# Discussion Paper

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# Funding Policy Options for Preventative Health Care within Australian Primary Health Care

Professor Doris Young, Professor Jane Gunn, Dr Lucio Naccarella
Department of General Practice, The University of Melbourne

### Purpose of this paper

The NHHRC is seeking to explore new service delivery and financing models for preventative health care. Professors Young and Gunn from the Department of General Practice at The University of Melbourne were invited to prepare a discussion paper that examined options for the creation of a new funding stream targeted at primary health care. We were encouraged to reflect upon existing funding models that were effective in supporting primary health care to focus on prevention and to enhance the role of prevention in the health system. This discussion paper has been prepared by rapidly reviewing existing literature on economic incentives and payment systems for preventative health care within primary health care, from predominantly English speaking countries, with health systems comparable to Australia. This paper has three sections: 1) the current evidence; and 2) the current context; 3) potential funding policy options.

## 1. Current evidence informing funding options

*Introduction*

Overall the international evidence base for preventative health care (particularly with regard to economic incentives and payment systems) within primary care is under-developed and limited mostly to descriptive rather than evaluative or experimental studies.[1] Nevertheless, international evidence shows health systems oriented towards lower cost primary care, rather than higher cost hospital care, achieve better health outcomes.[2] A recent Australian paper, on the false promise of GP Super Clinics for preventative care, argues that we lack evidence that receipt of preventative primary care leads to reductions in chronic illness, lifestyle risk factors or health costs. [3] Sammut argues that *'many recipients of Medicare funded preventative health services will fail to change their unhealthy lifestyle, and future governments will have to fund the recurring costs of ineffective preventive care that yields negligible health and cost benefits'*. Sammut also raises a concern that greater GP involvement in primary prevention (e.g., through Medicare Health Assessment items), may result in reduced access to medical care, as GP time is limited and preventive health care reform may result in limited health care resources being disproportionately consumed by the 'worried well', rather than those at high risk and most in need of preventative


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care. Such concerns can only be allayed by building a strong evidence base for any preventive health care reform.

The evidence upon which to base this discussion paper about the best way to pay GPs to meet preventive health care policy objectives is scant and inconclusive. Typically, GPs can be paid through any combination of: Fee-for-Service (FFS), salary, capitation, sessional payments, target payments and incentive payments. Evidence exists that the mode of payment impacts on how GPs conduct some aspects of their professional practice; however it is not clear how particular payment mechanisms impact on the quality of care or on patient outcomes in the short to intermediate-term. FFS is the predominant form of remuneration in English speaking and many European countries. However, within these countries, there are moves toward blended payment systems to alter how and where GPs practice. It is argued that the problem with FFS is that it leads to shorter, problem-based visits and increased patient volume, rather than a comprehensive approach to patient care. However, sub-optimal care quality can be a problem equally produced by solely salary or capitation models; through GPs only providing the minimum service required, or accepting only the healthier patients due to them requiring less time for care. Most commentators have argued that a 'blending' of different models of payment is optimal.[4] In addition to the economic arguments that relate to the differences in the costs and benefits of different payment systems, it is also important to consider the social and institutional context of the incentive and the existence of other objectives and sources of motivation to provide preventive care, such as: career concerns, personal and professional values, work satisfaction, idealism, and professional standing.

Providing GPs with a mixture of payments to support team-based care and meet population health objectives often involves linking incentive payments to meeting minimum quality performance criteria, population health targets, and attending continuing medical education programs. However, the mechanism of linking physician payment with the accountability chain through payment for performance (P4P) with the aim of improving quality remains controversial. The extent to which such payment systems lead to improved health outcomes in addition to better data collection processes is not yet clear. P4P is a type of FFS, but is usually only applicable when performance can be measured, or at least applicable only to *aspects* of performance that can be measured. These aspects of 'performance' are not related to volume of services as in FFS, but are more related to measurable processes and intermediate outcome indicators that may be linked to improvements in health outcomes or evidence-based guidelines. There are numerous types of P4P schemes; however all incorporate some level of risk to physician income, as payment is explicitly made for meeting a given goal. Examples of major P4P programs that specifically target physicians and GPs include: government sponsored Centres for Medicare and Medicaid Services Physician Group Practice (PGP) Demonstration in the US; the Quality Outcomes Framework in the UK; elements of the Practice Incentives Program in Australia; and the privately sponsored California Pay-for-Performance Program in the US.

