POLICY OPTIONS

REFinE-PHC. Paying for primary care: Financial incentives for efficiency, equity and sustainability

July 2016

Jane Hall, Kees van Gool on behalf on the REFinE Team

Policy context

Policy advisers across different health systems have been increasingly interested in developing new approaches to payment. In particular, in fee for service systems, there is widespread agreement that fee for service does not align well with system objectives of improved efficiency (better health outcomes with optimal use of resources) and equitable access. Blended payment systems use combinations of these different approaches to improve incentives. Bundled payments attempt to change the focus from the inputs of a care episode to a payment per episode (analogous to case-mix or activity based funding for hospitals). Pay for performance targets particular processes, population groups or outcomes with additional financial rewards. Pay for performance represents a complex form of funding arrangements which have proved difficult to evaluate, as targets, payment size and mechanism, recipients, and other contextual factors vary across schemes. As a recent European Observatory review conclude, the evidence on effectiveness remains fragmented, there has been little rigorous evaluation, and improvements, where found, tend to be marginal.

Australia has a strong primary care system and was one of the first countries to introduce a type of pay for performance scheme and other financial incentives to promote particular objectives. This provides an opportunity to learn from the Australian experience of alternative payment models and apply this to the development of new payment models.

Key findings

There has long been interest in understanding different payment mechanisms for health care providers, what the impact is and how to use different approaches to payment to improve health system performance. While the impact of the main approaches (fee for service, capitation, salary) are quite clear, none works in a simple and straightforward way. It is important to note the potential importance of other factors such as peer recognition, organisational culture, availability of information and ready access to scientific evidence as well as the intrinsic motivation to go a good job and care well for one's patients. However, each approach has undesirable consequences, and none explicitly reward better quality care.

To what extent is Australian General Practice fee for service and what can be learnt from previous attempts to reform the payment system?

Most general practice care is defined by time inputs rather than an element of service. This is despite a number of amendments designed to change the focus of Medicare payment towards payment for the provision of specific services. The move from funding time inputs to service elements of primary care is challenging. A previous attempt was the Relative Value Study (RVS), a

seven year collaboration, between the Australian Medical Association (AMA) and the federal health department in the 1990s, which was unable to reach a satisfactory conclusion.

How are non FFS payments used in Australian primary care?

There is a high rate of change in doctors relying on incentive payments, around one third of the doctors are changing their participation in any one year, but as the rate of exiting the schemes is higher than the rate of new entrants overall participation is falling. Larger practices and practices with more administrative staff are more likely to claim incentives. The response to incentives depends not just on the design of the incentive, but also on other conditions such as levels of demand, or changes in treatment approaches. For example, faced with increasing demand it may be less effort to expand numbers of consultations than to claim additional payments, particularly in areas with high demand. This applies to disincentives such as reduced rebates and/or higher patient co-payments also.

What was the impact of the bulk-billing incentives?

The Strengthening Medicare reforms reduced OOP costs on average for women (our data source did not include men). However, the magnitude of the average OOP cost reduction was relatively small compared to the cost to government, as practices already bulk billing eligible patients could also claim the new payment. Unexpectedly, OOP costs increased for those not eligible for the incentives ie most non-cardholders. For these patients, the reforms were associated with an increase in GP fees that was higher than the increase in the Medicare rebate which was also part of the package. This suggests that the reform has led to different pricing strategies among GPs, whereby they are more likely to charge lower fees to cardholders and higher fees to non-cardholders. More generally, it illustrates how important unintended effects are; and that reducing expenditure in one service area can be offset by increases in another service area.

What was the impact of SIPs?

This study showed quite a different immediate impact between the diabetes and asthma SIPs in terms of the take up and the group of patients most likely to have claims. Although asthma SIPS were more likely to be claimed on behalf of younger patients, the penetration into the target group was very low. So financial incentives work differently, and this does not provide generalisable findings about the impact of financial incentives. This underscores why the literature on financial incentives is so inconclusive. Funders can establish new payments but they will not be used equally by all providers or by all patients. These selection effects (patients choose their GP; GPs decide whether to participate in the pay for performance scheme) are a major challenge to rigorous evaluation.

Do financial incentives encourage GP labour supply?

Doctors' preference to live and practise in urban areas is well established, over time and over many different countries. As a result, rural and remote area residents face greater problems of access to care which may lead to poorer health outcomes. We showed that higher rural subsidies attract more GPs, thus improving the GP:population ratio. Male GPs respond more, perhaps reflecting that female GPs are more likely to be constrained by partner work choices.

However, incentives aimed at improving after hours care, particularly increasing the rebates for after hours attendances showed a quite different effect. The market has responded by increasing supply through the development of Medical Deputising Services which exploit a market niche, underpinned by MBS rebates. The rapid and pervasive growth of this may impact on the conditions more traditional general practices face, just as the advent of walk-in bulk billing clinics did in the 1980s.

What are the challenges in building viable models of integrated care or health care homes?

Australia has also made various attempts to improve the delivery of primary and out of hospital care from the Co-Ordinated Care Trials of the late 1990s through various approaches to develop

integrated care programs and in the recent announcement of the Health Care Homes Trials. Experience here and internationally has shown that simply agreeing that a more integrated approach is appropriate and designating a co-ordinator is not enough.

Policy options

Review and development of financial incentives

- There should be regular review of financial incentives to ensure that they are working as intended, that effects are not muted over time, and for unintended consequences.
- Improved targeting of incentives can enhance efficiency; new payments often reward existing behavior as well as provide incentives for change.
- Organisational structures and support for provider change and adaptation should be developed and aligned with financial incentives.
- There is a danger of attention overload if too many different targets are used concurrently.

Moves from fee for service

- Attempts to define more precisely the inputs of primary care face a number of difficulties
    - Defining productivity and efficiency is complex.
    - Health outcomes are important but often distant and primary care is only one factor.
    - Costs are not known and collection of cost data for reimbursement and pricing will introduce an incentive to increase costs.
- New payment mechanisms should be designed to ensure appropriate incentives for efficiency rather than managing inputs and processes
    - For those at low risk of becoming high cost users, bundling care into episodes may be more effective than fee for uncapped inputs.

Developing a market for integrated care

- Primary care providers are in business and need viable business models.
- There are different business models as a result of corporatisation or other ownership models. A greater understanding of these will help analyse likely impact.
- Developing payments for health care homes should consider the cages that need to be made at the practice level, recognising that there are different types of practice.
- An early consideration is the extent to which specialist providers of chronic disease management programs are to be encouraged.

Equity and sustainability

- Equity of access remains a challenge in Australia despite the universality of Medicare. New attempts to improve efficiency or reduce costs must be monitored for any unintended effects on equity.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health.