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Research Excellence in the Finance and Economics of Primary Health Care

Paying our GPs – is it all about money?

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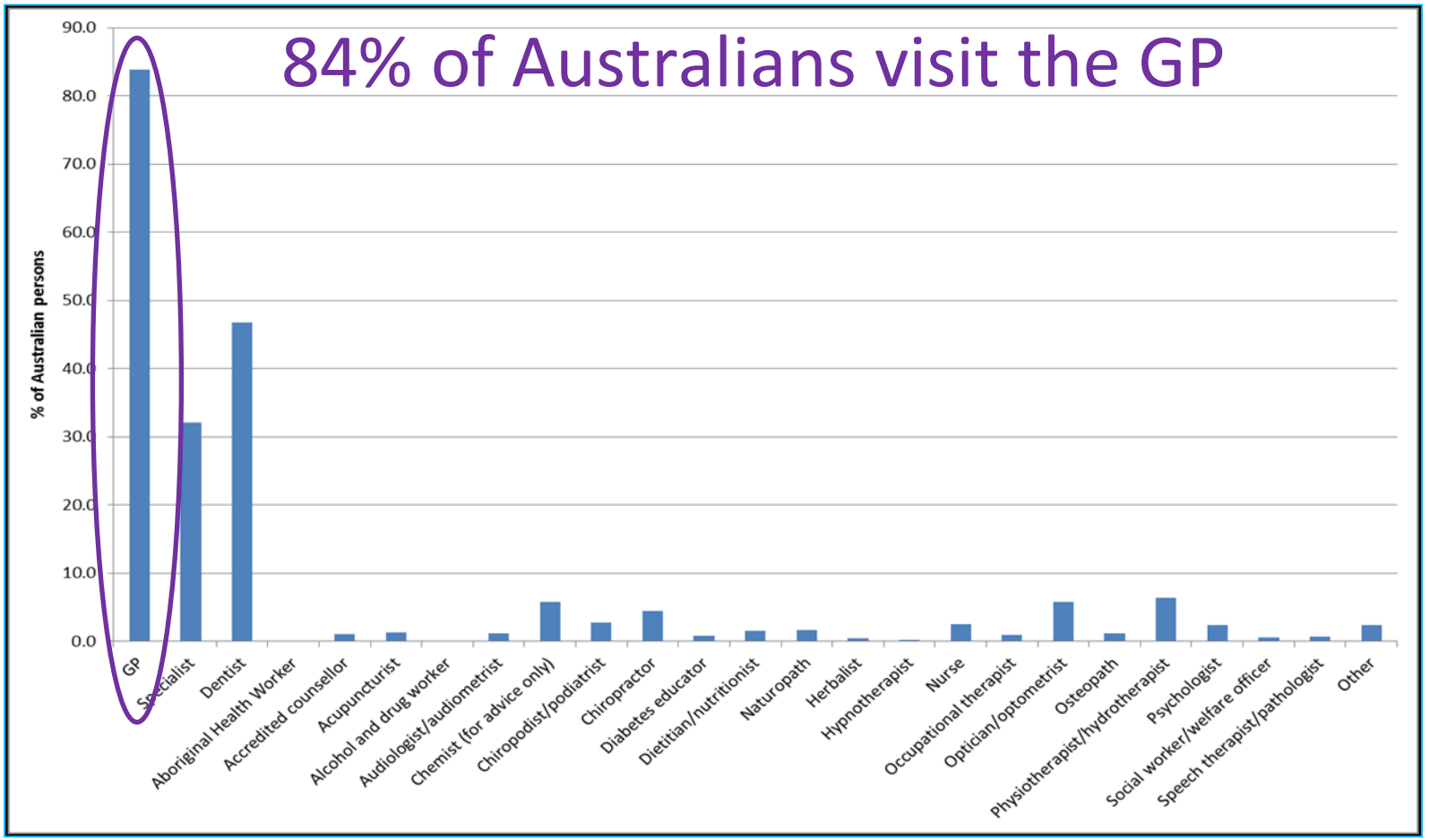
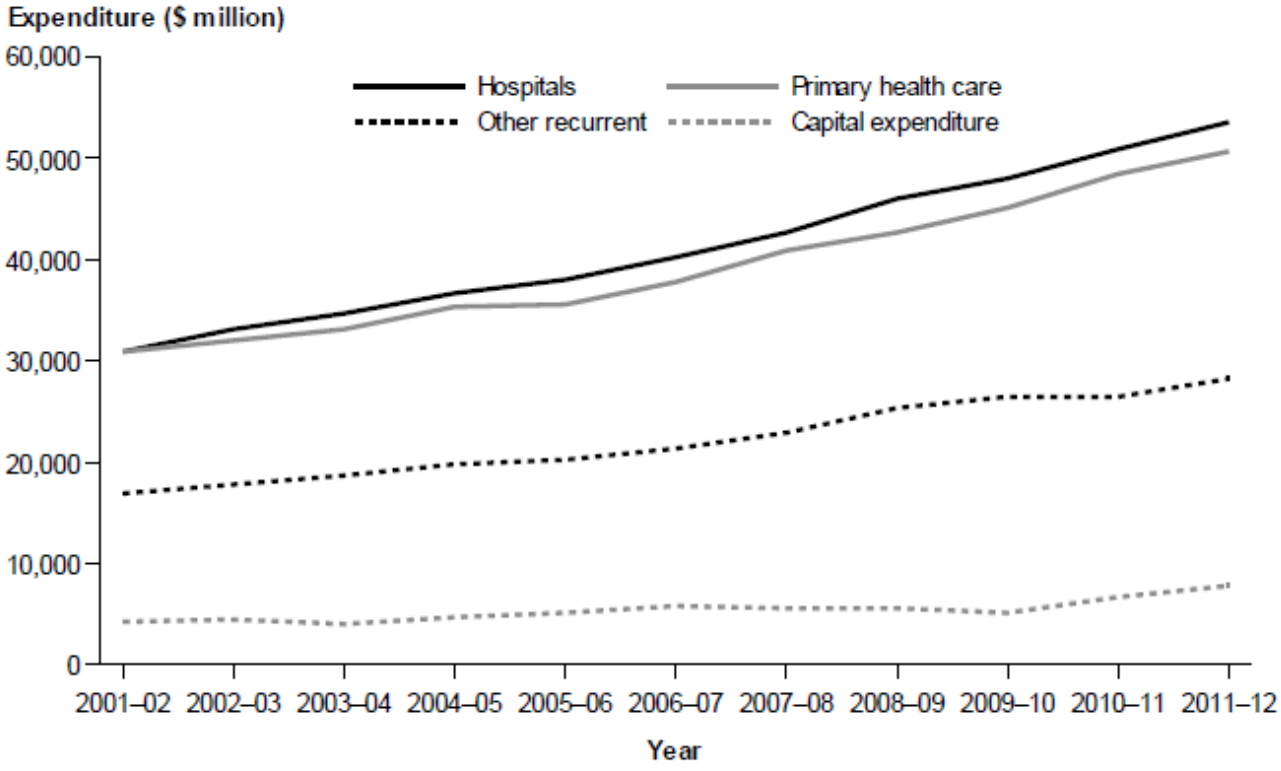
Accessibility