In summary, the use of a blended payment system to reward quality attempts to distribute risk and balance the costs and benefits of a single payment mechanism such as FFS, capitation or salary. **There is little empirical evidence to support any particular mix of payment system in meeting health policy objectives. Nor do we know whether particular payment systems are effective in reducing cost, nor do we understand how they might actually work to produce**


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**behaviour change.** Blended payments that reward quality practice and provide GPs with flexible work options may be more likely to elicit implicit motivating factors. For example, the success of GP fund holding in the UK may be linked to increasing professional autonomy because fundholding GPs had discretion over how they used financial savings.

*A brief review of the literature*
Differing health care institutions, health professional bodies, bargaining systems, historical and cultural contexts have resulted in a range of financial incentives within health care.[1] A large number of reviews have been conducted on the impact of specific financial incentives on provider behaviour, especially physicians[5]. A US review of economic incentives for preventative care to inform policy making revealed that financial incentives have been used in an un-coordinated manner at three levels: as motivators in the larger economic context, where savings are thought to be associated with prevention; as provider incentives to induce behavioural change and as consumer incentives to remove barriers, improve health education, and reward healthy behaviour.[9] Overall, the review concludes that system-level economic incentives can change the heath care environment, promoting individual provider and consumers to change, however, more research is required on the sustainability of such incentives.

A US systematic review of randomized trials published between 1966 and 2002 that addressed the impact of financial incentives on primary or secondary preventive care or health promotion behaviors revealed that only one of the eight financial interventions reviewed[11] led to a significantly greater provision of preventive services; providing evidence that small rewards did not motivate doctors to change their preventive care routines. [10]

A UK review found that preventative health policies have failed to improve the overall health of the population and there is only limited evidence to support targeted interventions employing financial incentives to improve the delivery of preventative services. [5] The review highlighted the lack of evidence about meeting the needs of disadvantaged groups.

A Canadian review also found few studies that focussed on evaluation of health promotion or public policy interventions to keep people healthy to guide this Discussion Paper. [12]

A review of managing primary care behaviour through payment systems and financial incentives for the European Observatory on Health Systems reported that of all the payment systems, capitation systems encourage physicians to provide preventative services, since they reduce future costs, and as they have fixed patient lists are theoretically in an excellent position to provide services that are targeted towards the population.[13] ***Overall they warn that empirical evidence on payment systems and financial incentives with high methodological standards is scarce, and that policymakers should be very careful about the distinctions between intended and actual effects of payment systems on primary care behaviour.*** (P195)

A recent paper by Starfield warned that the definition of prevention has expanded so that its meaning in the context of health services is now unclear.[14] Risk factors are increasingly considered to be the equivalent of disease for the purpose of intervention and hence the concept of prevention has lost its practical meaning. Starfield suggests the need to consider a population orientation (even for clinical medicine). She argues for a focus on population-attributable risk


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rather than individual relative risk; morbidity burden rather than disease burden; estimation of costs/benefits of population health strategies and distribution of health within population; setting of priorities based on reduction of illness and focus on adverse effects; all with the imperative to reduce inequalities in health.

Within Australia, a wide range of studies and reviews exist. For example, Segal reviewed over 250 disease prevention programs and found no relationship between program cost-effectiveness and the likelihood of funding. [15]

A recent systematic narrative literature review commissioned by APHCRI[16] of innovative models for comprehensive models for primary care delivery suggested that: flexible GP funding arrangements were required, including:

- ***funding general practices rather than individual GPs***: funding groups of GPs and primary care teams encourages local joint decision making, teamwork and discourages solo practice and may result in efficiency and quality gains. In Australia there are examples of payments to practices rather than individual GPs, such as the Practice Incentive Program (PIP). Reform could involve expansion of the PIP to a wider range of quality improvement initiatives. With such reform, GPs and practices could have a choice of funding arrangements including the extent to which practices continue with fee-for-service arrangements, the range of services and activities covered by the funding, and the size and breadth of the GP and primary care provider group included. Service Incentive Payments (SIP), chronic disease management payments and other specific payments are based on the number of services provided of a specific standard, paid through the Medical Benefits Schedule (MBS) to individual GPs. Such payments could be to practices rather than GPs and extended to other disease areas, as in the UK Quality and Outcomes Framework[18]

