participation in VPR, voluntary participation was strongly preferred and is being proposed as it aligns with the Australian model of health care which places patient choice as a cornerstone of health care delivery and meets the expectations of the healthcare sector voiced through extensive consultation processes on VPR in Australia through the Primary Health Care 10 Year Plan (2022), the Primary Health Care Steering Group (2021) and the Primary Health Care Advisory Group Report (2015).

Under option 2, VPR will be implemented from 1 October 2023. VPR will be voluntary for patients, providers and practices and available to all Australians. Patients will be able to

choose to register with their regular general practice and nominate their preferred GP. This information will be available on the patient's My Health Record to assist with coordination of care across the health sector (including in hospital settings). Over time the patient will also be able to reflect their broader multi-disciplinary team within their registration. This will provide greater visibility over their patients' care and support a cohesive team care approach among different health professionals. This includes (but is not limited to) their general practitioner, primary care nurse, midwife, allied health professionals and Aboriginal health worker.

VPR will link healthcare identifiers in such a way that a patient's Medicare number will be linked to their registered practice (through the Organisation Register), and their preferred provider and multi-disciplinary team (through Medicare Provider Numbers). The system will also link to Health Care Identifiers when available to enable linkages to other digital systems. Through the registration process, patients who belong to particular demographics and cohorts will also be identified, providing a new mechanism for funding reform as MBS items and incentives will be able to be linked to registration (see Section 5: Impact Analysis for more detail).

Patient Eligibility

Registration of a patient with their preferred practice will be established if the patient had at least two separate face to face visits with the practice in the last 24 months. A reduced eligibility criteria of one face to face visit in the previous 12 months will apply for practices in MMM 6-7 areas and for ACCHS, acknowledging that these groups may not satisfy the two visits requirement due to various factors. Access for populations that may experience issues in engaging effectively with primary care will be exempt from the eligibility requirements mentioned above. In particular, people experiencing family and domestic violence or homelessness, more mobile populations, people who have not engaged with primary care services previously and people experiencing social disadvantage will be able to register in VPR on their first visit to a practice (if it is deemed clinically suitable by their provider). The VPR communications strategy will support these at risk groups (who may face additional barriers to health care and are at risk of poor health outcomes) to connect to a provider and practice, and benefit from continuity of care.

Reduced eligibility criteria respond to the Taskforce's recommendation that investments in primary care should address inequities in access and outcomes, including for First Nations Australians, people in rural and remote areas, culturally and linguistically diverse people, people with disability and people on low incomes.

Patient Registration

The registration process for patients will be simple and initiated at either the practice as part of a visit, or by a patient online through their Medicare Online App. Keeping these processes simple and embedded in existing processes to see a GP or health practitioner will reduce the time taken by individuals to undertake the registration process.

Exit from program/changing enrolment

To ensure the delivery of person-centred care, patient choice and flexibility is central to the design of VPR. Registered patients will have the ability to attend any practice they choose, and can change their registered practice if they meet the eligibility requirements. Registered patients will still be able to seek care from other practices and GPs outside of their registered

practice (e.g, if travelling or if they wanted to visit a GP who specialised in particular services), which is a continuation of current patient behaviour. Patients will be able to withdraw their registration at any time, meaning that patients are not restricted in their ability to choose where they receive care, nor are they locked into a registration with a poor performing practice.

Practice Registration

Practice registration will be a streamlined process based on Services Australia systems that practices are already familiar with. These systems include Health Professional Online Services (HPOS), Provider Digital Access (PRODA), and the Organisation Register. Patient on-boarding to VPR will also be a streamlined process, done either at the practice as part of a visit, or by a patient online through their Medicare Online App. This will involve the capturing of two-way consent. Upon registering with a different practice, the patient's former registration will be automatically removed.

As at March 2023, over 6880 practices are accredited against the National General Practice Accreditation Scheme will be eligible to register their patients in VPR. In addition practices that are on a 12 month pathway to becoming accredited will also be eligible to participate (noting that the VPR proposal includes support for unaccredited practices to gain accreditation).

It is estimated that 1091 practices are currently not accredited under the General Practice Accreditation Scheme. Some practices are ineligible due to the scope of the requirements of the Standards for general practices (5th Edition) and definition of general practice determined by the Royal Australian College of General Practice (RACGP). Practices that offer general practice holistic care such as some ACCHS (that are largely-nurse led) or mobile and outreach practices (that do not have a bricks and mortar practice) will be able to participate in VPR if they are accredited under the National Safety and Quality Primary and Community Healthcare Standards, or on a 12 month pathway to becoming accredited. The RACGP is considering the definition of general practice following consultation, which may open up further options for practices to register through the RACGP standards.

Based on existing patterns of MBS claiming, it is estimated that 86.1 per cent of the population will be eligible to register with their general practice (as per the proposed patient eligibility criteria). It is expected that around 52.7 per cent of eligible patients are likely to register because they will directly benefit from the proposed linked funding packages and MBS items. This represents 45.4% of the Australian population, or around 11.5 million people. Over time as incentives and MBS items are linked to VPR, it is expected that practices will seek to expand their registered population through a greater focus on longitudinal care to patients they may not see regularly. Likewise, as targeted MBS services and incentives are linked to VPR it is expected that some patients will register to gain access to these services.