ABS Health Survey, 2013

Australian primary health care

- Universal coverage through Medicare
  - Commonwealth funded to scheduled fee
- Medicare also covers diagnostics, drugs
- Strong gate keeping
- Free choice of provider
- Fee for service based
- Private practice, ability to set fees
- 82% encounters are bulkbilled



Source: Table A1.

Figure 2.1: Total expenditure on health, by broad area of expenditure, constant prices, 2001–02 to 2011–12 ($ million)

What is already known …

- Payment systems provide incentives
- Main effects of major payment methods established
- No one payment mechanism achieves the right balance.
- Target performance with financial incentives
- Move to blend payment systems

Pay for performance in primary care

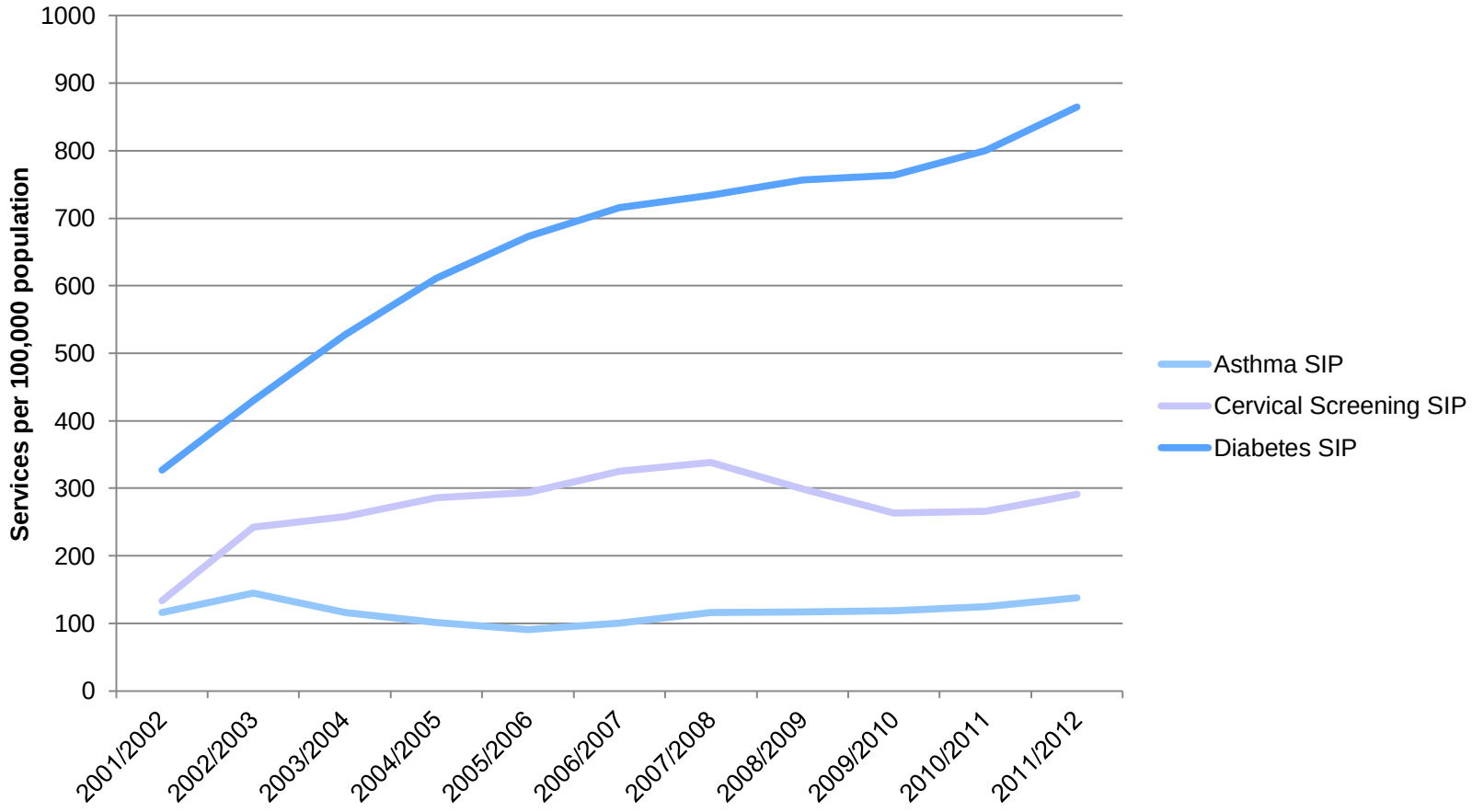
- Better Practice Program introduced 1996
- Became Practice Incentives Program 1998
  - 11 different incentives
- Service Incentives Program
  - Diabetes, asthma, cervical screening
- Bulk billing incentives
- Around 5% total GP income

The Practice Incentives Program (PIP)

Total practice participation = 68% (n=4,781)

PIP participation	Quarter ending June 2011	
PIP incentive	No of practices	%
Quality prescribing	761	16%
Diabetes sign-on	4,611	96%
Diabetes outcomes	2,157	47%
Cervical screening sign-on	4,634	97%
Cervical screening outcomes	3,159	68%
Asthma sign-on	4,521	95%
Indigenous health sign-on	217	5%
Indigenous health patient registration	913	19%
Indigenous health outcomes	85	2%
eHealth	4,189	88%
After hours	4,469	93%
Teaching	951	20%

Service Incentive Payments



Turnover in participation

- *In the last year, approximately what percentage of your total gross earning did you receive from –*
  - *Government incentive schemes and grants*
- Source: MABEL panel survey of 3,906 GPs

	2008	2009	2010	2011
% receiving payments	47.7	43.8	44.0	43.8
% drop outs		38.4	34.5	34.7

Who uses incentives?