- ***a plurality of funding mechanisms for general practices:*** different funding arrangements can accommodate variations in GPs working practices and styles and may improve recruitment, retention and local service provision. In the UK, GPs can choose General Medical Services or Personal Medical Services Contracts, with the latter including salaried and practice-level contract options. Allowing GPs (or practices) to opt in or out of available funding options may enhance recruitment and retention of GPs by accommodating personal work preferences (e.g. those who prefer flexible working hours and/or not to own a business). Given the feminization of the medical workforce such arrangements could encourage provision of services in remote and rural areas. Community Health Services in Victoria is an example where GPs are offered alternative funding arrangements, including salaried options. Funding arrangements could be negotiated locally between the practice and a regional primary care organisation or health authority.

- ***new funding arrangements between general practices and regional primary care organisations*:** Funding arrangements could be between a General Practice and a regional primary care organisation (PCO) or health authority, rather than central government (although government, either State or Federal, would need to allocate funds and provide a governance and accountability framework). This would allow local flexibility in service delivery and may enhance the capacity of the system to directly plan for and effectively address regional needs. International examples of this approach exist; for example Primary Care Trusts


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(PCTs) in the UK, which are responsible for negotiating funding arrangements with GPs under the General Medical Services Contract. This includes funding for essential services which all practices need to provide, but also 'additional' (such as cervical screening, immunization, maternity, minor surgery) and 'enhanced' (e.g. specialised services for specific populations) services, that practices can opt in or out of depending on their circumstances. In the US, physicians may be funded by one or more Health Maintenance Organisations (HMO), in addition to the Federal Medicare and Medicaid programs.

The Primary Health Organisations (PHOs) in New Zealand provide important insights for Australia with regard to funding arrangements, as PHOs negotiate funding arrangements with local general practices directly.[16] PHOs are funded by District Health Boards to provide a specified set of essential primary health care to an enrolled population. PHOs are geographical, not for profit, and have an enrolled population, initial enrolments being made through primary care (GPs) providers. There are minimum requirements for PHOs; they must show evidence of: local community (consumers and providers) involvement in decision-making and delivery of services to those with highest need (particularly Maori). PHOs must provide a minimum set of services which includes personal medical services and population based services. One of the most significant changes for general practice under PHOs was the move for the Government portion of income to shift from FFS to capitation payments. Practices can negotiate local capitation arrangements with the PHOs. The NZ PHO system uses blended payments including FFS with patient co-payments (up to half of the cost of a GP visit), plus capitation. Patient enrolment is undertaken through people's first point of contact with the service. In most cases this is via a GP contact. GP patient registers are taken as initial enrolment lists and the PHO has 3 years in which to tell their population about PHOs and to provide them with the ability to opt out.

PHO funding is explicitly linked to reducing health inequalities. Two formulae exist, an "access" and "interim" formula. "Access" funding is available to PHOs where >50% of their enrollees are Maori, Pacific Islander or from deprivation deciles 9 or 10 (the most deprived deciles). In these PHOs a higher capitation amount is paid to the PHO, who must then negotiate with the GPs and providers in the area to reduce patient out of pocket costs. In these PHOs, the Community Services Card (CSC) is not operational, as the policy is based on universal care principles. Transitional funding (to all other PHOs) sees lower capitation amounts being paid but higher amounts for CSC holders. It is planned that all PHOs move to the access formula.

Most PHOs (65 out of the current 81) are also implementing the Care Plus program for individuals with identified high needs for primary care (expected to be 2 hours of care in six months) – usually because of chronic conditions. The funding available for the program covers 5% of people nationally though at the PHO level the number of expected patients varies depending on the enrolled population. PHOs receive significantly higher funding to provide higher levels and more managed care for these patients (about $200 extra funding per patient per year). (New Zealand Ministry of Health 2004).