It is not expected that registration will cover 100 per cent of the population. Registration is estimated to be lower for people in good health as they have less need to visit a general practice and are more likely to visit for unrelated, episodic clinical needs. Approximately 3 per cent of Australian's have not engaged with the primary healthcare system for at least two years. People expected to register include those eligible for incentives and expected to use targeted MBS services, as well as those with a usual GP or a strong relationship with a practice as observed through MBS claiming.

Privacy and data
As part of the registration process, participants will be asked to formally consent to participate in the program. This will include consent for their registration and demographic data to be visible to the registered practice, stored by Services Australia in a secure database and provided to the Department of Health and Aged Care and other authorised parties. The data will be used in a manner that is consistent with the Australian Privacy Principles and the Privacy Act 1988 including for the following purposes (noting advice on scope and consistency of data use is still under consideration):

- Linking the patient with their preferred GP and practice;
- Assessing eligibility for MBS items and incentives linked to registration;
- Enabling relevant MBS items and incentives linked to VPR to be processed; and
- Enabling compliance activities to ensure that providers and practices are adhering to the rules and requirements of voluntary patient registration.

5. Impact Analysis

Option 1 (Status Quo)

Change in Costs ($m)	Business	Community Organisations	Individuals	Annual Change in Cost	Four Years Change Cost
Option 1 – Status Quo	$0	$0	$0	$0	$0
Option 1 was calculated on the basis that there will be no change to current arrangements.					

Individuals

Under Option 1, VPR will not be implemented. This will negatively impact individuals who would otherwise benefit from outcomes associated with VPR, including improved continuity of care, access to tied incentives and MBS items, and a strengthened ongoing relationship with their practice and GP. Without VPR individuals will be subject to the current fragmentation and lack of coordination of care in many primary care services.

Patients without a strong relationship with their practice and GP and those subject to fragmented and uncoordinated care have worse health outcomes. As mentioned above in Section 2, patients without a regular GP present more often to emergency departments, and are more likely to seek specialist care, thereby increasing overall system costs (Glazier, et al., 2008). There is evidence that a lack of a designated primary care provider can lead to fragmented care, poorer outcomes, and higher costs (Christiansen, et al., 2016). A report published by the World Health Organisation found that without good continuity or coordination of care and support, many patients, carers and families experience fragmented, poorly integrated care from multiple providers, often with suboptimal outcomes and risk of harm (World Health Organisation, 2018).

Over time, without concerted effort to link patients to their usual practice to ensure continuity of care through VPR, health outcomes will deteriorate, especially in the context of an ageing population and continually increasing rates of chronic disease. This will disproportionally impact at-risk populations (including rural and remote communities, Aboriginal and Torres Strait Islander peoples, communities, people with diverse backgrounds, people with disability, older people and hard to reach and at-risk groups).

Health care providers and practices

Without implementing VPR, providers and practices will continue to rely largely on MBS item claiming (fee-for-service). This approach misses an opportunity to help stabilise primary care provider business models and support sustainability through VPR, with incentives attached to registered patient cohorts providing greater financial certainty for practices.

Without VPR, there will be no linkage of patients to their provider/practice to incentivise delivery of best-practice care by the same GP. Likewise, practices will have limited visibility of their patient population and related care needs, and no ability to track their progress against the incentive criteria to alert providers as to their obligations to both deliver best practice care and to receive related incentive payments.

An example of the benefits for providers and practices that won't be realised if VPR is not implemented is highlighted through GPACI. This incentive will be replacing the existing Aged Care Access Incentive program. Within, each residential aged care resident will register with their regular primary care provider through VPR. Practitioners will be rewarded for providing their registered residential aged care patients with a defined quality bundle of care. Practitioners and practices will receive an incentive payment per patient per annum (plus loadings for rural Australia) for providing this bundle, for facilitating access to multidisciplinary care teams, and for coordinating alternative care in between visits and when the resident's usual practitioner is unavailable.

Option 2 (Implementation of VPR)

Overall Change in Costs ($m)

Business	Community Organisations	Individuals	Average Annual Change in Cost	Total Four Years Change Cost
-$91.7	$0	$0	-$22.9	-$91.7

Breakdown of Business Change in Costs ($m)

Year 1	Year 2	Year 3	Year 4	Average Annual Change in Cost	Total Four Years Change Cost
$9.3	-$21.4	-$33.8	-$45.8	-$22.9	-$91.7

By implementing VPR, the total regulatory save to business and individuals combined will be an average of $22.9 million annually and a total of $91.7 million over four years. See **Appendix 2** for further detail.

Overview of regulatory burden

VPR has been designed to make use of existing online portals routinely used by practices and primary health care services particularly in their interaction with Medicare. Through leveraging these existing systems there will be additional offsets through reduction in duplication of ICT and software systems – PRODA, HPOS, and the Organisation Register are currently used for multiple programs, not just VPR, and will be built upon further in regards to future policy implemented by the Department. Encouraging registration and training focusing on staff familiarity in using these programs will further offset initial costs associated with VPR implementation.

There are currently a significant number of practices that have already registered in these online systems which will be a prerequisite of registering in VPR. As at 10 March 2023, 2317 practices have uploaded their details onto the online systems that underpin VPR. For these practices there will be less of an effort and therefore less cost associated with registering for VPR.

