Discussion paper - Should General Practices Pay for Accreditation?

Executive Summary

General practice accreditation was one of a number of strategic policy initiatives from the 1990's that were aimed to support quality of care and better equip general practices to respond to evolving challenges in meeting health care needs. A collaborative effort between the Government, Australian Medical Association (AMA) and Royal Australian College of General Practitioners (RACGP), the voluntary system of accreditation was founded on a number of core principles including that:

- practices should not be discriminated against, financially or otherwise by size or location or membership of a practice group; and
- to ensure it remained under the control of the profession, accreditation should be self funding.

The principle of non-discrimination required the implementation of a community rating pricing model, where fees from larger practices would effectively cross-subsidise the costs of accreditation in smaller and more remote practices.

A consultancy commissioned by the then Department, recommended that the number of full time equivalent GPs (FTEGPs) be used as a basis for calculating practice accreditation fees, with a recommended amount of $1,200 per FTEGP applying.

The rationale for a cross-subsidisation convention was further reinforced when accreditation became required in 2002 for practices to receive Practice Incentive Program payments, which were more financially rewarding for larger practices.

This convention was also mandated in JASANZ Procedure 16 and later in the RACGP Standards themselves. It was also referred to in the Approvals Policy of the Australian Commission of Safety and Quality in Health Care (Commission) who assumed governance and administration of general practice accreditation under the National General Practice Accreditation Scheme (Scheme) in 2017.

The cross-subsidisation convention was generally applied by the two accrediting agencies initially approved by the Department to conduct accreditation assessment for the purposes of the PIP. It has now broken down and there is clear discrimination with discounting and examples of cherry picking by agencies to gain a greater market share of higher value or easier to service practices, with agencies charging minimum fees or for surveyor travel and accommodation. Cherry picking also occurs by practices seeking a simpler, easier or cheaper accreditation.

Accreditation is also now no longer a professionally controlled activity. While the Standards on which practices are assessed remain the responsibility of the RACGP, accrediting agencies are in effect, operationally, agents of the Commission.

Increased control and regulation is an inevitable consequence of linking accreditation to government funding through the PIP and other incentives. The recent significant investment in general practice through programs including the expansion of Medicare bulk billing incentives and the Bulk Billing Practice Incentives Program (BBPIP) raise the stakes considerably. Accreditation must be credible, accountable and achieve its purpose in providing assurance as to the safety and quality of care in general practice, if it is to continue as the basis for the annual distribution of hundreds of millions of dollars to general practices.

It is a key argument of this discussion paper that price competition poses significant risks to the integrity, impartiality, reliability and consistency of accreditation. This also has implications for the legitimate use of taxpayer funding and ultimately patient care. For the reasons given in the body of this document, it is proposed that general practices should no longer pay directly for accreditation but that instead, agencies should be reimbursed from the annual allocated PIP budget, for meeting surveyor recruitment, training and performance benchmarks, achieving assessment service and

quality performance indicators, and having the capacity and commitment to service all practices regardless of location and size.

This proposal is cost neutral for the overall Practice Incentives Program (PIP) budget. The contribution each practice ultimately makes, indirectly, is proportional to the benefit received. This is a true cross-subsidisation model. The proposal would ensure that accrediting agencies are adequately resourced, but with greater responsibility to provide an impartial, robust, high quality assessment to practices regardless of location or size. Removing price competition and having a central funding mechanism would provide the basis for greater accountability for agencies to defined outcomes.

This discussion paper establishes a budget neutral funding approach and pricing mechanism for general practice accreditation which:

- better supports the needs of general practices, accrediting agencies and the NGPA Scheme in meeting the core aim of providing assurance as to the safety and quality of general practice;
- removes price discrimination and distributes the costs of accreditation more fairly and in relation to benefits received by practices;
- eliminates many of the potential impartiality, influence, financial and other risks inherent with price competition identified across accreditation systems;
- is administratively more efficient and removes the direct cash flow burden from practices;
- ensures enhanced accountability for the increased scope and amount of funding of general practice;
- provides a quality foundation for other health reforms in general practice; and
- leads to greater integrity, consistency, reliability and accountability with assessments.

This paper describes the historical and policy background to general practice accreditation. It defines the core principles on which accreditation was founded and questions their current relevance and implementation as the NGPA Scheme has evolved. It articulates the risks associated with any accreditation program and highlights how availability of large amounts of government funding for accredited practices and price competition heightens risk. Finally, it explores options to remove those risks and takes a systems based approach to ensure a fairer, more sustainable and accountable accreditation program.