A recent review[16] of the evaluation of the NZ funding reforms reported concern regarding the linking of funding to enrolment processes, which led to significant variations in PHO income as equalisation (claw back of funds) arrangements came into play when patients visit GPs that they are not enrolled with. This problem emerges when a patient enrolled with a practice in an


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"interim" funded PHO sees little change to the costs they face to visit a GP, and decides to cross to an "access" funded PHO and sees a provider operating under a reduced up-front fee structure. The two-tier structure has created some perverse incentives and has become a contentious issue in NZ. The Government wants assurance that the increased funding accompanying wider application of the access formula will mostly go to reducing the patient co-payments and expects these PHOs to show that they have reduced fees accordingly.

In Australia, Community Health Services and GP Plus Health Care Centres in South Australia are examples of States negotiating arrangements for funding primary health care services, in addition to the Commonwealth. It would be possible to pool these funds which could be managed by regional PCOs.

A critique by Swerissen on funding programs for chronic disease prevention and management[17] argued that the current funding system provides disincentives to the development of effective systems for the prevention and management of chronic disease. He argues that the FFS funding system favours service provision that is focussed on high cost, inefficient use of medical, pharmaceutical, acute, and sub-acute services which leads to short term outputs (services, episodes) rather than longer term health gains. Swerissen argues strongly for enhancing the PIP payments for patients at high risk of developing chronic disease and those with established disease who need care planning, coordination, and enhanced services rather than expanding the existing Medicare FFS item schedule. The PIP could provide additional payments for performance (similar to the UK QOF) on risk factor and disease specific quality indicators. He also suggests reforming the existing funding arrangements for community health and home and community support services to ensure universal access, irrespective age.

Scott recently evaluated[17] the impact of the Practice Incentive Payment (PIP) on the quality of care in diabetes. The incentives in the PIP for increasing the quality of care include the combined effects of capitation payments, a Service Incentive Payment (SIP) and an Outcomes Payment (OP). The study found that the probability of a GP conducting an HbA1c test was between 15% and 20% higher for GPs in the PIP, compared to GPs not in the PIP. This study controlled for self-selection of GPs into the PIP, and also the simultaneous growth in practice size. Furthermore, it found that the activities of Divisions of general practice played a major role in the uptake and therefore the effect of the financial incentives on the quality of care.

The recent DRAFT Updated AGPN Primary Health Care Position Statement[19] calls for new payment systems in primary health care to encourage and reward care needed by the Australian consumer, particularly preventative health care. The Statement argues that for a population health prevention focus, general practice payments will need to be a blend of FFS, capitation and quality outcomes payments – an overall model that remunerates best practice care, recognises non-patient time and includes a component for infrastructure, to support multidisciplinary care. The Statement posits that the Australian General Practice Network will deliver primary health care funding by:

- Holding funds to administer coordinated care packages
- Directly purchasing multidisciplinary primary care services
- Promoting payments that support preventative and best practice approaches (e.g. Health checks, CDM MBS items)


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- Administering infrastructure payments to support multidisciplinary team working
- Administering expanded lifestyle modification programs that provide subsidised pathways to preventative health services.

The Advanced Medical Home – Comprehensive Payment for Comprehensive care model is a recent development in the US as part of their 'alternate funding system level scheme'.[20] The scheme is strongly supported by the Commonwealth Fund and the American Academy of Family Physicians as it provides a more holistic approach to primary care - where the primary care physician is both the patient advocate and care coordinator. The primary care physician is paid a substantial global fee to perform additional care management tasks that typically cannot be reimbursed in a FFS environment. Practitioners are required to use EBM and clinical decision support to develop integrated coherent plans for ongoing medical care in partnership with patients. The comprehensive payment care model differs from capitation methods as it calculates *actual* costs, thereby compensating providers for their *actual* work. It pays for modern systems and teams to provide integrated primary care; its payments are risk adjusted so that there are no obvious disincentives to treating more complicated patients and it includes performance-based measures that can be audited through electronic medical records, patient outcomes and patient satisfaction rates.

