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General practice financing in Australia: Towards a model that rewards value

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Summary

The current funding model for general practice in Australia, which is largely built on a fee-for-service approach supplemented by payments for quality, is likely to be unsustainable in the context of an ageing population, increasing chronic illness, and growing demand for and costs of medical care.

The future financing model for general practice in Australia must reward value. Key aims must be to improve the quality of care and health outcomes for the patient population, improve the patient experience, enable care to be delivered at a sustainable cost, and ensure the system is well accepted by and adds value for the general practice team who are delivering care.

Financing models for general practice are inextricably linked to models of care. Health care providers along with governments are working to develop models of care that deliver more value from the healthcare system, by achieving better patient outcomes within the available resources. The Health Care Homes approach is one step in this direction, and AAPM has actively supported this approach. The Health Care Homes approach is based on a bundled payments financing model, and AAPM acknowledges bundled payments will be central to the future delivery of general practice services in Australia.

Achieving better value care in general practice will require excellent healthcare management, so that new funding approaches and models of care can be efficiently implemented, costs and outcomes can be reliably measured, and enabling information technology platforms are in place and maintained.

Practice Managers[1] have a key role to play in these areas, and developing and equipping the profession to fulfil this role is critical and urgent.

The current general practice financing model in Australia

Fee-for-service payments through the Medicare Benefits Schedule (MBS), supplemented in some cases by patient contributions, have long been the basis of the general practice financing system in Australia. However, there are major concerns about the sustainability and suitability of the fee-for-service model. As our population ages and more people in the community have chronic and complex conditions, demand for general practice services will continue to grow. The challenge will

[1] Throughout this paper, the term "Practice Manager" is used to refer to professionals engaged in healthcare practice management, whose actual job titles can vary; for example, the job title may be Practice Manager, CEO, Business Manager, Operations Manager, Office Manager or Practice Owner.

be to meet this demand and achieve better outcomes for patients, whilst at the same time ensuring financial viability at the practice level and economic sustainability at the health system level. It is therefore vital that the financing model for general practice supports and rewards models of care that are efficient, effective, and cost-effective.

It is well recognised that fee-for-service models of care essentially reward health care providers for volume rather than for value. The more services that are provided, the more the health care provider is paid, regardless of the extent to which the services improve outcomes for the patient. This presents little incentive for providers to be cost-conscious or to be focused on high value services.

In fact, the fee-for-service system can work against effective and cost-effective models of care. The requirement for the general practitioner to deliver the service so that a fee can be billed, frequently results in GPs providing aspects of care that could be safely and effectively delegated to another team member such as a primary health care nurse. This is costly for the health care system, unsustainable in terms of managing demand for GP time and services, and not in the best interests of patient access and quality care. General practice financing needs to incentivise a multidisciplinary teamwork approach where all health care team members can work across their full scope of practice, improving efficiency and streamlining patient care.

The Australian Government has recognised that the fee-for-service model of general practice financing rewards volume rather than quality, and in response has worked towards a blended financing model which includes quality payments through the Practice Incentive Program (PIP). The PIP payments have over several years encouraged practices to take a quality improvement approach within specific areas identified as health priorities in the primary care context. The incentive funding has encouraged the development of quality improvement systems at practice level, including but not limited to improved data management, clinical audit, and patient recall systems. MBS fee-for-service funding on its own is not designed to incentivise such systems, so the development of a blended payments model including PIP incentives has been a positive for general practice and for patients. Linking access to the PIP with practice accreditation has also been a key factor in achieving high general practice accreditation rates in Australia, based on compliance with recognised quality standards. Practice Managers have taken major responsibility for overseeing work at practice level to achieve accreditation.

More recently, the PIP has been redesigned to bring together several PIP payments into one Quality Improvement Incentive, although implementation has been deferred to 2019. AAPM has been supportive of the concept of moving the PIP towards a broad quality improvement based approach which uses data to measure and drive improvement, provided that the system is flexible and outcomes-focused, that practices are well supported to make the transition to the new system, that data collection is fully automated, and that there is no increase in red tape.