- Location is very important
  - GPs in an outer (inner) regional location are on average around 35% (20%) more likely to use grants than those in cities
- GPs working in large practices are more likely to use government grants
  - Working in a practice where there are more than 10 GPs implies, on average, a 10% higher likelihood of using grants
  - Having more than 10 administrative staff in the practice was associated with a 10% higher likelihood of using grants in 2008 and a 27% higher likelihood in 2011

Conclusions

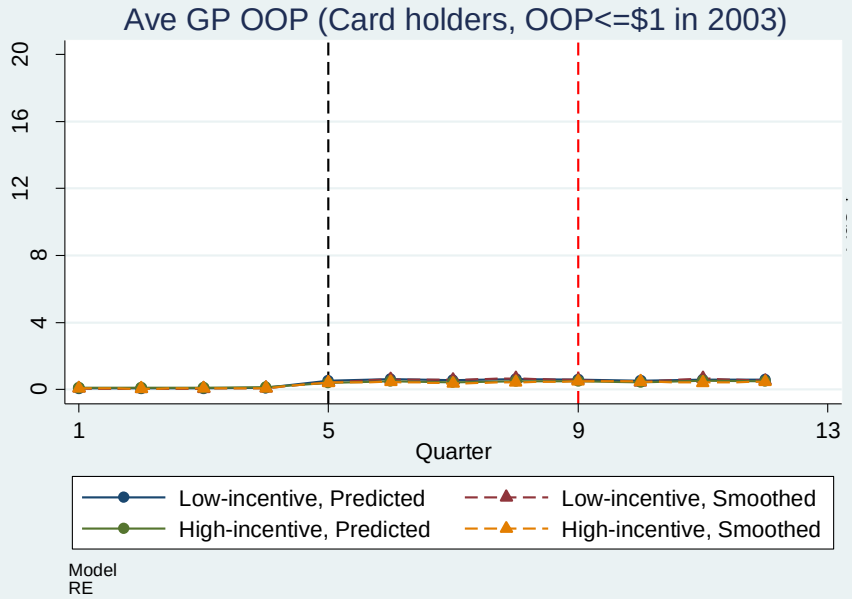
- Rural GPs target with more incentives
- Size may reflect administrative burden
- High turnover within scheme is not part of incentive design
  - Blunting effect of small incentive
  - Changing business conditions

Bulk billing incentives

	Children and Concession Cardholders		Non-cardholders	
	Metropolitan areas	Rural, Remote & outer areas	Metropolitan areas	Rural, Remote & outer areas
Bulk-Billing Incentive (February 2004)	$5 additional reimbursement to GP if GP 'bulk-bills'	$7.50 additional reimbursement to GP if GP 'bulk-bills'	No change	No change
Increase in Medicare Rebate (January 2005)	Increase reimbursement rate of GP services from 85% to 100%			

Data

- Australian Longitudinal Study of Women's Health
- Medicare Australia data
  - Individual level by quarter between 2003Q1 & 2005Q4
  - GP: Services and Out of Pocket costs
- Who gets bulkbilled? Who is charged? At what levels?