Evidence exists that general practice and GPs can play an essential role in preventative health care, including[21]:

- Health promotion – health lifestyle counseling- nutrition and physical activity
- Risk avoidance- ensuring those at low risk of disease remain low risk (e.g., through physical activity)
- Risk reduction- targeting individual patients and groups with moderate risk of disease or injury (e.g., advising on smoking, treating patients with high BP, or opportunistic screening for depression)
- Early identification- screening those in an at-risk group (e.g., pap tests for women)
- Reduce complications- prescribing treatments for those with an illness to prevent further complications (e.g., best practice management of chronic disease)

The provision of preventative care in general practice has also been found to be sub-optimal.[22, 23] Factors that limit general practice capacity to establish and maintain effective preventative care include: lack of time, competing priorities, workforce shortages, lack of support systems; remuneration, balancing preventative care with ongoing patient care and treatment, limited knowledge of the effectiveness of preventative medicine, and suboptimal office processes. [24]

Based on existing literature, [25,26] the creation of any new economic incentive and payment system for supporting prevention in primary health care should:

- address a priority public health problem stimulating the provision of evidence-based, cost-effective interventions
- be based on recognised clinic practice guidelines for preventive activities in general practice[27]
- be planned as one part of a broadly based solution to a public health problem


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- be linked to performance in terms of patients health outcomes
- be inked to evidence-based clinical guidelines
- be supported by systems based infrastructure and information technology
- be blended or mixed to avoid under or over-servicing
- be tailored to reflect the different motivations of physician
- be based on and rigorously evaluated using reliable measurement of valid indicators of preventative health care within primary healthcare setting

Furthermore it is widely recognised that preventative health care:

- can refer to primary, secondary and tertiary prevention
- needs to address multiple risk factors that influence health
- needs to include individual, community and population-wide strategies
- needs to be implemented within a system change that supports preventative approaches within primary care, through an enrolled population/patient registration, electronic patient record and quality audit/quality assurance[28].
- needs to be complemented by non-monetary incentives, including: explicit regulatory and legal approaches; and implicit approaches based on cultural norms, trust, duty of care and professionalism[29-33].
- should not add to the already complex and administratively burdensome payment arrangements.
- needs to have a change management strategy, that puts into place systems level adoption mechanisms, including:
    - Engagement – need strategies to engage GP, general practice and consumers in preventative health care
    - Practice re-design and support – need to fund initiatives focused on work practice change and support workforce redesign initiatives;
    - Workforce development & education – coordinate change in tertiary and vocational training programs to ensure workers provide preventative care.
    - Implement change to professional practice standards and certification to incorporate requirements for GPs to provide preventative care
    - Compliance – establish agreed upon compliance or regulatory processes for certification and accreditation of preventative care and for sanctions that will be applied against GPs not providing preventative care

# 2. Current Context informing potential funding policy options

Before suggesting possible funding options for preventive care in the Australian primary health care setting it is important to highlight the need to consider contextual factors. The practice represents the main organisational unit of Australian primary care. The past three decades have seen growth in larger practices, better equipped with information systems. Nevertheless, Australian general practices have a long way to go before they are staffed or equipped to the level of, for example, UK practices. UK general practice has received extensive financial input to reach the level of organization that it currently enjoys.


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*Models vs mechanisms*

When discussing health care reform the term 'model' (referring to a model of care or a payment model) is liberally used, both in published research and policy documents, when the authors are usually referring to a 'key mechanism' or 'mechanisms' required to elicit a particular behaviour change. Researchers and policymakers are searching for a mechanism that works in their context.[16] In other words, they are interested in an approach to doing things that can be described independently of the context of its application, and directly transferable to another setting. For example, a payment mechanism is Fee-For-Service; this can be used in many different health care systems (contexts), is transferable, although the details of the payment scheme itself may have developed within a specific context and policy strategy. This differs from a service contract which is an example of a model containing a payment mechanism. The service contract is context specific as it cannot be applied directly to another setting without modification. Another example is a Primary Care Trust which evolved from a GP Fund holding, Total Purchasing and PCGs, which all comprise multiple mechanisms.

The implication is that the replication or transferability of funding models / schemes that involve incentives and remuneration strategies becomes complex and is shaped by context. This needs to be kept in mind during any health care reform. In this paper we have focused on the funding mechanisms *within* models that are effective in supporting primary health care to focus on prevention.