Through consultations, the primary care sector have voiced support for VPR. System co-design has been undertaken with practice managers (as they will be the predominant users of the registration system within practices). The co-design approach has sought to streamline online portal use and access to ensure that administrative costs and time costs of signing up to VPR are minimised. A total of 54 practice staff over 77 hours have participated to date.

Participating in VPR will provide practices with more comprehensive information about their regular patient base, which will lead to offsets in a number of ways. Practices will be able to more efficiently identify their regular patient population for preventative health services, screening reminders, relevant referrals, and other patient-tailored services. Where a patient has left a particular practice or chosen to register elsewhere, this information will be visible and practices will not waste resources (and staff time) attempting to contact these patients. In December 2022, Departmental data indicated that 7.8 million patients were eligible to register at 3 or more practices. If these patients were to register in VPR, this results in a minimum of 2 practices per patient that will not have to use resources to ensure continuity of care follow up after a visit (which is estimated to be 10 minutes of staff time annually per patient). This efficiency is calculated to provide an average annual saving of $12.5 million over the first four years.

While this option represents an initial regulatory cost in the first year, over time, following the bulk of the initial registration work, this is mitigated through incentives linked to VPR and efficiencies gained (outlined above), resulting in a regulatory save.

Individuals

Implementation of VPR will provide patients with a ‘home base’ platform for their health care that has their relevant health information, including the health professionals they regularly

see and linkages to My Health Record. This will allow patients to increasingly develop stronger and more longitudinal relationships with the providers at their practice. Providers will then be empowered to tailor their care because they know their patients extensively. Patients will be more likely to receive preventative intervention for lifestyle risk factors, and to receive coordinated and comprehensive chronic disease management, leading to improvements in their health outcomes. This will be particularly beneficial for population groups that experience high rates of chronic disease, including rural and remote communities and Aboriginal and Torres Strait Islander peoples and communities that statistically have poorer health outcomes than the national average. People who are at the centre of new tied incentives and MBS items to enhance care through this Budget would also gain significant benefits.

Continuity of care

VPR will drive improvements in the continuity of care, which has been shown to contribute to higher quality, integrated and person-centred care. VPR builds off sector and stakeholder consensus that some services are best delivered by a patient's regular GP and practice where their clinical records are held. There is significant evidence that continuity of care leads to improved patient outcomes and satisfaction, lower mortality and decreased emergency department attendance and hospitalisation. A report by the World Health Organization found that formal links with an identifiable source of care means long-term relationships are more likely to develop, enabling continuity of care (World Health Organisation, 2008).

All patients who engage with VPR are believed to benefit from a greater continuity of care. With the introduction of targeted incentive payments, some patient groups may particularly benefit from an enhanced relationship with their practice and their GP, including patients with chronic conditions, Aboriginal and Torres Strait Islander people, and older Australians. Patients who register with their practice will benefit from practices' having increased knowledge of their patient bases and related health needs, who could then focus on offering tailored services and delivering targeted care.

Multidisciplinary Care

High quality primary care delivery depends on multidisciplinary care teams – harnessing the full strengths of the diverse health workforce, including GPs, nurses, nurse practitioners and midwives and allied health professionals. However, current barriers exist to inter-professional collaboration and teamwork, resulting in worse patient outcomes. VPR will contribute to breaking these barriers through enhanced connection and collaboration facilitated by better linking members of a patient's multidisciplinary care team.

Evidence shows that connected multidisciplinary care teams contribute to better patient outcomes and increase the efficiency of the health system. Benefits of multidisciplinary team-based care models include improved patient outcomes, prevention of disease, cost-effective and value-based care across the health system, greater use of the available workforce addressing shortages, reduced patient wait times, and improved attraction and retention of health professionals through rewarding career paths and job satisfaction (Philip 2015, Mickan 2005). There is a well-established body of evidence that supports the concept of multidisciplinary team-based care as best practice for treating many chronic conditions, which is currently a significant and growing burden on the primary care system (Lee et al 2021, Kruis et al 2013, Gregg et al 2011).

Access to services

VPR can act as a mechanism for targeted incentive payments that improve access to healthcare. For example, there are current challenges ensuring that people living in residential aged care homes have adequate access to GP services. The Aged Care Royal Commission found that access to GPs is limited for many Residential Aged Care Home (RACH) residents. Over the last five years, 40% of RACH residents have not received continuity of care (over 70% of care) from one GP (Maarsingh et al, 2016). Once VPR is implemented, all residents will be able to be matched with a GP and general practice to receive a quality bundle of care, with the matching process supported by Primary Health Networks and RACHs.

The Wrap-around Care for Frequent Hospital Users program would also utilise the VPR system to link people with chronic conditions with a regular general practice. The VPR system will enable the practice to which the patient is linked to access an incentive payment to facilitate continuous, coordinated and multidisciplinary care for that patient.

There is a risk to access for patients who choose not to, or are otherwise unable to, register for VPR. These patients may experience difficulty accessing services available through registration. This risk will be mitigated by the fact that access to primary healthcare through Medicare remains a fundamental principle and it is expected that the vast majority of services will remain available to both registered and unregistered patients. VPR unlocks additional services but does not change access to the services available through Medicare before its implementation.

In addition, reduced eligibility requirements for patients of practices in MMM 6-7 areas and Aboriginal Community Controlled Health Services, and other populations that may experience issues in engaging effectively with primary care (see Section 4 - Option 2 Implementation of VPR) will allow patients that have not previously been engaged in primary care to register. This will be supported by a targeted communications strategy, including engagement materials for national and local peak and community organisations.