Ave GP OOP (Card holders, OOP<=$1 in 2003)
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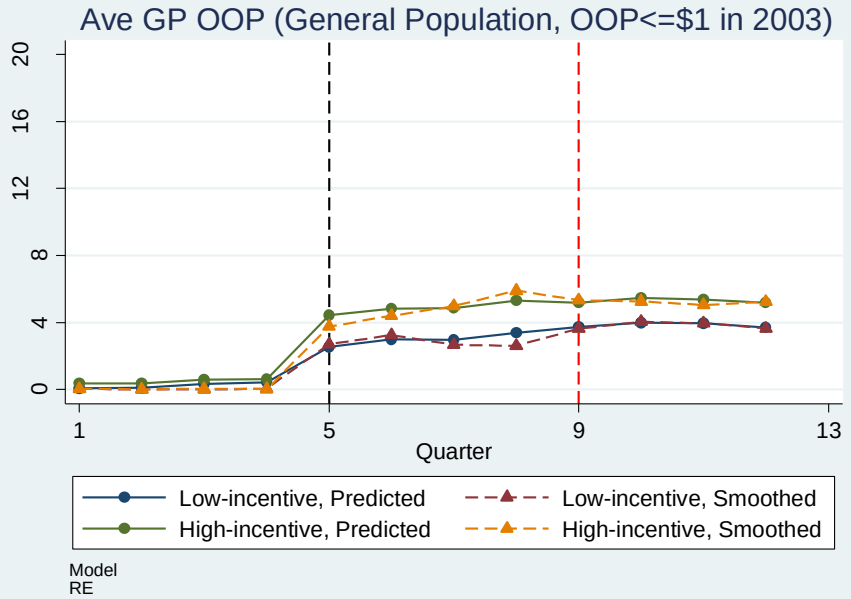
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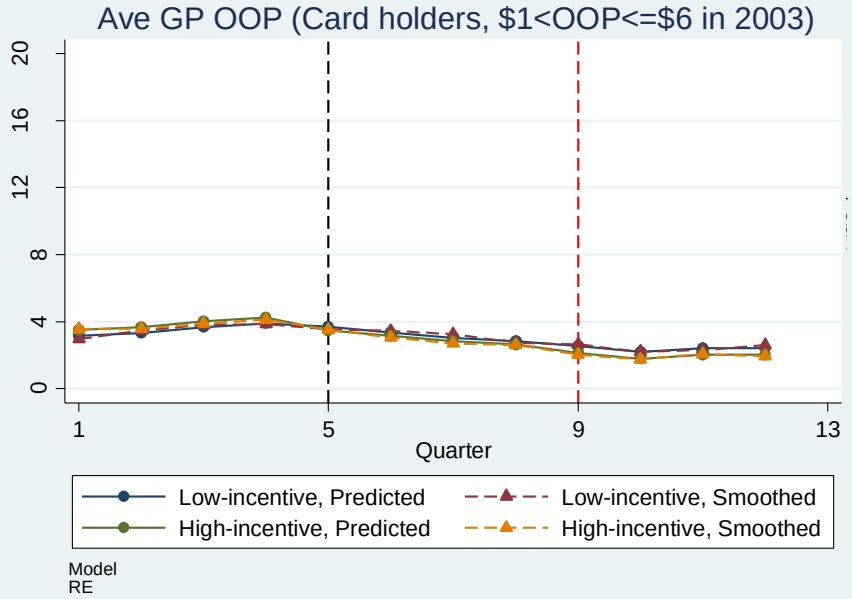
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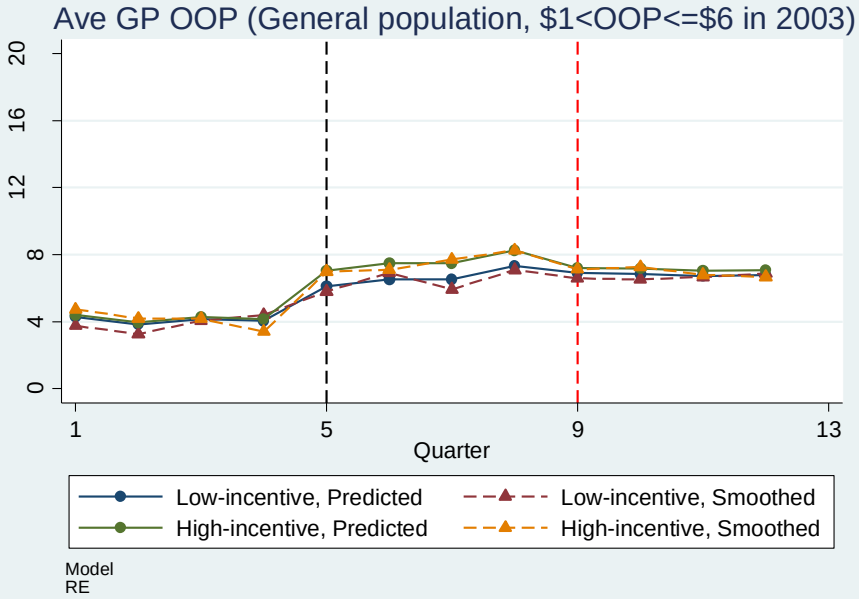
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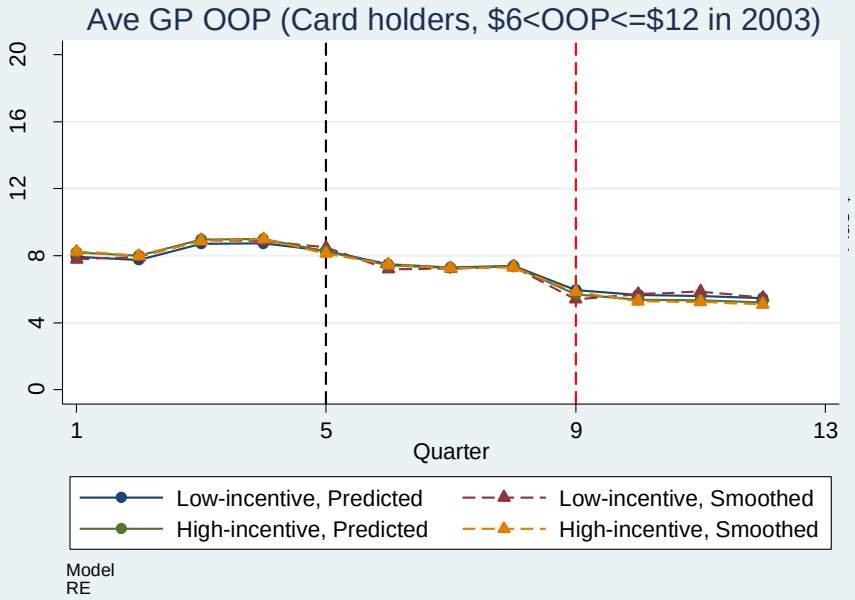