It is also important to note that patient contributions make up a not insignificant part of the general practice financing system in Australia. These out-of-pocket costs represent the difference between the fee charged by the medical practitioner, and the Medicare rebate provided for the service. While many practices bulk bill all patients to Medicare and receive only the rebate, others only bulk bill

patients who are Health Care Card holders (and/or other people demonstrably unable to afford a co-contribution), and sometimes children, and require patients who can afford to do so to make an out-of-pocket contribution to their care. Despite the freeze on Medicare rebates for general practice services, bulk-billing rates have been gradually rising and are at record levels of around 80%, but paradoxically at the same time the level of out-of-pocket payments has risen considerably in recent years.[2]

Patient contributions are seen by many practices as an important means of ensuring general practice remains viable and government health care expenditure remains sustainable, representing in effect a cross-subsidy which ensures those who are unable to afford the co-payment can continue to access general practice care, and general practices can maintain high standards of service and resources. The patient contribution is also seen by many as a price signal to counter excessive utilisation of general practice services. On the other hand, concerns have also been raised that patient co-payments can in some cases influence patients to either forgo necessary care, or to seek non-emergency care free of charge from hospital emergency departments. The role of patient contributions needs to be actively considered in any general practice financing models going forward.

Increases in the cost base for delivering general practice services also need to be taken into account. Any funding model for general practice must include built in indexation to respond to the rising cost of staffing, utilities, rentals, and other overheads. In addition, it must be recognised that patient expectations are changing, and the costs of meeting patient expectations are rising. For example, patients often expect a general practice to be able to offer the latest technologies, diagnostic tools, and treatments, which can often be extremely expensive but which may result in overall cost saving to the health care system. The cost of meeting patient expectations and delivering best practice care must be recognised in the funding model for general practice.

General practice financing models for the future

General practice financing models for the future should reward health care providers for delivering high value care, that is, achieving better patient outcomes within the available resources. As noted, fee-for-service funding rewards health care providers for volume rather than value. An alternative payment model widely utilised in health care systems internationally is capitation funding (a single payment to cover all of a patient's health care needs). This provides an incentive for providers to ration services, but does not provide significant incentives to improve outcomes for patients, or to increase the value of care.

There is increasing interest in introducing bundled payment approaches which cover the full cycle of care for acute medical conditions, the overall care for chronic conditions for a defined period, or primary and preventive care for a defined patient population. Payment is tied to overall care and outcomes for a patient with a defined condition, and providers benefit from improving efficiency

[2] https://theconversation.com/factcheck-have-average-out-of-pocket-costs-for-gp-visits-risen-almost-20-under-the-coalition-66278

while maintaining or improving outcomes. Well-designed bundled payments can encourage multidisciplinary teamwork and can promote high value care.[3]

While supporting the bundled payments approach, AAPM emphasises the importance of ensuring that there is flexibility in the system to address variations in the patient population. For example, weightings are needed for populations of lower socio-economic status, or with higher numbers of Aboriginal and Torres Strait Islander people, as the health status and needs of these populations, and the costs of delivering care, is likely to be higher. It is also important to acknowledge that that in the early stages of implementation of new bundled care financing systems, accurate cost data may be lacking and there may be many unknowns. The funding formula must be responsive to information and experience that is gained in the early implementation phase, to ensure the viability of participating practices is not put at risk.

The Health Care Homes model

Models of general practice in Australia going forward are likely to be built upon or adapted from the Health Care Homes approach, which is currently in the early stages of implementation, and which is built on a bundled payments financing model. The Health Care Homes approach is informed by the "Patient Centred Medical Home" model overseas[4], and focuses on improving care for patients with chronic conditions. The model is based on voluntary enrolment of patients with two or more chronic diseases. Practices will coordinate a comprehensive care plan for each enrolled patient, including identifying the best local providers to meet each patient's needs, coordinating care with these providers, and developing strategies to better manage patients' health conditions and improve their quality of life.

The model seeks to promote patient-centred care, continuity of care and a team-based approach to the care of patients with chronic conditions, as the removal of a number of MBS item restrictions will allow delegation to nurses and other health professionals. Bundled payments for enrolled patients aim to enable practices to take a long term approach to disease management and support, health promotion, and disease prevention, and to deliver care more flexibly, without being restricted by the requirements of fee-for-service billing. The amount provided by the Federal Government for each patient will depend on the patient's level of complexity and need using a common assessment tool.

All participating practices must be accredited or registered for accreditation, and must be registered for and actively use My Health Record. All enrolled patients must have a My Health Record. These requirements will help ensure there is capacity for data collection to support feedback, quality improvement, and evaluation of the model.

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[3] Porter ME and Lee TH (2013). The strategy that will fix health care. *Harvard Business Review,* October. https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

[4] See for example RACGP (2015), *Vision for General Practice and Sustainable Healthcare* http://www.racgp.org.au/vision; Primary Health Care Advisory Group (2015), *Better Outcomes for People with Chronic and Complex Health Conditions* http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-report; Consumers Health Forum of Australia, George Institute for Global Health, RACGP, Menzies Centre for Health Policy (2016), *Patient-Centred Healthcare Homes in Australia: Towards Successful Implementation* https://chf.org.au/sites/default/files/patient-centred-healthcare-homes-in-australia-towards-successful-implementation.pdf.