Background - History and Policy Context of Accreditation

General Practice Accreditation is one of several initiatives developed since the 1990s that aimed to enhance the quality of care provided to Australians by general practitioners and to equip the general practice sector to respond to emerging trends, challenges and opportunities as the health system evolved.

In July 1992, the then Minister for Health, the Hon Brian Howe, introduced a co-ordinated set of measures summarised in a document titled *The Future of General Practice: A Strategy for the Nineties and Beyond*. This document was produced by the Government, the AMA[1] and RACGP[2] and circulated to all Australian GPs. The stated aim of the package of measures was to *'allow general practice to reassert its role as the cornerstone of Australia's health care system and ensure the highest quality of care for patients.'*

Along with initiatives to influence the supply and distribution of the general practitioner workforce, the proposals included:

- development of a *blended payment system* through delivery of *practice enhancement grants,* now the Practice Incentives Program (PIP). Practice enhancement grants were originally determined through the calculation of a patient continuity index for practices;
- building on the vocational arrangements for general practice to make vocational training and certification (Fellowship) mandatory;
- support for the uptake of information technology systems in general practices; and
- establishing Divisions of General Practice, the precursors of Medicare Locals, now rebadged as Primary Health Networks.

This package also introduced a voluntary system of *accreditation for general practices*. Based on an earlier peer visit program established by the RACGP, as part of its continuing professional development package, accreditation was supported by the Commonwealth and developed largely through negotiation and co-operation with the AMA and RACGP. Accreditation of *general practices* was seen as complementary to certification and credentialing for individual *general practitioners*.

The stated aims of general practice accreditation in the strategy paper were *'to enhance the delivery of services and facilities by general practices through a process of continuing quality improvement.'*

The RACGP was commissioned and funded to develop and test the applicability, achievability, assessability and acceptability of standards for general practice[3]. Following the Field Test in 199 practices, the then Department requested the author and colleagues to conduct *local demonstration trials of standards and accreditation* in 500 practices nationwide, engaging with the new Divisions of General Practice.

In late 1997 AGPAL[4] was created. It received initial funding from the Commonwealth, and first offered accreditation services in May 1998. A second company GPA, now called Quality Practice Accreditation (QPA), was established at the invitation of the Department, after the Directors conducted the *local demonstration trials*. QPA offered accreditation services from 1999.

QPA did not seek or receive any direct funding from government. In addition QPA, unlike AGPAL, was required itself to become accredited by JASANZ to Procedure 16: *General Requirements for Bodies Operating Assessment and Accreditation of General Practices for Recognition under the Practice Incentives Program (PIP).* This procedure was first published in April 2000[5].

Accreditation uptake and funding

The practice enhancement grants precursor to the PIP program did not require accreditation for practices to receive funding. Practices could apply for *practice enhancement grants,* where the amount paid to a practice was determined by a *patient continuity index* formula. It was only later that the PIP included a range of quality indicators on which payments were based. The uptake for accreditation was initially very slow, until the mandatory linking of accreditation

to the PIP in 2002. Practices made a financial decision. By July 2003, eighteen months after the linking of accreditation with the PIP, some 87% of general practices in Australia had undertaken accreditation, to entry level standards, with around 4200 practices accredited by AGPAL and 500 by GPA. The PIP payments and access to GP registrars remain the key motivations for practices seeking accreditation.

In 2010 the Auditor General undertook a performance audit review of the PIP and reported:

'(The) PIP started on 1 July 1998. In 2009-10, approximately 4900 practices participated in the PIP, making it the largest Australian Government program aimed at general practices rather than general practitioners. Some $282m was paid to general practices under PIP in 2009-10, with an average payment of $57,800.'

Current challenges with the accreditation Scheme reflect prescient concerns expressed in an ANAO Performance Audit Report published in 2010-2011 into the Practice Incentives Program (Audit Report No.5, 2010-11).