Ongoing monitoring of barriers to registration and related impacts will be an important aspect of program monitoring and evaluation processes.

Health care providers and practices

Increased patient and service insights

Registration gives practices a better understanding of their patient base and their health needs enabling them to better tailor their services to deliver person-centred care. Insights from the sector through the Primary Health Care 10 Year Plan and the Strengthening Medicare Taskforce indicate that GPs and practices will be more invested in delivering preventative care and improving patient activation and health literacy of their registered patients, knowing that the patient has nominated them as their regular provider. Given there is no formal, national registration process, submissions from primary care sector leaders also suggests that most general practices do not formally track who their regular patients are, and risks associated with this are commonly not addressed. Without a system for patient registration, GPs are more likely to be uncertain of who their regular patients are, which makes it less likely that the benefits of continuity of care will be realised (Wright,

2018). VPR will encourage practices to build continuity of care into their business model, ensuring support for longitudinal care and population health, as well as acute/episodic care. It will also provide transparency of the quality care bundles for priority cohorts that will be incentivised by government and prompt and support practices and providers to meet these expectations providing an improvement in service delivery and health outcomes.

VPR as a platform for funding change

Through forming a platform for targeted incentive payments for specific cohorts most likely to benefit, VPR provides a mechanism for future funding reform to shift to more blended funded models. This aligns with the recommendations of the Taskforce, and with international evidence of best practice.

Participation in VPR could allow a practice to receive incentives based on the care needs of their patients, rather than purely volume-based, transactional care, and provide the basis for a more equitable distribution of funding for the care of disadvantaged groups. This change to revenue streams through an increased proportion of funding coming through incentive payments linked to registered payments would mean practices will have greater revenue certainty, with a smaller proportion of revenue being drawn from fee-for-service care. This would increase sustainability and improve ongoing viability for practices.

For example, the Wrap-around Care for Frequent Hospital Users program will enable practices to receive incentive payments for each VPR-registered patient in the program, enabling the practice to tailor care for the patients' complex and chronic conditions. The incentive payment will provide the practice with funding certainty so that appropriate services can be sourced for program participants, but will not inhibit the practice from accessing MBS items for services delivered.

Practices who register their patients will be able to better identify their consumer base, and provide tailored, comprehensive and coordinated health care to them. VPR will facilitate the systematic collection of patient-level primary care data that will support continuous quality improvement at provider and practice level. This will allow better collection of population-level clinical information and assist with system planning and resource allocation, especially providing more targeted blended funding.

Under this option, over the first four years there will be an average regulatory save of $22.9 million annually to business (noting that these saves will increase over time as implementation costs decrease and further incentives and MBS items that are more effective when supported by continuity of care are linked to VPR). Practice participation will require additional administrative work via familiar ICT portals, however, participation will be voluntary for practices and limited to patient's voluntarily providing consent to register. The system being built by Services Australia will leverage existing database attributes, support streamlined processes, and minimise the burden on practices and GPs where possible.

We anticipate that this proposal will have few competition impacts. Registered patients will be the practice's usual patients, and registered patients remain free to visit other GPs or practices. It is also important to note that practices already operate in a competitive market, and it is at their discretion how they operate their business and on the model of care provided to patients. There is potential for greater competition between registered practices

and non-registered practices, in the context of attracting and retaining patient bases. This competition is likely to have positive impacts for patients, as practices will be motivated to encourage patient retention through higher quality care.

The risk of enhanced competition leading to reduced business viability is unlikely given there is excess demand for general practice forecast over many decades due to increased need to address ageing and chronic disease, coupled with the need to boost workforce supply. The department will continue to undertake monitoring of the workforce and practice activity. There will also be communications explaining the benefits of VPR, including for patients' long term health outcomes and for primary care providers' business operations, and through training and supporting resources that will minimise administrative burden associated with a practice signing up to VPR. These potential competition impacts will be a consideration of monitoring and evaluation processes.

The requirement for practices to be accredited is outlined above in Section 3, and the cost for practice accreditation in order to participate in VPR has also been considered as a regulatory impact. However, practices register in VPR are likely to see considerable overall benefit. Most general practices choose to seek accreditation based on the assurance it provides around improved patient safety and effective risk management, assurance for patients of a high standard of care, increased insurance provider recognition and a better working culture for staff. The cost is small in comparison to financial incentives that are available to accredited practices through the Practice Incentives Program and Workforce Incentive Program – Practice Stream, and that will be available through VPR.

Access to services

Practices and providers signed up to VPR will be able to access increased funding through targeted incentive payments for eligible registered patients such as GPACI, Wrap-around Care for Frequent Hospital Users program, and exclusive access to certain MBS items. The additional funding supported through VPR will enable practices and providers to deliver continuity of care for their patients and will result in improved practice viability which will help to defray the initial costs of practice and patient registration.

For providers and practices, VPR will support enhancements to the current Indigenous Health Incentive (IHI) registration process. The current IHI requires eligible patients to annually register to an eligible general practice for the purposes of improved health outcomes through a continuity of care agreement, with payments made to the practice based on care delivered. This is only available in a paper based form. Streamlining the registration process of IHI and VPR (and providing electronic registration options) will reduce the administrative burden for practices, as they will only have to register with one system to access the IHI and other incentives to which they may be eligible.