The model potentially has benefits for patients in improved access to care, continuity of care with a longer term care approach, improved personalised care, improved self-management, and improved co-ordination of services. Practices and health professionals may benefit from increased opportunities for clinical development and leadership, improved opportunities for full utilisation of the multidisciplinary team, and reduced red tape. Benefits for the health system should include improved management of chronic conditions and reduced demand on hospitals, leading to savings for the health care system overall; and better data to guide resource allocation.

AAPM has welcomed the implementation of Health Care Homes as it has significant potential to improve patient outcomes, as well as having potential benefits for health care providers and the health system in general.

It is likely that the current phase of the Health Care Homes rollout in Australia will lead to broader implementation of models of care and funding models which evolve from this approach. General practices across Australia must be well prepared for these future models.

Quality of care and the overall costs of care are not necessarily aligned – in fact, better care can often result in reduced overall costs to the health care system. For example, better general practice care for patients with chronic conditions such as heart failure or chronic wounds can improve quality of life considerably, as well as reducing costly hospital readmissions. The financing system must reward general practice for achieving high value care. A financing system based on bundled payments will be one vital element of this approach.

Private Health Insurance

Proposals have been put forward to extend Private Health Insurance to broadly cover services provided in general practice. Such proposals require rigorous scrutiny and debate. The Royal Australian College of General Practitioners (RACGP) has warned that such approaches could compromise patient access to services, create a two-tiered system, and increase health system costs, without delivering benefits. The Australian Medical Association (AMA) has also warned that increasing involvement by insurers in the provision of care is pushing Australia towards a managed care approach.

As recommended by the RACGP, if Private Health Insurance is to be extended to general practice, the key principles should be: preventing fragmentation and duplication of care; recognising and supporting the clinical independence of GPs; and supporting access based on need, not on Private Health Insurance status. There may be benefit in Private Health Insurance involvement in areas such as preventive healthcare, chronic disease prevention programs, chronic disease management and hospital avoidance programs (such hospital in the home), co-ordination payments to GPs, and other supports to GPs and practices to meet patient needs.

The role of the Practice Manager

Practices implementing new models of care and new financing models, such as the Health Care Homes approach, will need to undertake a significant change process to be successful. This change process will require ongoing support for both clinicians and Practice Managers.

The role of the Practice Manager in the case of Health Care Homes will be to facilitate the flexibility and innovation needed to coordinate the patient's care, including ensuring members of the clinical team are well informed and supported in their roles, and have access to all necessary data; and that administrative and financial arrangements are in place to support the new model. At the same time, at least during the early implementation phase, non-enrolled patients will continue to present to the practice under fee-for-service arrangements, and a clear management plan for these parallel systems will be essential.

More broadly, the evolution of models of care and financing models for general practice will require significant change processes at general practice level. There will be a need for new approaches to multidisciplinary team care, which will need to be underpinned by sound patient health record systems and provider communication systems and protocols. Practice Managers will play a key role in embedding these new models in general practice.

New financing models based on bundled care will require Practice Managers to develop new financial models and systems at practice level, which ensure practice viability is maintained within the new funding context. Practice Managers will need to lead the implementation of more sophisticated financial tools to underpin sound budgets and financial reporting linked to key performance indicators. The new approaches to care and financing will also need to be underpinned by enabling IT systems and platforms, another area where Practice Managers will play a key role as change agents. Practice Managers will be critical to ensuring the effective uptake of digital health across private health care practices including general practice. They are instrumental in managing the practice's information and communications technology infrastructure and systems, and managing computer and information security issues. Practice Managers can play an important role in supporting capacity building in digital health among the practice's clinicians and other staff, developing practice policies for the appropriate use of digital health, and ensuring appropriate business tools including electronic communication systems are in place and well utilised.

AAPM will continue to play a key role in providing information and advice for general practice management to support participation in the Health Care Homes initiative, and to collect information and commentary from members involved and use this feedback to advocate for any changes required to the model. More broadly, AAPM is committed to working towards improved models of care and financing models for general practice in Australia, and to supporting the change process required for the successful implementation of these new models.

About AAPM

The Australian Association of Practice Management (AAPM) is the professional association for business managers of all healthcare practices including general practice, specialists, dentists and allied health as well as multi- disciplinary clinics. AAPM provides education, support, advice and advocacy for healthcare Practice Managers. Our aim is to ensure that they are able to effectively manage healthcare practices, that they are able to have the infrastructure and systems in place to provide high quality health services to the Australian community, and that they are up to date with changes in the health sector. Consequently, AAPM is ideally placed to assist in implementing the government's primary healthcare reforms.

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