Given that accreditation was (and still remains) the entry requirement for practices to access the benefits of the PIP, the ANAO report examined whether the department (then DoHA) was able to gain assurance over the quality of accreditation processes and compliance with the Standards. The report stated:

- *'without such assurance there is a risk that general practices could be assessed inconsistently, and that general practices do not maintain their compliance with the standards across an accreditation cycle,' and*
- *'a poor compliance regime could allow some practices to continue to receive PIP payments while not adhering to the standards,'*

both of which would effectively:

- *'limit the achievement of high quality primary health care that the government expects from accreditation'.*

Further the report noted that each of the (then) two accreditation agencies:

- '*used their own accreditation framework that general practices were required to follow.'*

The report also described two risks that can affect the quality of accreditation, namely "*inconsistency in accreditation outcomes"* and "*practices dropping adherence to the standards across the accreditation cycle".*

The ANAO report stated (Summary para(s) 33 - 36, page(s) 23/4)

'The following features for the accreditation of general practices limited DOHA's assurance on the quality and rigour of the accreditation processes:

- *when conducting accreditation assessments, the two accrediting (agencies) AGPAL and QPA - each used their own accreditation framework that general practices were required to follow;*
- *while both accrediting bodies seek assertions from general practices on adherence to the standards across the accreditation cycle, there are no checks on these claims through risk based interim assessments; and*
- *there is a lack of clarity as to the auditability of the current standards and their applicability to all general practice settings such as those that operate outside office settings*.'

The Auditor General also recommended that the Health Department *'develop the means to inform itself of the quality of general practice accreditation.'*

This recommendation was one of the factors that lead to the new, enhanced oversight of general practice accreditation, the National General Practice Accreditation Scheme (Scheme), introduced in 2017 by the Australian Commission for Safety and Quality in Health Care (ACSQHC).'

In a 2016 Consultation Paper[6] the Department indicated that it saw the PIP as *'a key driver of quality care in the general practice sector.'* The Department's stated aim was to *'move towards a system that would result in practices participating in quality improvement processes that use data to drive continual improvements in the care provided.'*

'Practices would measure themselves against their own performance and it is anticipated that practices would be paid for quality care, continuous improvement and data driven quality.'

The Commonwealth budgeted $354m for the PIP in 2017-18. It was estimated that in 2016-17 of all non-referred attendances that attracted an MBS rebate, 84.1% were provided in accredited practices. The Government stated the aims of the PIP program are to *'support activities that encourage continuing improvements, increase quality of care, enhance quality of care, enhance capacity and improve access and outcomes for patients.'*

Review of General Practice Accreditation Arrangements

The Department commissioned an independent consultancy group, mpconsulting, to conduct a Review of General Practice Accreditation Arrangements[7] in 2021. Referring to information sourced from the Australian Institute of Health and Welfare, mpconsulting noted in their Review (page 14), that 84% of the 7,900 practices in Australia were accredited by 2020.

Further mpconsulting stated:

'In 2020-21, a total of $443 million was paid in PIP payments across 6,533 general practices, indicating that on average each practice received $68,000 in PIP payments (noting there is significant variation in payment amounts depending on the practice size and number of incentives the practice is participating in[8].'

While the stated key motivation for implementing and funding accreditation was continual improvement, quality assurance, enhanced capacity and patient safety, mpconsulting also reported in the Executive Summary that:

'*Critical to the effectiveness of any accreditation scheme is that the accredited entities and end service users (general practices and patients in this case) have confidence in the scheme – including that it is fit-for-purpose, fair and equitable and that assessments are robust, independent and consistent. The accredited bodies also need to see benefits in the process, noting that it necessarily involves some cost. Practices need to view accreditation not as a bureaucratic process that is completed once every three years for the purposes of accessing government funding, but as part of good clinical governance that occurs every day and involves the whole practice team…'*

Further it noted that:

'*the NGPA Scheme does not have the overall confidence of general practices and health practitioners and is not broadly viewed as a foundation for safe, quality practice. Throughout the Review, many general practitioners (GPs), practice managers and owners and other stakeholders described the accreditation process as a 'tick a box' exercise and a 'pathway to PIP payments.'*

'*Stakeholders also described a range of limitations with the existing standards, a perceived lack of support for practices seeking to become accredited, concerns about the quality and consistency of assessment, apparent inequities in the way accreditation fees are charged and the administrative burden that accreditation can place on practices. Stakeholders made a number of suggestions for change, in many cases drawing on years' of experience in the general practice environment.' (author underlined)*

The Review also described a *lack of engagement by GPs* with accreditation, and by implication practice based quality assurance relating to the services delivered by GPs.

Finally, in a summary on its website, the ACSQHC notes that from April 2023 - May 2026, there were 6,846 practices (including aboriginal medical services) with assessment outcomes data[9]. The Commission also notes that, across all agencies, 24% of practices had all mandatory indicators in the Standards met during the initial assessment, but this

percentage (of practices meeting all mandatory indicators) is more than double the percentage for one agency[10] for practices where all indicators were met, implying considerable ongoing variability with assessment methods and findings between accrediting agencies.