Practices that are either ineligible or opt not to participate in VPR will be unable to access any incentives or MBS items exclusively linked to patient registration. It should be noted however that access to non-linked MBS items or incentives will remain unchanged.

Exit from program/changing registration

There are multiple ways a patient could exit VPR or change their registration. These processes have been designed to be automated where possible to minimise burden on practices. For example if a patient chose to register with a different practice, their new

registration will automatically nullify the previous one and there will be no requirement for action from the initial participating practice. If a patient chose to withdraw, they could call Services Australia to action the withdrawal request on their behalf or utilise a self-service withdrawal functionality that will be available to patients through their Medicare Online Account (with no administrative burden for the initial practice). In addition, a patient could also be automatically withdrawn if they do not receive a face to face service from their registered practice for two years.

6. Consultation

Initial consultations to inform development of the policy framework around VPR commenced in late 2019 as part of development of the 10 Year Plan (see Australia's Primary Health Care 10 Year Plan 2022–2032 | Australian Government Department of Health and Aged Care). Consultations included 20 themed roundtables focusing on various population health groups, provider groups and issues in primary health care, and a large consultation group in November 2019. These specific sectors and themes included Rural and Remote, Older Australians, Dementia, Allied health, After Hours, Intellectual Disability, LGBTI, and First 2,000 days. Over 240 organisations were represented in the consultation process, including people with lived experience, academics, peak organisations and PHNs.

The Primary Health Care Reform Steering Group (the Steering Group), which included the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association, the Australian College of Rural and Remote Medicine, and the Consumers Health Forum met 20 times between October 2019 and September 2021 to inform advice and develop recommendations for primary care reform. The Steering Group identified VPR as a key building block and foundation for reform in primary health care.

A second consultation period, involving consultation on the Steering Group's discussion paper with a set of draft recommendations to inform the 10 Year Plan commenced on 15 June 2021 for a 6 week period and closed on 27 July 2021. Consultation on the recommendations sought stakeholder views, particularly on the proposed direction and any challenges or omissions.

The consultation on the discussion paper involved inviting more than 420 organisations and individuals to provide feedback. The invitation was further disseminated through the professional networks of those originally invited. Over 200 submissions were received, many were substantial in both depth and coverage. They included peaks, consumer organisations a number of research entities, PHNs and state/territory governments and people with lived experience.

A common theme identified through consultation was the health system is difficult to navigate, particularly for parents of young children, older Australians and their carers, people with complex chronic conditions, people with disability and their carers, people from culturally and linguistically diverse (CALD) backgrounds, LGBTI people, people in socioeconomically disadvantaged circumstances and people experiencing mental illness.

Feedback from this consultation informed the final recommendations of the Steering Group. The Government considered the recommendations, and released a Consultation Draft of the

10 Year Plan (Draft Plan). Feedback on the Draft Plan reflected the input received through previous consultation.

Some stakeholders, generally smaller more specialist interest groups, raised concerns with linking services such as MBS items to VPR due to the perceived potential restriction of access to medical services for some patients. VPR will not restrict patients from accessing services from other GPs, but it will restrict patients who are not registered from accessing services exclusively linked to VPR.

Consumer peak bodies highlighted the need for the model to include some exceptions/reduced eligibility requirements for vulnerable populations such as Indigenous communities. This has been taken into consideration in the VPR model, which includes exemptions and reduced eligibility criteria for vulnerable cohorts.

Consultation with the sector also occurred through the external expert and clinician-led MBS Review Taskforce. The MBS Review Taskforce established over 70 Clinical Committees to provide it with expert advice about each area of clinical practice that the MBS supports. During this 5 year process more than 700 clinicians, consumers and health system experts participated in these committees, providing detailed advice on how to improve the MBS.

The MBS Review Taskforce recommended that high rebate MBS items, such as chronic disease management items, be restricted to the provider a patient is registered with. These items are currently open to misuse. Current Medicare explanatory notes require that some frequency-limited, high-fee GP services should only be provided by the patients 'usual GP', but this is not defined. Such items include chronic disease management, health assessments, home medicines reviews, and team care arrangements. Currently, a GP may claim an item for any patient, even if they are not that patient's usual GP. This in turn could prevent the patient's usual GP from claiming that item. This scenario is problematic for both the patient and the patient's usual GP as it reduces care continuity and places additional burden on the usual GP to provide care for which they are not appropriately reimbursed. This recommendation is noted for further consideration.

On 3 February 2023, the Minister for Health and Aged Care, the Hon Mark Butler MP, released the report of the Taskforce. The members of the Taskforce were health leaders from across Australia's primary care system. The report recommends significant changes to how primary care is funded and delivered to enable high quality, integrated and person-centred care for all Australians. In the development of the report, the Taskforce conducted a number of deep dives, including on VPR. In recognising the value of VPR to patients and practices, it was a key component of their recommendations as a way to support better continuity of care, strengthen relationships between the patient and their care team, and provide more integrated, person-centred care. Further details on the Taskforce can be found at: Strengthening Medicare Taskforce | Australian Government Department of Health and Aged Care.

7. Preferred Option and how it will be implemented

The preferred option is the implementation of VPR (Option 2), as it supports better integrated, coordinated health care, which will benefit patients, practices, providers and the broader health system.