We have identified four main types of remuneration strategies which include:

- **Fee-For-Service**- where GPs are paid according to the volume of services they provide;
- **Capitation** – where GPs are allocated a fixed amount of money per patient per year to service the health needs of their registered patient population;
- **Fixed payment per unit of time** - This includes ***salaried payment*** where professionals are employees, or sessional payments where professionals are in private practice. In salaried payment, behaviour change is motivated through the subjective assessment of performance via promotion up the salary scale which provides a clear career trajectory. The length and increments of the salary scale itself provides financial incentives, alongside criteria used for promotion that can be related to a number of performance criteria;
- **Pay-for-performance and target payments**. Similar to FFS, except the fee/payment is for specific improvements in the minimum standards, processes, intermediate outcomes, or health outcomes based on evidence-based guidelines.

An opportunity exists to reduce the complexity of current item-based and incentive based funding arrangements (SIP, PIP) which have grown at considerable cost and in an uncoordinated way without delivering major health improvements. After considering the evidence, limited though it may be, it appears that any reform aimed at improving preventive services in primary care will need to use a 'mechanism' that is situated at the practice level and has clear incentives for both patients and practitioners to be involved.


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# 3. Potential Funding Policy Options

Our rapid review revealed a limited and inconclusive evidence base to guide decisions about funding options for preventative primary health care and highlighted the need to consider contextual factors when deciding upon options.

Limited current evidence suggests that any new funding scheme attempting to deliver cost-effective, equitable, accessible and sustainable population-based preventative primary care needs to be:

- underpinned by key generic PRINCIPLES to identify the target population and problems, and PRINCIPLES to guide implementation and monitoring;
- supported by a PRACTICE level FUNDING system that supports the primary care team to deliver preventative health care with information management support, education and training, and research and evaluation strategies;
- monitored according to PRACTICE level TARGETS such as the provision of a 'basket of clinical services'; critical health workforce mass; information management e-health system; and research and teaching opportunities;
- measured in relation to service OUTPUTS, SHORT and LONG-TERM HEALTH OUTCOMES

**3.1 KEY PRINCIPLES UNDERPINNING FUNDING OPTIONS** (see Appendix)

- **Focus on the population:** Evidence supports systems that link appropriate payment closely to clinical outcomes rather than outputs or process measures and then leaves the system to develop the processes and outputs necessary to achieve the outcome and hence receive funding. At present the Australian funding system fails this test in the way it funds practitioners, practices and Divisions of General Practice.
- **Comprehensive health care:** Evidence suggests that preventive care should be provided in a way that enhances comprehensive health care leading to improved continuity of care and avoiding fragmentation of health care.
- **Evidence-based risk factor identification**: General practice and primary care teams need easy access to relevant, timely, up-to-date and independent evidence that risk factors exist for specific population groups. The RACGP Red Book: Guide to Preventative care in General Practice[27] provides a good starting point.
- **Evidence based interventions**: The Australian population deserves evidence-based interventions and general practice and primary care teams need easy access to evidence that is clear, relevant, timely, up-to-date and independent to convince them it is worth doing. The RACGP Red Book: Guide to Preventative care in General Practice provides useful summary.
- **A known population:** General practice and primary care teams need an identified patient population that they are responsible for to deliver preventative care and measure their effectiveness. The evidence exists and the time is right to initiate either a voluntary or compulsory patient registration system at the practice level. Patients who register could also obtain a higher MBS rebate or be 'bulk-billed' for services.
- **Appropriate infrastructure support: Tools to do the work:** general practice teams need the appropriate tools and technologies to get the work done cost-effectively. This will require **information management –e health systems:** general practice teams need an IM –e health system that helps them find targeted population groups and patients, communicate with them,


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maintain and monitor them using electronic medical records and allows information exchange between providers and patients (shared medical records).

- **Appropriately trained workforce:** preventive health care requires practitioners skilled in the delivery of preventive care. Evidence suggests that skill-mix needs to be context specific. This has implications for team composition, training and professional development.