The figures also suggest that a significant majority of practices are not continuing to meet the requirements of the standards throughout the accreditation cycle, echoing the prescient concerns of the ANAO in its 2010-2011 Performance Audit Report No 5.

Tangible benefits of accreditation

The benefits of accreditation are not limited to payments through the Practice Incentives Program, Workforce Incentives Program and other grant structures. Practices seeking to host registrars are required to be accredited as a general practice and also to have training practice accreditation. Accreditation confers considerable workforce advantages with increased capacity to service more patients and generate fee for service income.

The initial intent of the blended payment model under the PIP was that the payments would be around 8% of Medicare outlays for GP services. Changes to Medicare and evolving health needs for team based management of chronic disease have seen calls for this to be increased to 40% of Medicare outlays[11]. This is in recognition of the need for different funding models to better accommodate continuity and comprehensive team based approaches to chronic disease management.

Recent changes to the Medicare and PIP incentives structures designed to better support *affordability* and *access* have seen a 12.5% loading on specified Medicare services, payable equally to practices and GPs through the Bulk Billing Practice Incentives Program (BBPIP), when their practices become registered bulk billing practices. The government's stated policy objective with the BBPIP is to ensure that by 2030 at least 90% of general practices will bulk-bill all patients for defined general practice services.

In the first three months $61.4M was paid to 2,949 participating practices, an average of just under $21,000 per practice[12]. By April 2026 over 3,700 practices had registered for the BBPIP, according to the Department.

While accreditation is not yet mandatory, (to streamline entry into this system) it is likely that accreditation will be required as a future means of ensuring accountability.

The introduction of the BBPIP and further bulk-billing incentives that apply for all eligible services has increased practitioner and to a lessor extent practice incomes significantly. This raises the stakes considerably for accreditation and the Scheme. There is the need to ensure equity of access and cost for practices seeking accreditation, as well as an even greater imperative to provide assurance that the NGPA Scheme is robust, reliable and consistently applied.

One of the key problems cited with accreditation is that it is perceived and accepted as a 'practice manager' exercise with doctors not generally engaged in the process[13]. This is notwithstanding that around 76 of the Standards indicators require clinician input. In October 2024, the RACGP clarified the relevant indicator to remove independent contractors or tenant GPs from the requirement to have performance assessments or reviews. Given that accreditation will not only be required for access to the PIP but also significant bulk billing incentives paid to individual practitioners as well as practices registered for the BBPIP, the question as to how individual GPs will be accountable for accreditation outcomes and meeting the Standards, and whether and how they should also contribute to the practice costs for accreditation, needs consideration.

Principles and promise

Since its inception in the late 1990s, and subsequent linking to government funding through the Practice Incentives Program (PIP) in 2002, the general practice accreditation system has been underpinned by several key principles. Along with enshrining the principle of peer review and gradual quality improvement, these principles also included that the accreditation process should be voluntary, independently controlled and funded by the general practice profession. This was specifically stated in the 1992 strategy document (cited above) *'to ensure its independence,*

accreditation should be self-funding.' Self-funding was then seen as a guarantee of professional independence and control.

A further underlying principle was that general practice accreditation should be accessible and affordable for small practices and practices in isolated regions. Specifically, it was intended that smaller and regional, rural and remote practices should not be disadvantaged, either financially through price discrimination, or otherwise, such as by limiting or denying access.

Since 2017, the Scheme is effectively no longer controlled by the profession. One might also argue that it is no longer effectively voluntary given the PIP, BBPIP and other funding changes. It is likely that any future increases in funding for general practice will not be accommodated through Medicare rebate increases, but through incentive arrangements that target specific policy or quality outcomes.

The Scheme is now governed and administered by the Australian Commission on Safety and Quality in Health Care. The Commission is established in legislation and has legislated responsibilities under the National Health Reform Act 2011. Prior to this the Commission had been an entity created under the former Commonwealth Authorities and Companies Act. The Commission now administers the National General Practice Accreditation Scheme (Scheme) through its Approvals Policy and various requirements (Advisories), that specify (inter alia) procedures for notification of significant risk, reporting of change of location or transfer of certificate.

The Commission receives advice from professional and other stakeholder representation through the General Practice Co-ordinating Committee, and from accrediting agencies through the General Practice Accrediting Agencies Working Group.