Although VPR is associated with some upfront costs and reducing ongoing regulatory burden (as outlined in Section 5), it results in a regulatory save over the first 4 years of the program, which will increase over time. This option also better addresses the current issues impacting primary care, including inadequate continuity of care and fragmentation of care. As indicated above, several years of consultation with the sector have consistently identified VPR as a reform that will improve patient outcomes. These consultations have informed aspects of program design to ensure that the program is equitable and sustainable.

Without commencing VPR, primary care will continue to be delivered without the benefits of enhanced continuity of care which puts patients at risk of low value, fragmented care that is financially inefficient for the health care system.

Implementation

VPR will be implemented through a Services Australia based platform called the Organisation Register. As outlined above in Section 4, this system leverages existing Government platforms such as PRODA and HPOS that are already familiar to practices, and uses existing Medicare numbers, provider numbers and My Health Record infrastructure. The system currently has the functionality to enable patient registration to a practice and provider. The funding being sought to finalise the development of VPR systems will enhance existing functionality to include multidisciplinary team care arrangements, nurse-led practices, and expand payment capabilities. In addition, the Department of Health and Services Australia will work with practice management software vendors to co-design options for integration with clinical software over time.

Activities prior to go-live in October 2023 will focus on final testing of the end to end system capabilities, on-boarding additional practices, working with the sector on change management, and developing and disseminating communications materials.

To support implementation (as part of this proposal), funding is being sought for the establishment and ongoing management of an expert advisory committee. This committee will be a key mechanism to ensure VPR meets sector needs and expectations whilst delivering quality health outcomes and value for government.

A tailored stakeholder and communications strategy will be developed and delivered through a range of media to ensure that both patients and practices understand VPR and its benefits. This will include specifically targeted engagement with rural and remote communities, First Nations peoples, culturally and linguistically diverse populations, at risk and/or disadvantaged populations as well as the broad range of primary health care providers. In addition, training materials, fact sheets, and stakeholder kits will be developed to support practices to engage with and register their patients, and for consumers to be well-informed about their choices and the benefits of VPR. Specific training and support for practice managers, as key sector partners and delivery champions, will also be provided. To support practices in gaining accreditation, funding is proposed for PHNs to work with unaccredited practices in their regions, and develop resources and supports to ensure those practices are able to achieve accreditation with the ACSQHC.

It is expected VPR will be implemented through a staged process that supports practice registration in the first instance with patient registration following broader consultation and

communications. The Expert Advisory Committee and ongoing market research processes will also help to inform implementation.

8. Evaluation

Ongoing program monitoring will consider a number of metrics to track progress of registration rates at patient and practice level, and monitor other metrics related to the program. A comprehensive evaluation of VPR will form part of a broader evaluation project of policy measures implemented under the Strengthening Medicare Fund. The specific VPR evaluation plan will be in place prior to 1 October 2023.

An evaluation framework will develop a baseline for primary health care and performance indicators. The evaluation will consider patient and practice experience, measures of patient activation and care coordination, and measures of patient outcomes, as well as aspects such as reported misuse of high rebate MBS items linked to VPR, any competition effects arising from practices choosing or choosing not to participate in VPR. A formal whole-of-plan evaluation will be undertaken in 2024-25 and 2027-28. A final evaluation will be undertaken in 2030-31 to help inform future plans and strategies.

Policy objective	Evaluation metric	Data to be collected	Frequency of data collection	How will data be collected	Required stakeholders	Responsible entity
Continuity of care - To formally recognise and strengthen relationships between a patient, their provider and practice	Evaluation metrics will be developed through the formal evaluation design as part of the Strengthening Medicare Fund evaluation.	From 1 October 2023 – Practice and de-identified patient registration data will be available to support analysis. Participating practices, providers and patients.	Ongoing monitoring throughout duration of evaluation activities	Automatic de-identified registration data feed. Data collected through registration	Patients successfully engaged in system. Participating practices and providers	Department of Health and Aged Care
Funding reform - To support payment models that enable wrap around, patient centred care	Evaluation metrics will be developed through the evaluation design once the scope and timing of new incentives and MBS items are confirmed	From 1 October 2023 – Practice and de-identified patient registration data will be available to support analysis Incentives and new MBS items commence, as decided by Government.	Ongoing monitoring throughout duration of evaluation activities	Automatic de-identified registration data feed. Data collected through registration	Patients successfully engaged in system. Participating practices and providers	Department of Health and Aged Care

Appendix 1

National policy work in primary health care reform: 2009 to present

In 2009, the National Health and Hospitals Reform Commission identified and proposed a number of primary health care solutions to Australia's fragmented health care system. This included trialling of a Health Care Home (HCH) model for general practice and Aboriginal Community Controlled Health Services (ACCHS), and much closer integration between primary and acute care.

In 2013, Australia's first National Primary Care Strategic Framework recommended the formation of Medicare Locals – since 2015, Primary Health Networks – to better integrate the diverse players across the sector, and create a geographically based representation and commissioning body for relevant primary health care services. In 2016, the Primary Health Care Advisory Group made 15 recommendations to better equip primary health care to deliver optimal services for Australians with chronic disease. It more fully defined the HCH model of care, and its centrality to linkages between key elements of Australia's complex health care system; and raised the importance of patient activation and partnership in a continuity of care relationship.

The 2016, Council of Australian Governments (COAG) reform agreements again re-enforced the HCH model of care, and in addition, committed jurisdictions to the consideration of joint commissioning and joint planning arrangements for general practice and primary care at Primary Health Network (PHN) / Local Health Network (LHN) level.