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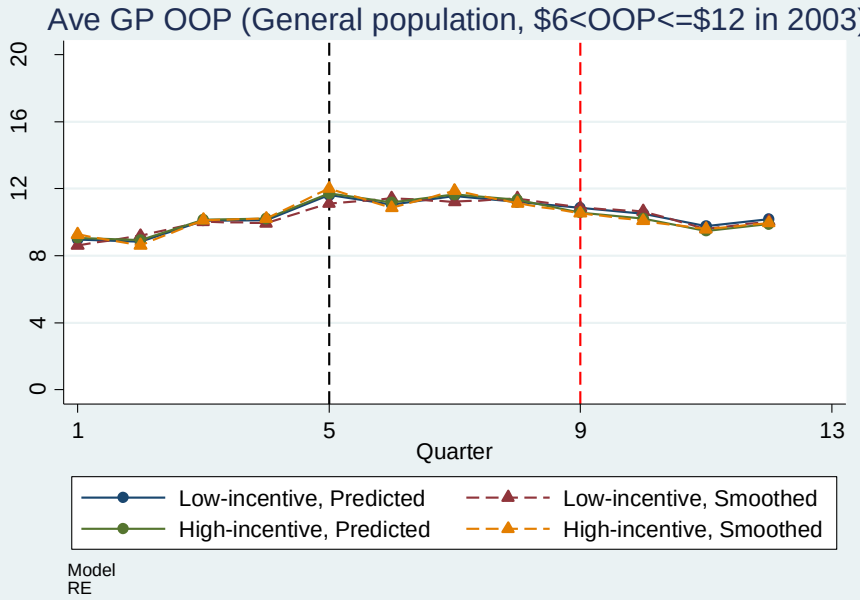
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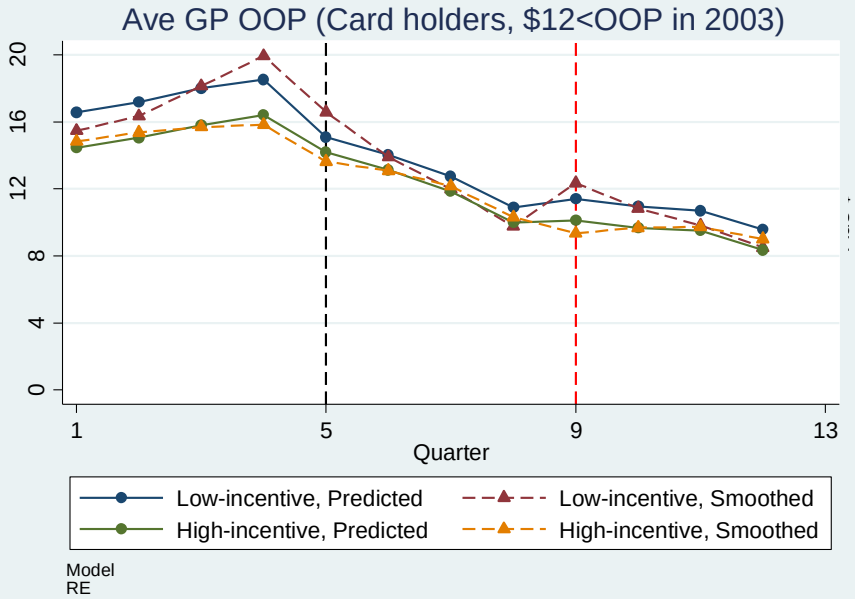
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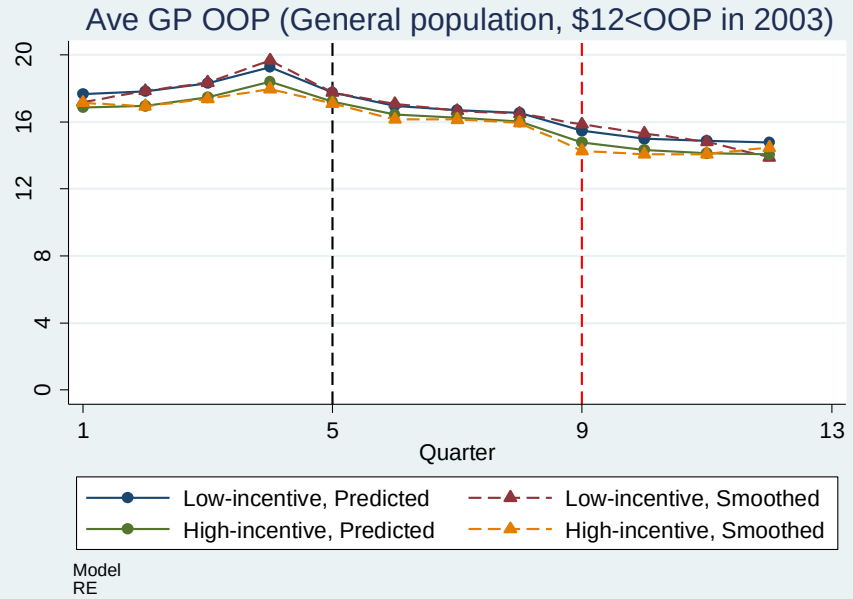
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Conclusions