These key principles would combine to form three key pre-conditions for preventative care, namely:

- Identification of the populations most in need of preventative care
- Implementation of effective interventions for the specific risk factors
- Monitoring progress of health status and continuous quality improvement of preventative care

### 3.2. INPUTS: A KNOWN POPULATION and PRACTICE BASED INCENTIVE SYSTEM

To provide population based preventative care requires a known population. This will need to be considered at the geographical or at the practice level. For the Australian context, we propose the practice level as the starting point.
Two mechanisms are required:

1. practice-based patient registration to determine the known practice population;
2. an upfront per capita payment (weighted by population group) to practices to deliver and coordinate a person-centred 'basket of team-based preventative care'.[i] This model would require a blended flexible payment system.[ii] This would decrease general practice reliance on the current Fee-For-Service payments, Practice Incentive Payments (PIP), Service Incentive Payment (PIP), Outcome Payment (OP) schemes for income and incentives, all of which have come with historical baggage and "red tape'. The 'person centred basket of team-based preventative care' is also designed to ensure continuous, integrated, comprehensive care and avoid fragmented care.

Importantly, any new funding system needs to be embedded within: an ongoing information management e-health strategy; education and training strategy; and research and evaluation strategy**.** To ensure that the upfront payment to practices for planning, implementation and monitoring of population-based preventative care occurs in the most cost-effective way, support for information management, practice organisation and team management is required. This could be accomplished via contractual clinical support from the divisions of general practice network (similar to the Scottish Clinical Managed Networks). This would require funding and accountability arrangements for divisions, where divisions would become directly contracted,

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- [i] Similar to the ***US Advanced Medical Home – Comprehensive Payment for Comprehensive care model, which*** provides a global fee to primary health care teams to provide integrated population-based preventative health care within the primary care setting
- [ii] This approach shows the most promise for proactive approaches which are required for preventative heath care within primary health care. For example, in Canada[ii], family physicians working in practice networks with blended capitation payments have been shown to provide incentives for promoting preventative health care and chronic disease management and to improve professional satisfaction. The Ontario Family Health Network Blended Payment System is based on: a capitated rate for all registered patients; FFS payments at a rate of 10% of the provincial schedule for most services; bonuses for targeted preventative care; payments for taking on new patients; continuing medical education allowances; practice management fees; and access to nurse practitioners paid by the government


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funded, responsible and accountable to practices. Similar models of support exist in the US (HMOs), NZ (Primary Health Organisations, (PHOs; UK (PCTs); and Canada (Family Health Teams).

The upfront payment would enable the:

- **identification of the practice population at risk** for the SNAP risk factors. The division of general practice network could assist practices to establish an information management e-health practice level system using existing methodologies and tools (e.g., PenCAT Clinical Audit, Practice Health Atlas, National Primary Care Collaboratives, GRHANITE) to establish patient registers, recall and reminder systems for patient monitoring and quality improvement. The division could assist in practice level data collection, aggregation and use for population based planning, benchmarking and continuous quality improvement.
- **whole practice to organise preventative care** for their registered practice population, based on the RACGP Red book for risk factors and interventions in general practice. The division's network could support practices to implement evidence based interventions as per the RACGP Red Book in clinical practice settings. For example, after a practice identifies their practice population health needs, the divisions could assist in the creation of '**basket of services'** (in modules) for practices to deliver or to buy in or to coordinate available preventative services (e.g., smoking cessation programs, physical activity programs, group and individual therapies, youth services etc depending upon the local context). For this to work most effectively requires mechanisms to ensure seamless co-ordination with local allied health and community services.
- **involvement in non patient contact work**, including: administration, continuing education & training, research & evaluation (see below); and quality improvement initiatives

### 3.3. PRACTICE LEVEL TARGETS

- The upfront per capita payment at practice level would need to be linked to explicit practice level performance improvement targets that if met or if progress is made, would be linked to rewards (incentive payments similar to those included in the UK Quality and Outcomes Framework). Targets would need to be established in four domains, including:

- **Provision of a 'basket of clinical services':** the practice would need to provide evidence that they have the capacity to deliver and/or coordinate a basket of preventative care services: e.g., smoking cessation programs, cervical screening services, immunisation, dietary and physical activity advice for diabetes prevention, bowel cancer screening).