It is the Commission, however, not accrediting agencies, that mandate requirements for reporting of assessment data; when surveillance through a standardised repeat assessment[14] is required; timeframes for the closure of non-conformities; the layout and content of the accreditation certificate.

These requirements and probably others that perhaps could or should be embedded in the NGPA Scheme[15] are necessary to give general practice accreditation credibility as a public recognition of quality and safety. They also should provide confidence as to the allocation of taxpayer funding. While responsibility for the standards remains with the RACGP, it is the Commission's Scheme now, not the profession's, and not the accrediting agencies'.

Current accreditation business models

Since its commencement accreditation has been funded through fees paid by general practices directly to accrediting agencies. While t*his model remains at the centre of the general practice accreditation process, this paper argues the model is no longer appropriate, desirable or effective in achieving the intended purpose of the Scheme, namely to provide assurance to patients as to the safety and quality of general practice, or as a basis for the allocation of taxpayer funding.*

It is now no longer sustainable to argue that accreditation should be self funded, through direct payments by practices to accrediting agencies, because this funding ensures professional control.

Current funding mechanisms with price competition can lead to incentives that are in direct conflict with the aims and requirements of the Scheme.

With the introduction of accreditation there was also a clear premise that no practice would be discriminated against, either financially or otherwise, by virtue of size or location. This convention implies some form of 'community rating' or internal cross-subsidisation pricing or fee structure. Accreditation providers by convention initially sought to ensure that costs such as travel, surveyor fees and accommodation are spread equitably across practices regardless of size or location.

The Department commissioned JAS-ANZ[16] to develop a consistent, internationally based standard to establish rules for accrediting agencies wishing to accredit practices for the purposes of recognition for the PIP. This *Procedure 16 -*

General Requirements for bodies operating assessment and accreditation of general practices for recognition under the Practice Incentives Program (April 2000) was developed in consultation with key stakeholder groups, including the AMA, RACGP and community groups, and included the two established general practice accrediting agencies AGPAL and QPA[17].

Procedure 16, mandated that an accrediting agency (or conformity assessment body) itself accredited by JASANZ was prohibited from discriminating against any practice. Clause 5 required that:

- *'The policies and procedures under which the accreditation body operates shall be non-discriminatory, and they shall be administered in a non-discriminatory manner. Procedures shall not be used to impede or inhibit access by applicants other than as specified in this procedure (clause 5.1.1.1).'*
- '*The accreditation body shall make its services accessible to all applicants. There shall not be undue financial or other conditions. Access shall not be conditional upon the size of the general practice or membership of any association or group, nor shall accreditation be conditional upon the number of general practices already accredited (Clause 5.1.1.2).'*

The guidelines to this clause further specified that:

- '*Accreditation bodies shall not practice any form of discrimination such as hidden discrimination by speeding up or delaying applications for accreditation. (G.5.1.3).'*

In effect, Procedure 16 made it mandatory for an agency accredited by JAS-ANZ to maintain a cross-subsidisation or community rating fee schedule, which by definition excludes discounting and cherry picking more valuable (larger) practices and those less costly to service.

It also reflects requirements laid out by the two entities that oversee the standards and assessment framework within which GP accreditation operates, the Royal Australian College of General Practitioners (RACGP) through its Standard and the Australian Commission for Safety and Quality in Health Care (ACSQHC) through its Approvals Policy.

The introductory notes to the 5th edition of the RACGP Standards state that accrediting agencies 'in order to use the standards', are required to demonstrate to the RACGP various capacities including:

- '*The capacity to efficiently accredit general practices across Australia'*
- *'A commitment not to refuse an application for accreditation from a practice that meets the RACGP's definition of a general practice, regardless of location or size'*
- *'A commitment not to financially or otherwise discriminate against a practice because of location or size'*

The ACSQHC under the provisions of the 2017 National General Practice Accreditation Scheme (Scheme) has advised approved accrediting agencies they must:

- *'advise the Commission if the fee structure for members/clients is based on a community rating scale, where fees are equally distributed across clients regardless of factors that impact their serviceability, or is quoted individually based on actual costs.'*
- *'It would be intended that general practices in rural and remote locations were not disadvantaged.'*

Apart from these statements, to the effect that accreditation should be *non discriminatory* and *affordable* for all practices, neither the ACSQHC nor the RACGP has provided guidance on what it would regard as an effective or legitimate *community rated* pricing methodology or fee structure.

