



Primary health care funding models

Keep up to date with new Australian primary health care research

ISSN 1839-6348

Issue 33
September 2013

J Oliver-Baxter
L Brown

The way primary health care (PHC) services are funded ultimately impacts on the quality, access and coordination of health service delivery. Financial mechanisms have long been used to influence provider behaviour, for example to increase productivity, control costs and improve efficiency.¹ Health system administrators are charged with the task of meeting growing demand for services with finite resources, emphasising quality and placing a financial value on it.

This *RESEARCH ROUNDup* examines the funding models that impact on PHC service delivery.

Funding health care in Australia

Australia's health system is funded and administered by several levels of government (national, state/territory and local) and is supported by private health insurance. Medicare, Australia's national public health insurance scheme, is funded and administered by the Federal Government and consists of three health care components: medical services (including visits to general practitioners (GPs) and other medical practitioners) through the Medical Benefits Scheme (MBS); prescription pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS); and hospital treatment as a public patient (the latter is jointly funded by the Federal and state/territory governments).² The Federal and state/territory governments also fund and deliver PHC, population health programs, community health services, health and medical research, Indigenous health, mental health, health workforce and health infrastructure.

Funding models

There has been growing interest in payment models to influence PHC service delivery (Table 1). Broadly, funding models for PHC fall into two categories: **population-based funding** and **patient-focused funding**. Population-based approaches, as their name suggests, are focused at funding needs at the population level (eg. capitation payments). This type of funding is a block-funding arrangement whereby funds are allocated to service providers in a lump sum on a periodic basis; and based on the population size and the perceived health care needs of the population served. These approaches are less well-known in the Australian PHC context and more common for hospital funding. Patient-focused funding is defined as any method of funding providers that uses incentives and supports to improve the appropriateness, quality and efficiency of care for patients.¹ Pay for performance³⁻⁵ (P4P; GP paid/penalised for not meeting activity or health outcome targets), fee for service (FFS; services are unbundled and paid for separately), and activity-based funding (ABF; hospitals are paid for an episode of care) are perhaps the most well-known examples.

In Australia, financial incentives are the major funding mechanism for bringing about desired changes in practice and typically operate at the individual patient level.⁴ These incentives are often incorporated into blended payment systems in General Practice, to form a model termed 'Practice Incentive Payments' (PIP). That is, services must be coordinated by the patient's GP in order for the items to be claimable, though parts

of the work can be delegated to other allied health workers or nurses, and can be coordinated through incentives such as Chronic Disease Management Items (CDM) care plans which involve the community health sector in a partnership approach to care. Service Incentive Payments (SIP)⁶, CDM payments and other specific payments are based on type/number of services provided of a specific standard, paid through the MBS to individual GPs. One current investigation of alternate funding models is the Diabetes Care Project,⁷ replacing care-planning MBS items with diabetes-related PIP payments. Evaluation not currently available.

Although payment systems may be used to achieve policy objectives (eg. cost containment or improved quality of care), little is known about the effects of different payment systems in achieving these objectives. It has been proposed that financial incentives may be effective in changing health professional practice⁸ thus there are several systematic reviews exploring methods of physician payment and clinical behaviours.⁹ A review of managing primary care behaviour through payment systems and financial incentives for the European Observatory on Health Systems reported that of all payment systems, capitation encouraged primary care physicians (PCPs) to provide preventive services. This approach reduces future costs, and as PCPs have fixed patient lists they are theoretically in an excellent position to provide services targeted towards the population.¹⁰ However, while the use of financial incentives to reward PCPs for improving services is growing, there is insufficient evidence to support, or not support, the use of financial incentives to improve the quality of PHC.¹¹

International approaches

Recently there has been an international focus on system-level approaches to funding. For instance, shared savings approaches are used by Accountable Care Organizations in the United States. Providers receive all of their usual FFS payments; however, they also receive bonus payments if their efforts to improve care through better care coordination and other delivery reforms translate into both slower risk-adjusted health spending growth and improved performance on quality measures for their patients.¹² In Germany a similar approach "The Kinzigal-way"¹³ aligns payment with value rather than volume. In this approach measurement of health outcomes is central to further investment and payers and providers are aligned to the most cost-effective interventions. Furthermore, incentives for the delivery of holistic care span health and social care.