The HCH model was implemented in a trial running from 2017 to 2021. The trial saw general practices become home bases for patients with complex and chronic conditions to receive team-based, coordinated care from within the practice. Most evidence of the success of the HCH trial and the continuity of care that it supported, comes from individual GP and patient experiences, which indicate that when the model is fully accepted and well-implemented, the result is increased patient-centred care and improved outcomes, achieved through stronger team-based culture in participating practices.

In 2019, the Expert Advisory Group on Primary Care recommended the introduction of a population focused enrolment program to support enhanced access to non-face-to-face services, and support the changes necessary to provide care which meets the modern day expectations and needs of the community. It was also recommended that the model formalise and strengthen the existing relationship between a patient and their regular general practitioner through a simple process of 'voluntary patient enrolment'.

In 2020 the Medicare Benefits Schedule Review identified the need for a sharper focus on continuity of care and chronic disease management for primary health care, a shift away from volume based funding models and also supported a patient enrolment model.

In 2021, The Primary Health Care Reform Steering Group (the Steering Group), which included the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association, the Australian College of Rural and Remote Medicine, and the Consumers Health Forum, recommended the Government pursue a model of voluntary patient registration post COVID-19.

In 2022, the publication of Future Focused Primary Care: Australia's Primary Health Care 10 Year Plan 2022-2032, laid out a vision for reform and structural change of the primary health

care system. Aiming to improve access to care that is better integrated and more efficient, this roadmap proposed introducing voluntary patient registration within general practice.

Appendix 2

Options 2 Regulatory Burden Estimate

Option 2 was calculated on the basis that VPR will save businesses an average of $22.9 million over the first four years and the total regulatory save will be $91.7 million.

The analysis of the business regulatory burden includes costs for medical providers/practices (including standard general practices and other practice models such as ACCHS, mobile and outreach practices) to establish VPR. This includes:

- Average annual cost of $1.1 million over four years for practices to set up VPR in terms of staff time and salary (noting that currently 2317 practices are already on the organisation register which reduces cost and time for those practices).
- Average annual cost of $2.4 million over four years for accreditation costs for currently unaccredited practices.
- Average annual cost of $12.3 million over four years for the salary and time associated with the practice registering a patient (noting a proportion of patients are expected to register through a self-service functionality, which reduces practice time and effort).
- Average annual save of $12.5 million over four years for efficiencies gained from VPR in terms of greater visibility of registered population and not wasting resources on proactive health prevention and other activities with patients who no longer wish to see providers within the practice (see Section 5).
- Average annual save of $26 million over four years relating to incentives being linked to VPR.

There is no regulatory burden identified for individual consumers/patients as a patient's personal registration in VPR is consistent with existing standard health care processes.

Are all new costs offset? Yes

Total (Change in costs - cost offset) ($ million): -$91.7

What are the offsets for increases in regulatory costs associated with this proposal?

The business change costs are offset by the efficiencies gained from VPR at the practice once the registration is established. In addition, the linking of incentives to VPR will result in significant regulatory saves for businesses.

It should also be noted that individuals will also benefit (as they will be receiving better health care, and therefore will have better health outcomes.

Option 2 Regulatory Burden Estimate Calculations

Summary

Implementation year	1	2	3	4	Total	Average over 4 years
Patient registration cost	$16,900,596	$24,340,661	$5,193,178	$2,822,923	**$49,257,358**	$12,314,339
Process, procedures and training cost	$2,745,247	$656,412	$437,608	$437,608	**$4,276,875**	$1,069,219
Accreditation cost	$6,289,070	$1,347,658	$898,439	$898,439	**$9,433,604**	$2,358,401
Practice efficiencies from VPR (saving)	-$16,653,000	-$23,790,000	-$4,758,000	-$4,758,000	**-$49,959,000**	-$12,489,750
Practice Incentive (saving)	$	-$23,937,485	-$35,536,765	-$45,210,611	**-$104,684,861**	-$26,171,215
TOTAL	**$9,281,913**	**-$21,382,754**	**-$33,765,540**	**-$45,809,642**	**-$91,676,024**	**-$22,919,006**

