

Payment Systems for General Practice Teams

General practice multidisciplinary teams can offer real solutions to the challenges facing Australia's health system by delivering quality primary health care in an accessible, cost effective setting. AGPN believes that reform to the current payment system is required if such teams are to function optimally to:

- Improve the quality of health care
- Increase equity of access to care
- Promote prevention and self management
- Reduce or slow the rate of hospital admissions
- Encourage coordinated, team based approaches to primary health care
- Support the increasingly important role of practice nurses as core team members
- Keep red tape to a minimum
- Ensure a population health focus as well as a patient centred approach.

Various factors point to the need for a more effective general practice payment system, particularly for primary care services for people with complex and chronic disease:

- The rising prevalence of chronic disease, changes in patient demography and ongoing health workforce challenges have put significant pressure on health budgets with resultant gaps in costs and quality.
- Existing payment systems - which reimburse inputs rather than outcomes, have few incentives to avoid hospitalisations, and little investment in preventative health care - are not best set up to deal with the current issues facing the health system.
- AGPN does not support an erosion of fee for service arrangements but does acknowledge that fee for service can create incentives to provide services which may be unnecessary or of low value. This can reinforce fragmentation of care by paying multiple providers for multiple services for the same patients regardless of whether the care is coordinated or duplicative.
- The growing complexity and inequities of the current system. There has been an exponential growth in the number of Medicare Benefits Schedule (MBS) item numbers. The result is a system that is difficult for primary care providers to navigate to best benefit their patients.
- Distribution of health workforce and access to medical services is inequitable. Access is often least available where health need is greatest, yet funding additional services through more MBS items does not alleviate this situation - Medicare spending per capita decreases with increasing rurality¹. Payment systems that offer flexibility to attract and retain workforce are required.

- Blended payment systems which offer a mix of quality incentive payments as well as fee-for-service show most promise for dealing with the variety of reactive and proactive approaches required within primary care².

AGPN does **not** support US style fundholding³ where capped funds mean that providers can choose to provide only certain services, so reducing patient choice and restricting access to needed services. AGPN proposes investigating **new** ways to better remunerate general practice, especially in the area of chronic and complex patient care. AGPN supports a general practice payment system that will deliver value driven health care through:

- Linking a level of payment to outcome
- Rewarding and promoting quality multidisciplinary care
- Adapting to changing disease, population and workforce demographics
- Emphasising preventative health and self management
- Minimising red tape
- Being evidence based
- Recognising non-patient contact time
- Policy solutions that reduce health disparities and improve outcomes
- Promoting a more equitable distribution of health workforce and access to government subsidised care.

In particular, AGPN supports:

- **A review of the current Medicare Benefits Schedule (MBS)** to ensure funding arrangements promote quality of care, chronic disease prevention and self management. The present focus of the MBS on time-based consultations, reimbursement of inputs and lack of incentives to avoid hospitalisation is inconsistent with the new directions for health set by the Government.
- **Direct purchase of multidisciplinary primary care services by divisions of general practice** using funds provided by the government (or other primary funder). This approach offers patients greater access to multidisciplinary teams, improved access to care for patients who need it most, as well as offering GPs more referral options for chronic disease management. It also offers divisions flexibility to purchase a mix of services according to local need and to offer health professionals attractive recruitment and retention packages - a benefit in areas of workforce need. This approach could be extended beyond current examples of More Allied Health Services Program (MAHS) and Access to Psychological Services (ATAPS).
- **Service coordinators** to assist patients with their multidisciplinary team care service coordination needs, whilst ensuring that GPs remain the clinical coordinators of care. In this

approach, current general practice and allied health funding mechanisms remain in place but patient care is enhanced through:

- better coordination and continuity of care
- more proactive management of care appointments
- better patient self management and
- the avoidance of unnecessary hospital admissions.

Care coordinators would typically be clinically qualified (eg a nurse) and could be employed by a division in order to serve a critical mass of practices.

- **Incentives for coordinated 'packages' of care for specific chronic diseases.** Such packages are required where patients need multiple interventions, the involvement of several providers as well as the GP, and where patients can also benefit from lifestyle modification programs. To identify and support eligible patients, practices will need to have appropriate recall-reminders systems in place.
 - AGPN supports the concept of a payment for such packages to provide incentives to complete annual cycles of care. This does not mean 'cashing out' the MBS but provides further incentives to ensure more effective use of existing MBS items and other referral pathways to achieve **optimum chronic disease care**
 - AGPN supports voluntary patient registration with practices for the delivery of chronic disease packages of care. This promotes a population based approach to primary health care and monitoring of population health outcomes. Voluntary registration arrangements should not prevent patient choice of provider for all or other aspects of their care.
 - Provision of data indicating improvement in chronic disease outcomes would be required to trigger the payment. Decisions about how this payment could be administered would be flexibly determined in consultation with the local GP community. The payment could be provided direct to those practices who have the infrastructure and workforce to coordinate and deliver cycles of care. Alternatively, practices may elect for the payment (or a component of it) to go to their division who would then coordinate delivery of relevant aspects of the cycle of care, such as the purchase of services from other providers.

¹ ALP 2007. New Directions for Australian Health Taking responsibility: Labor's plan for ending the blame game on health and hospital care <http://www.alzheimers.org.au/upload/LaborAug07.pdf>

² Scott A. 2005. For love or money? Alternative methods of paying physicians http://www.melbourneinstitute.com/research/micro/downloads/Health%20page/docpayment_Tony.pdf

³ Cresswell J 1997. *US-Style Health Organisations are likely in Britain* BMJ 314:323. <http://bmj.bmjournals.com/cgi/content/full/314/7077/323/n>