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Financing and the quality framework

BACKGROUND

Using a quality framework can assist in the design of payment arrangements to ensure that the optimal effects of health funding are achieved.

OBJECTIVE

This article examines the finance domain of The Royal Australian College of General Practitioners Quality Framework for Australian General Practice.

DISCUSSION

The quality of the care general practitioners and their teams provide is affected by the way the GPs and team members are paid, both within the practice and through programs such as the Medicare Benefits Schedule. These payment arrangements do not always promote high quality and can have unintended negative consequences.

Case study

Hamish has a dilemma. As practice manager at Caritas Health Centre, he needs to find a replacement for the practice principal who usually does tomorrow afternoon's session at the local nursing home, Blue Hills. He knows that Adam, their young part time general practitioner, will not want to go. Caritas pays him on a percentage basis (50% of his fees). Last time Adam went to Blue Hills he pointed out that he had foregone over \$100 for the afternoon compared to if he had consulted in the clinic. Hamish does not want the quality of care compromised by quick visits, and he wants the people at the practice to be happy – especially Adam – as they would be lost without him.

A quality framework assists by suggesting that challenges at different levels of the health system be addressed. The financial arrangements underpinning general practice affect the behaviour of doctors, although not necessarily in the direction of quality.¹ Caritas began comprehensive medical assessments (CMAs) for their new nursing home patients, only to be inundated with calls to take new patients. Hamish looked at the routine care of these patients after their CMAs. He found it was financially unsustainable to charge only the government rebate. Caritas would receive about \$150 for the 2.5 hours Adam spends at Blue Hills because he bulk bills the four patients he sees when he spends enough time with each patient. This barely covers practice overheads. Therefore,

despite the benefit of the CMAs, Caritas will not see patients from other practices who relocate to Blue Hills.

A supportive, stimulating working environment plays a significant role in achieving high quality, sustainable care. This reflects the important contribution that nonfinancial factors can play in promoting quality.^{2,3} However Adam, like other general practitioners,⁴ has found that nursing homes employing a large proportion of casual or agency staff results in little time or commitment to building cooperative relationships, and little chance to facilitate team spirit in residential aged care facilities. He spends more time speaking with Blue Hills' staff and families of residents than he does with the residents themselves

– and he does not get paid for these informal interactions. At Caritas he can see nine patients in the same time and bill about \$280 in rebates, plus co-payments.

The fee-for-service model gives Adam an incentive to work hard. This is valuable as there is a workforce shortage, but there is little incentive for him to provide high quality care, or to participate in extra activities (such as Caritas' monthly clinical meeting). Adam does not want to be an employee. Without additional incentives, there is no reward for the 'hard yards' he puts into building up the practice's patient base.

Hamish is also affected by the same problems. He has a good salary but it does not really recognise the contribution he has made to the overall growth of the practice. He is thinking about leaving, despite liking his work.

Therefore, because payment systems have an important although not exclusive impact on the provision of quality health care,² discussions about providing quality general practice are limited unless they include discussions about payment, as shown when a quality framework is used to analyse these issues.

Financing and quality – the national level

The questions for Hamish and Adam reflect those at the national level. All focus groups in the development of The Royal Australian College of General Practitioners Quality Framework for Australian General Practice identified finance as impacting on the quality of care.

Australia has a large, almost universal 'health insurer': the Australian government. It provides subsidies to patients in the form of rebates through the Medicare Benefits Schedule (MBS) and other programs. The fundamental 'contract' between patient and doctor has not altered since before the introduction of Medicare. Overall, GPs continue to be paid by the patient, rather than by the government.

However, the introduction of Medicare (and bulk billing) can be seen as a 'social contract'⁵ between the government and the community, under which the government would fund certain parts of the community's health care. Thus, it can be useful to see the MBS as a third party insurer, with many of the same value for money and cost containment imperatives as other insurers, and with the same obligation to provide sufficient 'cover'.

Although Medicare is not the only third party insurer – with several others operating at national and state/territory level, eg. the Department of Veterans' Affairs (DVA), road accident and workers' compensation schemes – the size and pervasiveness of Medicare results in a strong focus on the effectiveness of this scheme in

promoting quality of care.

The pervasive incentive within the MBS for general practice is to provide short consultations. On a per minute basis, a 6 minute consultation between Adam and a patient generates about five times what a long consultation does, despite evidence about the value of removing disincentives to appropriate, longer consultations and proposals to review the structure of the rebates for general practice patients to address this problem.⁶ Similar concerns about whether payments under the Practice Incentive Payment (PIP) scheme really act as incentives have also been raised.⁷

National general practice groups support a fee-for-service model as the basis for Australian general practice financing and support some non-fee-for-service payments as part of the payment arrangements.⁸ The differences in viewpoint appear to have centred on the mix of the payment 'levers' and the proportion of funding to be channelled through them (eg. how much should fee-for-service comprise of the total, and which non-fee-for-service elements need to be included or strengthened).

However, there is no 'blank slate' for financing and funding in Australian general practice. There is a history of decisions (including the way that the MBS is structured) on which change and innovation must be based.

Adverse and unintended consequences

No payment model is without its problems.¹ A continuing process of learning from experience and a mix of financing mechanisms are both needed if high quality care is to be promoted. Adam would love to have their practice nurse accompany him to Blue Hills and take a role in the CMAs. She does this for their 75+ annual health assessments, but this is not possible for his patients at Blue Hills.

There is a tendency to 'adverse selection' (the process of selecting patients who are easier or 'cheaper' to manage, and the dissuading of those who are more difficult or costly to care for) where financial incentives alone are used.^{9,10} Additionally, practices with the lowest baseline performance may improve the most, but garner the smallest amount of performance pay if threshold performance targets are used.¹¹ Both of these problems are apparent in incentives to meet targets for preventive health care (eg. cervical screening) in highly transient populations.

Incentives might encourage a particular activity when the money and effort might be better allocated differently (the idea of allocative efficiency). It has been suggested that financial incentives have not been shown to be cost effective.²

Under current funding arrangements many strategies to improve quality of care would increase overhead costs but would not increase revenue. This is particularly evident in quality improvement activities that require capital and equipment (eg. having a refrigerator designed for vaccine storage or a height adjustable bed). Although grants and incentives under the PIP scheme for the provision of equipment may assist, that approach begs the fundamental question of whether the costs of such equipment are adequately reflected in patient fees (or the MBS rebate) – designed to fund both the professional services and overheads of general practice. As a result, overhead costs are a major issue for any strategy to build on the quality of general practice.

Conclusion

Changes in health systems that aim to improve quality need to align at the individual, team or group, organisational, and environmental level to maximise the chance of success. It is desirable to consider all levels of the health system simultaneously when making change. These requirements apply to improving financial systems that improve the quality and safety of general practice care.

A range of decisions is needed. These include the:

- types of care that need to be funded (eg. high cost drugs)
- types of services that need to be funded (eg. chronic disease, acute care, preventive health)
- optimum magnitude, frequency and duration of payments and incentives
- basis of the payment (activity, output or outcome)
- source of funding (consumers and/or government and/or other third party insurers), and
- target of the payments (patient, health care provider, practice, service, organisation or insurer).²

As a result, a focus on quality requires discussion of: national level financing (eg. funding by the DVA or national health insurance funds); state/territory level payments (eg. Workcover payments); and business/financing decisions at the practice level – together with their impact on the quality of care provided – if changes are to optimise the chance of improvement.

A quality framework can assist in analysing the issues and challenges that face those who want to deliver sustainable high quality care.

Conflict of interest: none declared.

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