# 5

# Funding Models

## Introduction

5.1 At the centre of effective health care for chronic disease is the requirement to have funding and payment models that encourage and incentivise the best chronic disease prevention and health promotion, as well as the best coordinated care.

5.2 The health care system in Australia is a robust, yet divided, system of primary and secondary care that mostly treats patient 'transactions' on an individual health concern basis, such as General Practitioner (GP) care for a short-term ailment or a hospital visit for surgery or an emergency, brief recovery, then discharge.

5.3 The funding for this system is therefore predicated mainly on a fee for service (FFS) basis. However, the lack of flexibility in such a model and the requirement for flexible patient-centred care, and the funding that supports it, has led to the promotion and introduction of alternative models.

5.4 Incentive payments and the ability for bundled payments and alternative systems (such as capitation payments) to increase the benefits for chronic disease care is an increasing focus within the primary health care system, both domestically as well as internationally.

## Fee for Service Models

5.5 The current method of payment for GPs, specialists and most other primary health care providers in the Australian health care system is under the FFS model. Under this model, the medical practitioner bills their patients an amount for the provision of an individual service, as

defined and listed in the Medicare Benefits Schedule (MBS), with Medicare paying the practitioner for providing the service. Often the practitioner will charge a gap payment above the MBS fee, though they may 'bulk-bill' Medicare directly with the patient not being required to pay at the time of service at all.

5.6 This model of payment is based on the principle that each item of service is for a 'complete medical service', that each item will provide the complete treatment or service defined by the item descriptor related to that service.[1]

5.7 For example, the item descriptor for a level B standard GP consultation (MBS item 23) is:

> Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant:
>
> a) taking a patient history;
>
> b) performing a clinical examination;
>
> c) arranging any necessary investigation;
>
> d) implementing a management plan;
>
> e) providing appropriate preventive health care;
>
> in relation to 1 or more health-related issues, with appropriate documentation.[2]

5.8 Many would argue that if a patient were to present with a simple medical complaint, the complete medical service that a consultation such as that outlined above would meet their care needs. However, the complex needs of a patient with chronic disease do not necessarily fit comfortably within the framework of a complete medical service from one service interaction.

5.9 As expressed by Dr Jodi Graham:

> FFS is considered to be suitable for short, acute care illnesses, but ill-suited to chronic disease management.[3]

5.10 This view is shared by the Centre for Primary Health Care and Equity:

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1 Department of Health, MBS Online, 'Complete Medical Service', <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Complete_Medical_Service>, viewed 14 April 2016.

2 Department of Health, MBS Online, 'Item 23', <http://www9.health.gov.au/mbs/search.cfm?q=23&sopt=I&=>, viewed 14 April 2016.

3 Dr Jodi Graham, *Submission 1*, p. 2.

> Fee for service rewards the frequency and duration of care but does not adequately reward anticipatory, long term co-ordinated care.[4]

5.11 The FFS framework of paying medical practitioners to perform individual services has potentially acted as a disincentive to the establishment of integrated care practices,[5] instead making practitioners focus on individual care transactions.

5.12 The focus on individual episodes of care has widened in recent years though, as the MBS introduced chronic disease management items (items 721 to 732) intended for 'GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management plans' (CDMPs).[6]

5.13 The CDMPs are intended to help the GP assess and coordinate care for the patient across the spectrum of health care providers, however the allied health sector still feels that the integration between their providers and GPs is fragmented and that this funding does not cater for the required coordination between their sectors:

> The current model of funding, rather than promoting service integration and supporting team-based care, has created "professional silos", which results in medical and allied health professionals working independently of each other, leading to poor overall services and outcomes.[7]

5.14 Also, the Royal Australian College of General Practitioners (RACGP) identify that the chronic disease management items, while a move in the right direction to create coordinated care, have some identified shortfalls, with the appropriate allocation of this funding being addressed in their last point:

- No real differentiation between simple and complex chronic disease impacts on patients;
- Lack of flexibility in tailoring the plans that stem from the items, with excessive red tape to meet requirements;

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4 Centre for Primary Health Care and Equity, UNSW, *Submission 6*, p. 2.

5 Caroline Nicholson, Claire L Jackson and John E Marley, *Best-practice Integrated Health Care Governance – Applying Evidence to Australia's Health Reform Agenda*, Medical Journal of Australia 2014; 201 (3 Suppl): S64-S66.

6 Department of Health, MBS Online, 'Note A36', < http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A36&qt=noteID&criteria=chronic%20disease%20management>, viewed 14 April 2016.