Discounting and cherry picking are now embedded in the general practice accreditation market. This has broader implications for the Scheme as there are significant and well documented risks[18] where price competition is employed with a general market based accreditation program. For a regulatory program such as the NGPA Scheme, these risks

to impartiality, influence over accreditation decisions, conflict of interest and financing are amplified because of the taxpayer provided financial incentives. The amount of risk is proportional to the amount of funding provided.

Do accreditation business and pricing models matter?

Fees charged for accreditation have typically been based on the number of full-time equivalent GPs (FTEGPs), which were self reported by practices and derived from practitioner hours worked.

The lack of an objective measure to determine FTEGPs is problematic, particularly when the metric is used as a basis for fees under a cross-subsidisation pricing model. General practice has changed in the past twenty six years. The average number of GPs in a practice has increased, many practices are corporatised and the engagement models often no longer include equity or ownership in the practice. GPs work less hours and many GPs work part-time or in different locations. There is a significant gender related income differential between GPs. For most practices now, calculating the full-time equivalent number can be administratively difficult and vary from week to week. All these changes make the collection of accurate FTEGP data difficult for most practices. Objective measures for establishing GP full-time equivalents have been developed within the Health Workforce Division of the Department[19]. However this information is not made available for individual practices. Using point in time self reported hours as a basis for a pricing model, which is supposed to be non-discriminatory and deliver equality of access, is highly problematic.

The Department has an interest in ensuring that funds are issued fairly and transparently to practices based on established principles and rules that support the achievement of stated objectives. This fairness and indeed policy outcomes are potentially affected if the costs for accreditation are not likewise equally applied, fair for all, or transparent. If equity of access to accreditation for all practices remains as a principle then there is a need to ensure that costs are distributed in proportion to benefits.

In 2024, the Department commissioned a short term, $243,980 consultancy[20] to better understand the demand for accreditation across different geographic locations and types of practices, costs drivers, and to investigate the current market operation of accreditation services under the National General Practice Accreditation Scheme.

The stated objectives of the consultancy were to better understand:

- demand for accreditation, including from different geographic locations and types of practices,
- issues around sustainability for accreditation agencies in delivering services,
- cost drivers in meeting standards and providing accreditation services.

Subsequent to this, the Department, with Ministerial approval, announced a Stakeholders Working Party. QPA agreed to and signed off on the terms of reference and committed to actively and transparently participating in this Working Party. However, the Working Party did not proceed and the report has not been published.

Discussion

Change in the funding model for general practice accreditation is long overdue. General practice is not the same as it was twenty-six years ago. The cross-subsidisation model has clearly broken down since the introduction of the 5th edition Standards. Repeated requests for clarity on what constitutes an appropriate and fair cross-subsidisation model from either the ACSQHC or RACGP with the introduction of the 5th edition of the Standards, have not had a productive response. Smaller and more remote practices are potentially discriminated against by higher fees, cherry picking and denial of service. Larger practices are provided discounts by some agencies that provide considerable financial benefits for large practice networks or corporate groups, again effectively discriminating against smaller and more remote practices. Some agencies use a fixed pricing formula, others apply minimum fee structures. Some agencies bundle in travel and accommodation for surveyors, others reserve the right to charge more where the costs to service a practice are high.

While it may be argued that smaller practices or those in rural and remote areas are still being serviced and accredited, they are in effect being financially discriminated against by virtue of location and size.

Price competition brings about its own set of risks. These risks have increased over time with the increased corporatisation of medicine. While entrepreneurial medicine has benefits in terms of the potential for greater access and affordability, the size and complexity of organisations centralises power in a price competitive market, increasing the risk of inappropriate influence over accreditation decisions.

Coupled with a lack of consistency in assessment frameworks and lack of assurance that a practice meets the Standards across the length of the cycle, as noted by the ANAO, discounting and cherry picking open the door to a lack of assessment robustness and integrity, risk to impartiality and influence over accreditation decisions, inadequate assessment and even fraud. Not only is there active discrimination with the current business models, but the Scheme and accrediting agencies are exposed. *If a large practice or group can command a significant discount, what else becomes negotiable*?