	Implementation year	1	2	3	4
Summary Impact Components					
Patient registration cost	Total patients expected to register	3,957,985	5,700,389	1,216,201	661,106
	Rate of uptake of general practices	70%	15%	10%	10%
	Number of patients expected to register through paper form	1,978,993	2,850,195	608,101	330,553
	Time taken to register per patient in person (hours)	0.08	0.08	0.08	0.08
	Staffing cost per hour	$73.20	$73.20	$73.20	$73.20
	Sub Total - registering through paper form	**$ 12,071,854**	**$ 17,386,186**	**$ 3,709,413**	**$ 2,016,373**
	Number of patients assumed to self-register	1,978,993	2,850,195	608,101	330,553
	Estimated practice time taken to register patients using self service	0.03	0.03	0.03	0.03
	Staffing cost per hour	$73.20	$ 73.20	$ 73.20	$73.20
	Sub Total - registering using self service	**$ 4,828,742**	**$ 6,954,475**	**$ 1,483,765**	**$ 806,549**
	Total	**$ 16,900,596**	**$ 24,340,661**	**$ 5,193,178**	**$2,822,923**
Process, procedures, training	Number of new practices expected to be participating	5,580	1,196	797	797
	Number of practices expected to be setting up - not on Organisation Register	3,263	1,196	797	797
	Number of hours spent on process, procedures and training - not on Organisation Register	7.5	7.5	7.5	7.5
	Staffing cost per hour	$73.20	$73.20	$73.20	$73.20
	Sub Total - not on Organisation Register	**$1,791,222**	**$656,412**	**$ 437,608**	**$437,608**
	Number of practices expected to be setting up – already on Organisation Register	2,317	-	-	-
	Number of hours spent on process, procedures and training - already on Organisation Register	5.625	5.625	5.625	5.625
	Staffing cost per hour	$73.20	$73.20	$73.20	$73.20
	Sub Total – already on Organisation Register	**$ 954,025**	**$ -**	**$ -**	**$ -**
	Total	**$ 2,745,247**	**$ 656,412**	**$ 437,608**	**$ 437,608**
Accreditation cost	Number of practices seeking to become accredited (uptake assumes growth)	764	164	109	109
	Number of hours to complete accreditation	113	113	113	113
	Staffing cost per hour	$73.20	$ 73.20	$73.20	$73.20
	Total	**$ 6,289,070**	**$ 1,347,658**	**$ 898,439**	**$ 898,439**
Efficiencies at the practice (*saving*)	Rate of uptake of registering patients for patients who see 3 or more practice per year	35%	50%	10%	10%
	Estimated number of these patients registering in VPR (and saving other practices administrative burden)	682,500	975,000	195,000	195,000
	Number of hours in follow up time for practices	0.17	0.17	0.17	0.17
	Staffing cost per hour (assuming 2 practices will realise efficiency gains per patient)	$ 146.40	$ 146.40	$146.40	$ 146.40
	Total	**$ 16,653,000**	**$ 23,790,000**	**$ 4,758,000**	**$ 4,758,000**
Incentives income to business (*saving*)	Number of patients expected to participate in incentives (total)	0	100,313	111,859	123,374
	Incentive per patient (average)		$ 239	318	$ 366
	Total	**$ -**	**$ 23,937,485**	**$ 35,536,765**	**$ 45,210,611**

Key assumptions

Assumption	Value	Detail
Number of patients expected to register	11,535,680	We expect 53% of eligible patients will register with a provider in the first 4 years. This represents the estimated number of patients who will participate in newly created incentive programs and the number of people who belong to patient cohorts who traditionally have strong relationships with their primary care providers and/or who we wish to build new incentives for. The latter group includes: people with a chronic disease management plan, people with a mental health treatment plan, people with children in the first 2000 days of life, older Australians living in the community. It is unlikely that all patients will commence participation in the first year. The first year assumes approximately 34% of the 11.5 million to register, taking into account timing of roll out and communications required. The participant uptake rate also accounts for the dynamic nature of patient registration and growth over time (e.g. patients changing practices or new individuals becoming eligible for linked incentives).
General Practice uptake over 4 years	-	It is unlikely that all practices will commence participation in the first year. As such, we have assumed that 70% would register in the first year, 15% in the second year, and 10% in the third and fourth year. This number exceed 100% due to the dynamic nature of business and assumes practices close, open, change and grow over time (i.e. sales, new practices, amalgamations etc.). This growth assumes a 5% net growth on current practices. These figures inform the number of new practices expected to be participating and the number of practices seeking to become accredited.
Time taken for practice to register a patient under VPR (hours)	0.083	Based on user testing at Services Australia.
Practice manager staffing cost (per hour)	73.2	Based on average hourly rate for practice manager.
Time taken for patient to self-register at a practice (hours)	0.033	Based on user testing at Services Australia.
Proportion of total patients expected to register on a paper form	50%	An estimate based on the expectation that at least half of patients will register when they are physically at the practice for an appointment.
Total number of practices (accredited and unaccredited)	7,971	We estimate there are currently around 7,971 general practices in Australia. Based on observed historical growth rates, we expect this number will increase by 5% over 4 years.
Number of practices already on the Organisation Register	2,317	Based on Organisation Register data from March 2023.
Number of hours spent on process, procedures and training - practices not on Organisation Register	7.5	Based on estimates from Services Australia.
Number of hours spend on process, procedures and training - practices on Organisation Register	5.625	Based on estimates from Services Australia.
Number of practices unaccredited	1,091	Based on Department of Health estimate of unaccredited practices. Number of new practices becoming accredited over the 4 years has been calculated using the number of practices to become accredited multiplied by the expected uptake by practices.
Average time taken at practice to complete accreditation (hours)	112.5	Estimate based on a practice taking 12 months to achieve accreditation and includes time spent on preparation/establishment of processes and the desktop and onsite assessment.
Number of Australian patients who have seen more than 3 practices in 1 year	7,800,000	Based on unpublished MBS data.

Proportion of patients who have seen more than 3 practices in 1 year who require follow up from the practice	25%	Based on anecdotal evidence from sector.
Time taken within practice to administer/follow up with infrequent patients (hours)	0.17	Based on anecdotal evidence from sector.
Average incentive amount per patient paid to practices	$ 312.00	This is the average payment amount per incentivised patients across new incentive streams.
Number of patients expected to participate in incentives	335,546	This is the number of people we expect to qualify for incentive payments over the next 4 years. It does not include people we expect to qualify for future incentive payments/programs.

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