- The Strengthening Medicare reforms reduced OOP costs on average for women
- Concession cardholders and people in remote areas had greater reductions on average OOP
- OOP costs increased for most non-cardholders following the first policy. This suggests greater price discrimination among GPs after the reform by charging lower fees to concession cardholders and higher fees to non-cardholders
- The magnitude of the OOP cost reduction was relatively small compared to the government pay out

Medical homes

- Regular source of care
- Continuity and comprehensive care
- Easy access
- Medical records available

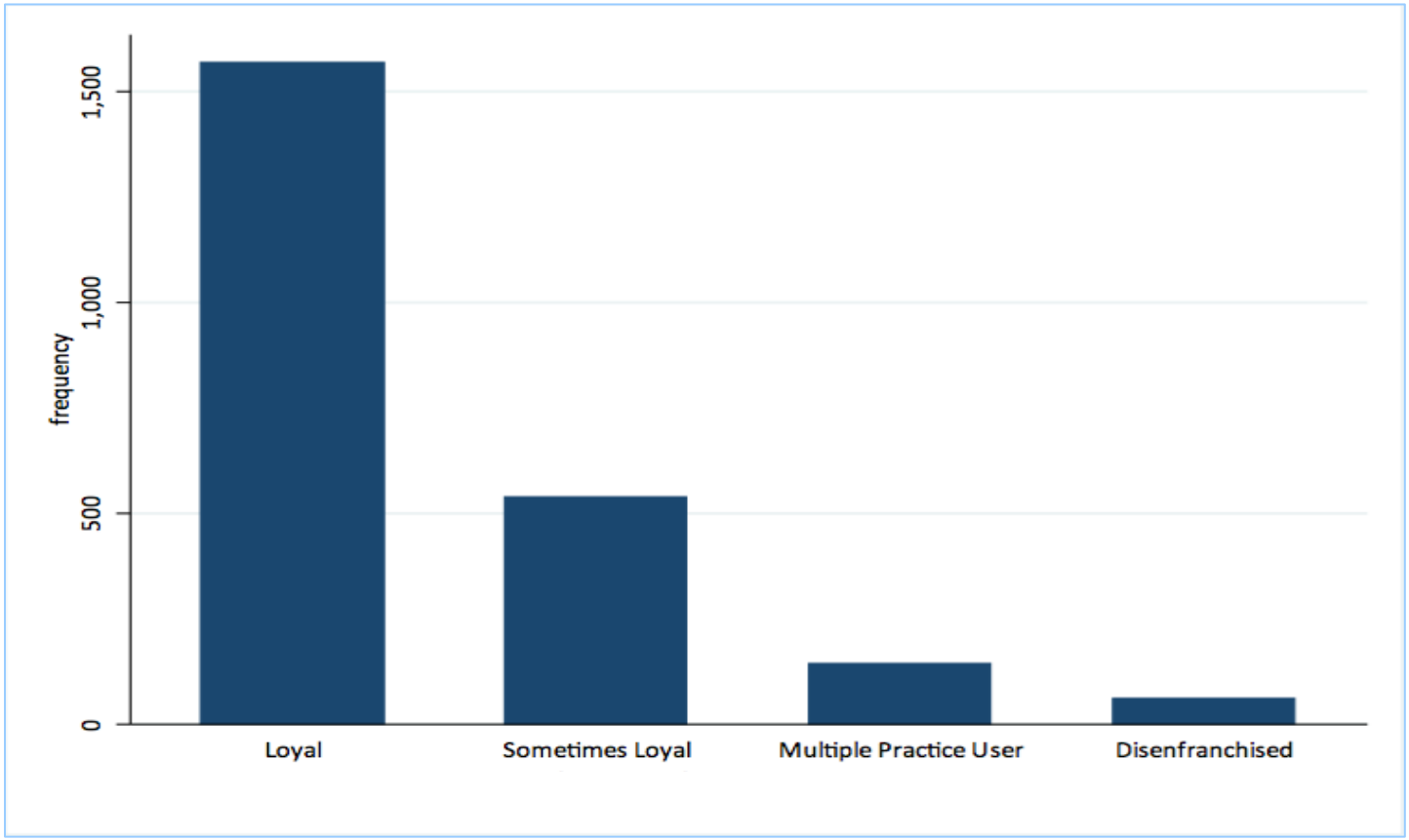
Supported by

- Capitation
- Some form of risk sharing
- Targeted incentives

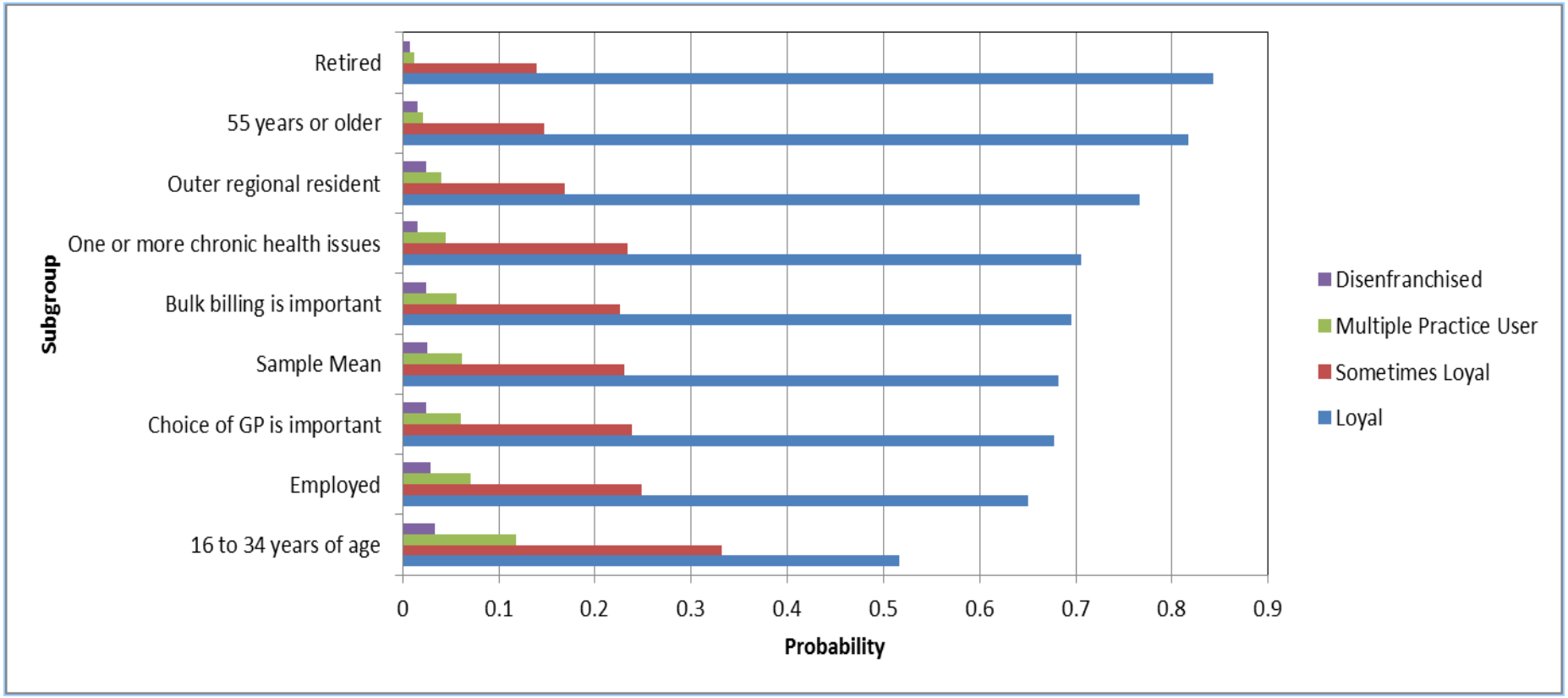
The REFinE Survey

- patient perceptions of GP practice structure, payment methods & patients' experience of using health care services
- Used online panel – more chronic disease, older, more urban, less insurance
- 2,477 respondents provided completed surveys for analysis