Type	Benefits	Challenges	Examples in Australia
Fee for Service Providers bill for each item of service they provide.	Access to care, greater service provision and productivity IF patients can afford to pay. ¹	Rewards activity rather than quality, may lead to shorter visit times, provision of too much or fragmented care. ¹⁶	Most PHC providers use this via the MBS and out-of-pocket expenses to the consumer.
Fixed Payments per Unit of Time Salaries negotiated centrally (eg. between provider associations and government), with individual-based adjustments to allow for experience, location and other considerations.	Allows funders to control PHC costs directly.	May lead to under-provision of services (to ease workloads), excessive referrals to secondary providers and lack of attention to the preferences of patients.	Inala Primary Care
Capitated Funding Allocation of funding among GPs is determined by patient registrations.	Allows funders to control the overall level of PHC expenditures, easier to devise in theory than in practice.	May lead to under-servicing, patient selectivity by GPs. Lack of incentive to improve performance, efficiency or more appropriate use of services; patients viewed as source of costs rather than revenue. ¹	Confined to NGOs, including Aboriginal Community Controlled Health Services, some Victorian community health services, and other NGOs that employ or contract GPs on a sessional basis. ⁴
Pay-for-Performance Payments to individuals (GPs) or organisations (practices) based on type/number of services provided of a specific standard/type. Payments to practices instead of individuals as compensation for risk.	May improve processes and access (quality), provides additional payments for tasks that are beneficial to patients and not otherwise remunerated via existing payment mechanisms.	Rewards activity; context and socioeconomic status may affect ability to meet benchmarks. ¹⁷ Achieving targeted outcomes but does not encourage improvement beyond targeted threshold; could be prohibitive to areas with low baseline quality thereby discouraging participation.	Service Incentive Payments, chronic disease management (CDM) items paid through the Medical Benefits Schedule (MBS), Practice Incentive Payments (PIP), Practice Nurses and Allied Health Professionals (eg. Access to Allied Psychology Services).
Activity-based Funding Providers are funded based on expected activity, ie. expected costs for clinically-defined episodes of care.	Promotes technical efficiency.	Reduced flexibility if funds cannot be moved across items; episode-based classification is difficult in PHC setting.	WA implementing ABF for outpatients; ¹⁸ mainly hospital-based services. Opportunity for gathering information from GP and specialist billing codes to develop an episode-based classification and funding model for outpatient care. ¹⁹

Conclusion

Every funding system brings its own set of desired and perverse incentives.^{14,15} The situation is often worsened when multiple funding models are implemented simultaneously and when financial incentives between sectors are not aligned (eg. GPs paid through FFS whilst hospitals receive ABF: ABF gives hospitals an incentive to limit the volume of cases, whilst FFS gives GPs incentive to increase volumes).¹ Ensuring funding goes towards improving patient care rather than simply rewarding achievement is the challenge for financing health care across the globe.

References

- British Columbia Medical Association (2010). *Valuing Quality: Patient-Focused Finding in British Columbia, A Policy Paper by BC's Physicians*. Council on Health Economics and Policy.
- Australian Bureau of Statistics. (2010). *Health Care Delivery and Financing*. Canberra: Australian Bureau of Statistics.
- Appleby J, Jobanputra R. (2004). Payment by Results. *New Economy*. 11(4), 195–200.
- McDonald J, et al. (2008). The implementation and impact of different funding initiatives on access to multidisciplinary primary health care and policy implications. *Med J Aust*, 188 (8), S69.
- Scott IA. (2008). Pay for performance programs in Australia: a need for guiding principles. *Australian Health Review*, 32(4), 740–749.
- Department of Health and Ageing. (2012). *Service Incentive Payments. Office for Aboriginal and Torres Strait Islander Health (OATSIH) Accreditation Manual*. Canberra: Department of Health and Ageing.
- Victorian Government. (2011). *Diabetes Care Project. 2009–2014*.
- Flodgren G, et al. (2011). An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes. *Cochrane Database Syst Rev*, (7), CD009255.
- Gosden T, et al. (2000). Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians. *Cochrane Database Syst Rev*, (3), CD002215.
- Saltman R, Rico A, Boerma W. (2006). *Primary Care in the Driver's Seat: Organizational Reform in European Primary Care*. Berkshire: Open University Press.
- Scott A, et al. (2011). The effect of financial incentives on the quality of health care provided by primary care physicians. *Cochrane Database Syst Rev*, (9), CD008451.
- Keckley PH, Hoffmann M. (2011). *Accountable Care Organizations: A new model for sustainable innovation* (pp. 1-19). Deloitte Center for Health Solutions.
- Hildebrandt H. (2012). Money for value: the Kinizigal-way to measure the produced value and health gain in a local area. *Int J Integr Care*, 12(Suppl3), e175.
- Robinson JC. (2001). Theory and practice in the design of physician payment incentives. *Milbank Q*, 79(2), 149–77, III.
- Young D, Gunn J, Naccarella L. (2008). *Funding Policy Options for Preventive Health Care within Australian Primary Health Care: Discussion Paper, in Funding Policy Options for Preventative Health Care*. Melbourne: Department of General Practice, The University of Melbourne.
- Wranik DW, Durier-Copp M. (2010). Physician remuneration methods for family physicians in Canada: expected outcomes and lessons learned. *Health Care Analysis*, 18(1), 35–59.
- Eijkenaar F, et al. (2013). Effects of pay for performance in health care: A systematic review of systematic reviews. *Health Policy*, 110(2–3), 115–30.
- Government of Western Australia. (2013). *Activity Based Funding and Management*. Delivering a Healthy WA <www.health.wa.gov.au/activity/>
- Dwyer J, Eagar K. (2008). *Options for reform of Commonwealth and State governance responsibilities for the Australian health system*. Commissioned paper for the National Health and Hospitals Reform Commission.

Acknowledgement: Thank you to expert reviewer Guus Schrijvers for his comments on a draft of this paper.