The fundamental problem in economic terms, is that there is a lack of symmetry between various stakeholders of the aims of, or desired outcomes from accreditation. There is a potential divergence between incentives and goals. For general practices, the overriding motivation for accreditation is funding through the PIP and other incentives. It is not inflammatory, cynical or demeaning to general practices to recognise this. Practices themselves admit as much. The Government recognises the impact of financial incentives in shifting behaviour, through its programs. PIP and BBPIP funding is designed to get an outcome and policy objective. When the profession argues for policies designed to improve or support quality patient care, arguments are substantively made through the prism of the Medicare Benefits Schedule.

Having standards may be seen as a good thing by practices and there may be some educational opportunities and reassurance to practices that these standards are met, but ultimately the PIP payments and access to GP registrar workforce have driven the uptake of accreditation. With virtually all practices being accredited, the accreditation certificate itself does not confer a public market advantage for practices, that might apply in other accreditation programs. It is not a question of whether financial incentives work, but how financial resources can be best used and leveraged to achieve the best outcomes.

General practices are very price sensitive. In many practices the PIP payment is the only profit the practice makes after expenses. Competition for GPs, payments based on a percentage of billing and the independent contractor model of engagement, creates a general practice funding paradox. While incomes for GPs have increased significantly, practices have not necessarily seen the financial benefits of the major funding investment through increases in rebates, enhanced bulk billing incentives and even the BBPIP. When it comes to accreditation, practices ultimately make decisions based on the price and PIP equation.

For the funder, administrator, patient and taxpayer, the motivation for accreditation is quality assurance, improvement, access and affordability. Price competition between accrediting agencies, limits the effectiveness in achieving the ultimate aims of the Scheme. Price competition dumbs down the Scheme. Under the current business model, with practices paying agencies directly, the relationship depends on the certificate. Whoever pays the piper gets to call the tune. Practices naturally want simpler, easier, cheaper options. Agencies are potentially exposed to inappropriate influence and not protected in making hard decisions.

Inappropriate influence, impartiality, conflict of interest and lack of assessment rigour and inconsistency are risks in any accreditation scheme. In the health care industry, it is acknowledged that price competition poses structural risks that can trigger a dangerous compromise in quality oversight, particularly where the financial imperatives for accreditation are high. Price competition may lower the robustness of the assessments or processes for closure of non-conformities; force surveyors to conduct superficial or tick-a-box audits instead of undertaking deeper reviews that explore organisational safety and quality culture; reduce surveyor expertise by limiting the ability to recruit, train, retain and performance review clinical and non clinical professionals who conduct assessments; shift the focus from continuous quality improvement to entry level compliance; and weaken an organisation's resistance by trapping agencies in a position of financial dependency.

Accreditation has not encouraged a striving for excellence in general practice, but actually supports a minimalist approach to quality care. Price competition of itself tends to drive quality down to the lowest common denominator. This is the potential in the general practice accreditation market, as it is in any other market.

The mpconsulting review established that accreditation was seen as a bureaucratic exercise to access government funding. There is a clear incentive to go with a provider that promises simple, cheap and easier, rather than one that promises rigor and integrity in its assessments. Negotiation becomes about price, not service or quality or risk management or patient care.

Within the Scheme this leads to significant anomalies and sometimes inappropriate pressure being placed on agencies. If an agency establishes that a practice has a major number of non-conformities during a survey visit, then it is more likely than not that the practice will cherry pick providers to choose whichever is deemed cheaper, easier or simpler.

The Scheme supports this approach, where if a practice is not accredited then they have the option to simply register with another provider, thereby ensuring that their PIP payments are not affected.

What is required is a structural change that shifts the structures and imperatives from a lower price strategy to a value based strategy.

Implementing centralised pricing arrangements would remove any price based market incentives, provide greater opportunity for quality assurance and improvement and remove many of the systemic risks associated with accreditation systems. Practice choice of accrediting agency would be based on service and support.

Conclusion

Designed as a peer visit exercise, based on minimal entry level standards, general practice accreditation has evolved since it was first proposed in 1992.

Self funding no longer provides assurance as to professional control. The original cross-subsidisation pricing model no longer applies. There is no confidence that particularly small and rural and remote practices are not financially or otherwise discriminated against.

Price competition poses unacceptable risks for accrediting agencies, interpretation and assessment of practices against the Standards, administration of the Scheme, taxpayer funding and indeed the health care system, practices and patient care.

Significant system-leveraged improvements can be gained by funding accreditation through a centralised, budget neutral mechanism, rather than putting the direct burden on individual general practices.