Survey Experience: Stated Loyalty



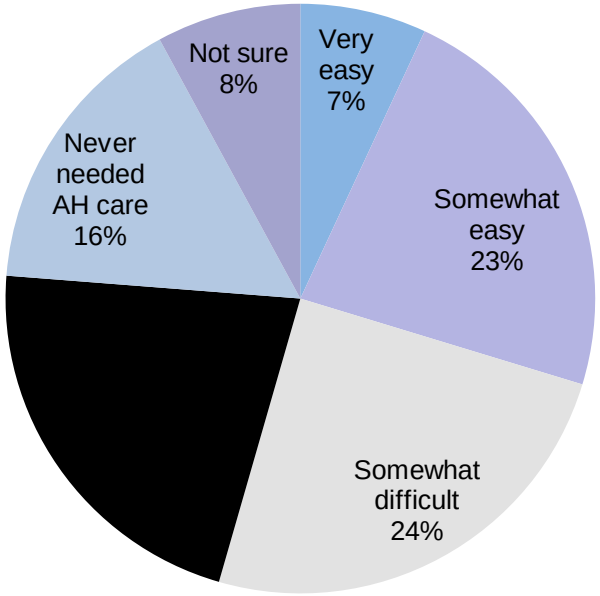
Practice Loyalty by Subgroup

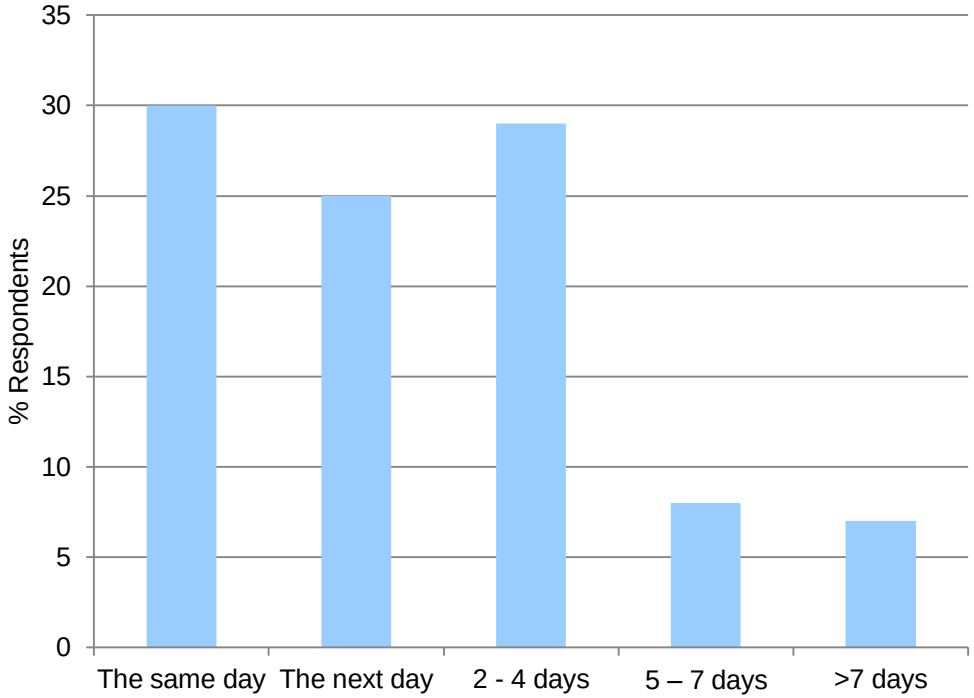


Conclusion

- High degree of patient loyalty to practices
  - Linked to being older, retired, living in larger outer urban cities, presence of chronic health issues
  - Where choice of GP, or availability of multiple GPs is important.
- Patients who want bulk-billing more likely to be multiple practice users.

Availability of care





Availability of care (cont)

- About a third (n=813) reported needing GP visit but did not (last 12 mths).
  - 43% too busy with work/personal/family
  - 34% appointment not available when required.
- 81% (n=2031) reported no visits to an ED
- 23% (of 466) visited ED as GP substitute
  - 56% = 1 visit, 37% 2-3, 6% 4-11 visits

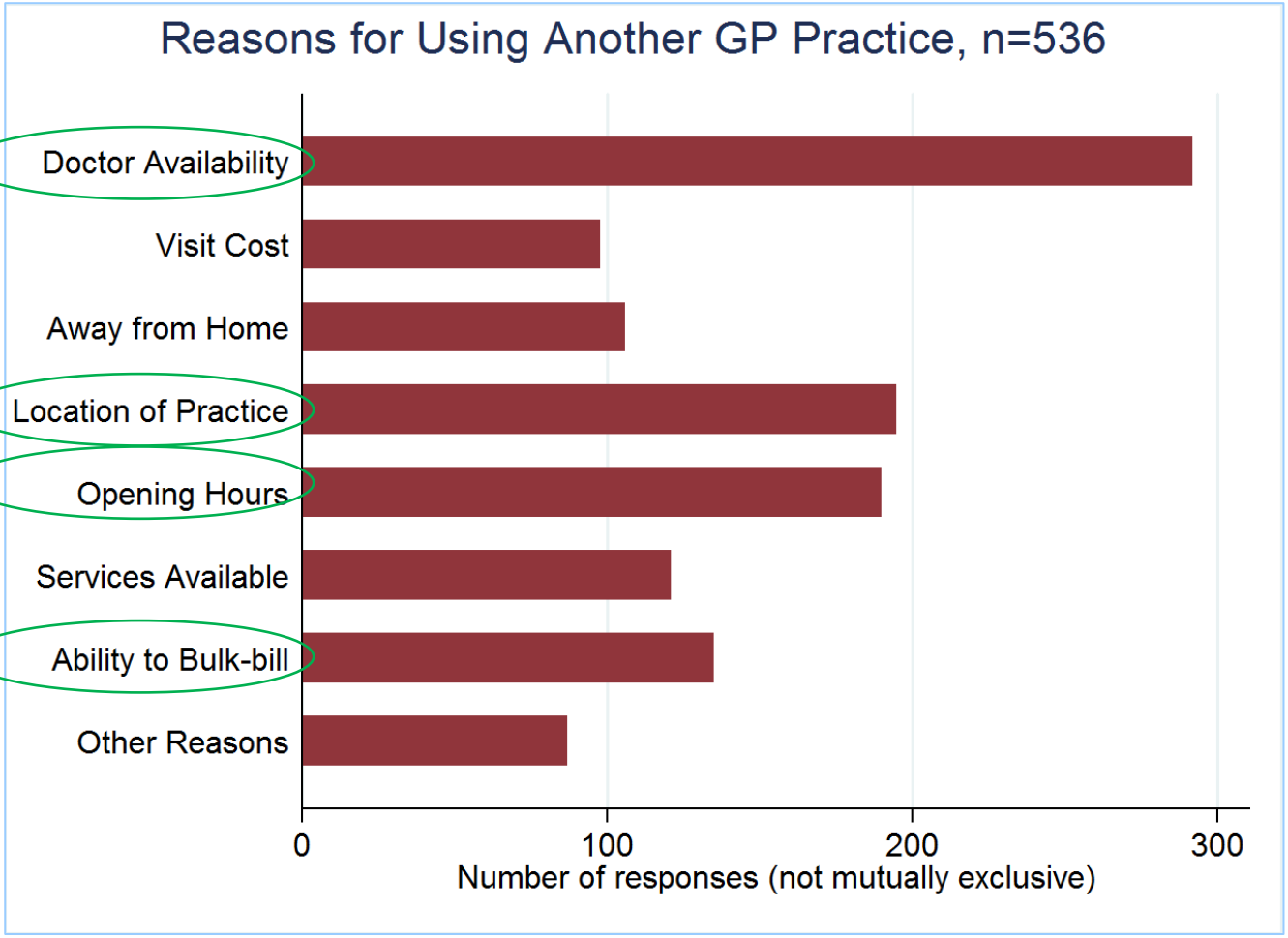
The consultation (cont)