- **Building a critical mass for the health workforce:** the practice would need to explicitly provide evidence that the practice is using funding for: infrastructure (e.g., staff employment (full-time practice nurse; data manager); facilities (e.g., appropriate space (rooms) and time for team meetings and skill development). Furthermore, the practice would need to show how the payment will be used equitably i.e. all core practice staff (GP, PN, PM etc) are rewarded appropriately for the practice outcomes and commitment to provide preventative health care.


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- **Establishment of information management e-health systems:** the practice would need to provide evidence that they have put into place organised office systems such as electronic medical record systems with independent decision support.

- **Provision of research and training opportunities**: the practice would need to provide evidence that they are research active, (e.g. involved in a 'practice-based research network) for the purposes of building evidence about what preventative care works for whom and in what circumstances. Furthermore, the payment would be linked to the provision of clinical placement opportunities for all primary care providers (GPs, PN, and allied health).

### 3.4. SHORT-TERM HEALTH OUTCOMES:

Given the recognition that longer time frames are required to realize preventative care outcomes, a range of measurable short-term outcomes attributable to the upfront per capita payment at a practice level are required, including:

- Improved documentation of risk factors (monitored via practice audit)
- Improved participation rates in preventive health activities (nutrition and physical activity, cervical and breast screening, bowel cancer screening, cardiovascular risk assessments, diabetes screening, immunization)
- Reductions in smoking, substance use, unhealthy eating

### 3.5. FINAL OUTCOMES

Ultimately a new funding scheme needs to contribute to the delivery of cost-effective, equitable, accessible and sustainable population-based preventative primary health care.

**In the longer-term this will lead to:**

- **Reduced patient mortality, morbidity and improved quality of life**: given that population health is a multi-dimensional phenomena, the contribution of general practice needs to be weighed up relative to other non-health interventions (e.g., education, housing etc)
- **Reduced sick days or job absenteeism (for patients and populations)**: given that workforce productivity is also a multi-dimensional phenomena, the contribution of general practice needs to also be weighed up relative to other non-health interventions (e.g., workforce and educational reforms etc)
- **Reduced expenditure on overall medical care during a life course**: given that preventative care can refer to primary, secondary and tertiary care, the contribution of community based general practice (in primary or secondary care) needs to be weighed up relative to tertiary - specialist/hospital care expenses such as reducing hospital admissions.

## Conclusion

This paper has documented the limited empirical evidence upon which to base reforms aimed at improving delivery of preventative primary health care. We propose practice based patient registration and 'up-front' practice based funding as two fundamental mechanisms worth testing


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in Australian primary care. Australia has the chance to conduct health care reform and to simultaneously contribute to the evidence base about the cost-effectiveness of such reform. The lack of randomized controlled trials to guide this discussion paper highlights the need for governments to invest in the highest quality research evidence to guide health care reform. The mechanisms proposed in this paper could be (after relevant developmental work) tested using a cluster randomized trial and thus provide conclusive evidence (or not) of cost-effectiveness before being 'rolled out' across the Nation.

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## Appendix:

*Scenario:*
*The Australian Government announces a new opt-in funding scheme for general practice. In return for supplying an agreed 'basket of team-based preventive care' the practice will receive a payment per registered patient and then offer preventive care with no co-payment. The practice manager reviews the call for interest. She identifies that the practice has 12 months to register patients (this will require getting patients to sign-up for preventive health care at the practice – which means that the patient will receive their preventive services for no out of pocket cost only if they attend their registered practice). Upon registering interest the practice receives a lump sum payment and at quarterly intervals over the first year the practice will receive an amount per registered patient. In subsequent years the payment will be on an annual basis based on the number of registered patients and tied to key performance indicators.*
*To be included in the program the practice is required to:*
*-submit a practice-based prevention strategy and document at least bi-annual review*
*-employ at least one full-time equivalent nurse*
*-use comprehensive electronic medical records and prescribing software*
*-have an identified prevention strategy co-ordinator*
*-have an identified practice data and audit co-ordinator*
*-undertake annual prevention audits*
*-routinely record essential risk factor data*
*-participate in approved prevention quality improvement activities*
*-have at least quarterly prevention team meetings*
*-provide access to approved smoking, nutrition, alcohol and substance use programs and physical activity programs for all eligible patients.*
*-have identified referral and communication pathways for allied health*
*-achieve minimum targets for designated prevention activities*


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