This paper proposes reforms that:

1. Removes the inherent risks associated with price competition detailed in this discussion document.
2. Implements a funding model that ensures all practices can access accreditation where the ultimate cost to the practice is directly related to the benefits received.
3. Ensure agencies are supported, funded adequately and accountable for the delivery of high quality assessments to all practices, regardless of location, size or organisational structure.

It is recommended that:

1. An independent pricing authority, agency or committee, determine specific practice location based payments to accrediting agencies to service practices in individual locations across Australia. The pricing formula would take into account distance from the closest capital city, surveyor fees including travel and accommodation allowances, reporting, insurance and administration and other on-costs.
2. Subject to some exclusions detailed below, practices will no longer pay accrediting agencies directly for accreditation.
3. The costs of accreditation be included in the annual Commonwealth PIP/ BBPIP budget. This ensures that all practices would ultimately contribute in direct proportion to the benefits they receive.
4. An accrediting agency approved by the ACSQHC under the NGPA Scheme may not refuse an application from any practice. However, the agency may request another agency to conduct the accreditation on their behalf, paying the other agency the published fee plus a service penalty percentage loading dependent on practice location.

Notes:

i. It is not intended that the cost of education and training programs for practices, or individualised practice support should be funded through this mechanism.

ii. The centralised funding mechanism should not include payment for administration and time taken in closure of non-conformities. This would remain the responsibility of the practice and act as an incentive for maintaining standards throughout the accreditation cycle.

iii. The Department should establish an Independent Pricing Committee which evaluates on an annual basis the costs in delivering an assessment in all local areas across Australia. Historical data may be used and robust models created using artificial intelligence methodologies.

iv. This assessment would include surveyor fees (based on an assignment), and allowances for travel and accommodation where required to assessments conducted in individual sites. The travel and accommodation component should assume travel from the closest capital city and reflect either road or commercial air or charter for remote locations.

v. The need for travel and accommodation should take into account surveyor welfare, length of the survey visit and occupational health and safety requirements. For example, where travel time by road exceeds more than two hours each way, then it would be mandatory for at least one overnight stay to be organised and funded. Accommodation rates would be consistent with current public service travel and accommodation allowances. Mileage rates for use of own motor vehicles would be consistent with Australian Taxation Office rates.

vi. Agencies would remain responsible for the engagement and remuneration of surveyors. The figures determined for each location would be used as the basis for which an accrediting agency was reimbursed on the completion of an assessment.

vii. The fees paid to accrediting agencies should include on costs and other expenses such as for surveyor training and practice administration and not be restricted to cost and time for the survey visit.

viii. A complete exploration of risks with accreditation is beyond the scope of this discussion paper. However, a further paper will be published on this topic in due course.

References

[1] Australian Medical Association

[2] Royal Australian College of General Practitioners

[3] RACGP Field Test of Standards in 199 practices

[4] Australian General Practice Accreditation Limited

[5] QPA was the only agency required to be accredited against JASANZ Procedure 16.

[6] Australian Government Department of Health, *Redesigning the Practice Incentives Program,* 2016

[7] MPConsulting, *Review of General Practice Accreditation Arrangements*, October 2021

[8] MPConsulting, *Review of General Practice Accreditation Arrangements*, October 2021, page 19

[9] https://www.safetyandquality.gov.au/accreditation/assessment-outcomes-data/assessment-outcomes-data-and-lessons-learnt-ngpa-scheme

[10] Quality Practice Accreditation

[11] Expert Advisory Panel Report, *Review of General Practice Incentives*, 30 September 2024

[12]Karen Burge, RACGP News GP, *Clinics share $61M in first BBPIP payment*, 13 February 2026

[13] MPConsulting, *Review of General Practice Accreditation Arrangements*, October 2021, page

[14] A form of surveillance where a practice does not meet 20% or more of the mandatory standards indicators

[15] relating to surveyor training, management including performance assessment, standards interpretation and assessment, conduct of the survey visit and closure of non-conformities are not yet defined or documented. These are required to improve integrity reliability and consistency.

[16] Joint Accreditation System of Australia and New Zealand

[17] QPA was the only agency required to be accredited against JASANZ Procedure 16.

[18] see for example https://www.linkedin.com/pulse/impartiality-under-microscope-understanding-managing-anastasopoulos-v8vyc

[19] Department of Health Disability and Ageing, *Method Paper General Practice Full time Equivalent - Workforce* V 1.2 August 2025

[20] https://www.tenders.gov.au/Cn/Show/a1ea59b9-1efa-4009-b426-3d8656c61e3f