- Very few reported issues with quality or cost of care. Less than 3% reported:
  - medical records or test results not available
  - medication prescribed/test(s) ordered/referral made that was either too costly/not taken up
  - GP did not perform a physical examination even though patient believed it was needed.

The consultation (cont)

- A positive process: almost 99% reported:
  - GP spent sufficient time on the consultation
  - knew their medical history
  - listened to their concerns and needs
  - explained the condition and proposed treatment in an understandable way
  - involved them in any decision making.

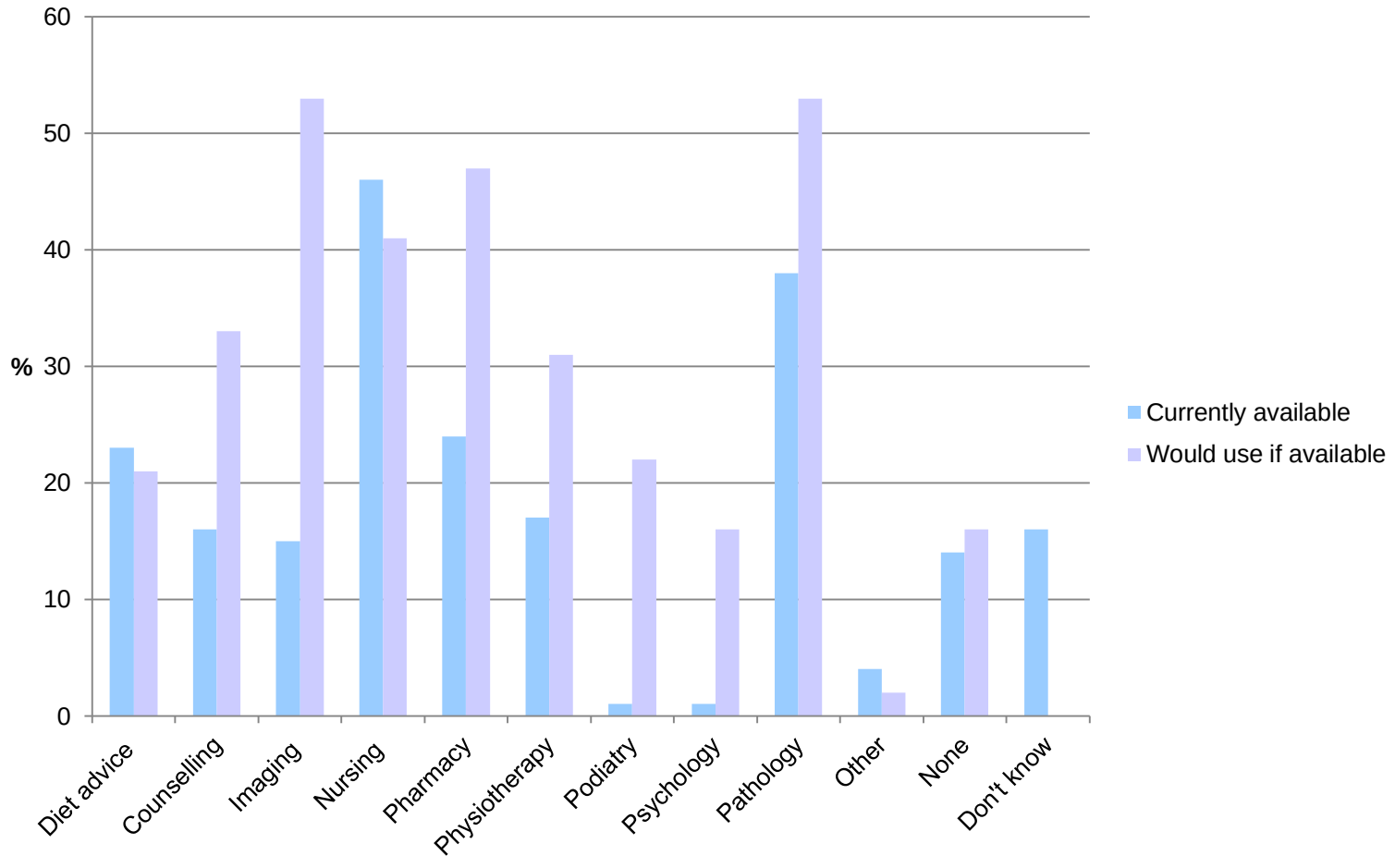
Reason for Multiple Use



Factors which lead to ED use

- People are more likely to visit
  - With more chronic conditions
  - With more GP visits
- And less likely to visit
  - With no need of out of hours care
  - With high quality GP care
- And makes no difference
  - If out of hours care is difficult

Services available compared to what would be used if available



Conclusions

- Australian patients are loyal
- They find care readily available and high quality
- They tend to stick with services they know
- They seek high quality care
- They would like more one stop care
- Lack of access/availability drives multiple use
- Cost is a factor but not the most important
- High quality care seems to reduce ED use

What have we learnt

- Financial incentives
  - One-off actions are easy
  - Administrative burden matters
  - Can have unintended effects
  - Are expensive if they reward existing behaviour
  - Impact depends on non-financial incentives too
  - Effectiveness can change over time

Disclosure

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The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Commonwealth of Australia (or the Department of Health).

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