7 Allied Health Professionals Australia, *Submission 77*, p. 3.

- Referrals to allied health professionals is complicated by the requirement to create team care arrangement plans; and
- The weighting of the rebate payment is on creating the GP management plan, and not on the follow-up monitoring and outcome consultations, where the real outcomes and benefits from chronic disease management can be realised.[8]

5.15 While these chronic disease management items are a progressive move, as long as they are still based within the traditional bounds of the FFS MBS system, they will be weighed down with the expectation of being a single fee received for a discrete service, without any real incentive for follow-up treatment or management.

5.16 Similar international FFS health care systems to Australia, such as the United Kingdom and Canada, have moved away from a reliance on FFS as the foundation of primary health care, especially for chronic disease care. Some of these systems are outlined later in this chapter.

5.17 Similarly, the 'Healthier Medicare' program of reviews and reforms underway by the Australian Government are focused on modernising the current system and bringing more flexibility to health care, not only for chronic disease patients, but all Australians.

## Medicare and the Medicare Benefits Schedule – Building Flexibility

5.18 As mentioned throughout this report, the 'Healthier Medicare' review and reform program underway in the Department of Health is intended to 'deliver a healthier Medicare to ensure Australians continue receiving the high-quality and appropriate care they need as efficiently as possible'.[9]

5.19 The Primary Health Care Advisory Group (PHCAG) helped deliver the *Better Outcomes for People with Chronic and Complex Health Conditions* report, which is the genesis for the Health Care Home trials announced to commence in July 2017. The PHCAG ceased operation from December 2015.

5.20 The Medicare Benefits Schedule Review Taskforce is still ongoing and is tasked with 'considering how the more than 5 700 items on the MBS can

8 Royal Australian College of General Practitioners, *Submission 135*, p. 7.

9 Department of Health, 'Healthier Medicare', <http://www.health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare>, viewed 14 April 2016.

be aligned with contemporary clinical evidence and practice and improve health outcomes for patients'.[10]

5.21 The MBS Review would appear to be a vehicle for looking at the modernisation of the system of FFS payments in Australia, however as highlighted by Kidney Health Australia 'the MBS review is essentially not looking at structural changes'[11], and the review itself lists 'innovative funding models for people with chronic and complex conditions' as being out of scope and the purview of the PHCAG.[12]

5.22 The final element of the 'Healthier Medicare' program is the review of Medicare compliance rules and benchmarks, but this review focuses purely on administrative compliance, measurements and fee information for consumers.[13]

5.23 Therefore, outside the completed work of the PHCAG, the reform of the MBS and Medicare to provide more flexible funding options for chronic disease is currently limited to the Health Care Home trials.

5.24 Multiple suggestions for MBS reform were made during the inquiry, including, but not limited to:

- Expanding MBS rebates for telehealth activities to include allied health consultations;[14]
- Creating MBS rebates for health professionals to spend time with families and carers of people with dementia to assess care needs;[15]
- Increasing the rebate amounts for Nurse Practitioners to continue to be able to support viable general practice;[16] and
- Creating rebate items for 'lifestyle intervention, including medical nutrition therapy, for pregnant women with gestational diabetes or

10 Department of Health, 'Medicare Benefits Schedule Review', <http://www.health.gov.au/internet/main/publishing.nsf/content/mbsreviewtaskforce>, viewed 15 April 2016.

11 Professor Timothy Usherwood, Member, Kidney Check Australia Taskforce, Kidney Health Australia, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 8.

12 Department of Health, 'About the Medicare Benefits Schedule Review', <http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-about>, viewed 15 April 2016.

13 Department of Health, 'Healthier Medicare', <http://www.health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare>, viewed 15 April 2016.

14 Services for Australian Rural and Remote Allied Health, *Submission 115*, p. 3.

15 Alzheimer's Australia, *Submission 98*, p. 3.

16 Australian Nursing and Midwifery Federation, *Submission 110*, p. 5.

obesity during the prenatal period and during the early developmental years of a child'.[17]

5.25 However, as can be seen by the focus on MBS item numbers in a lot of these suggestions, as long as the MBS focuses treatment and management principles on the rebates associated with providing care 'transactions', the incentive to provide coordinated care is diminished.

## MBS Rebate Indexation Freeze

5.26 As part of the 2014-15 Federal Budget, the Australian Government announced a freeze on the indexation of the majority of MBS rebate rates, along with a number of other payments and programs. The freeze commenced on 1 July 2015.

5.27 A number of peak body submitters commented on the negative impact this would have on their association's members or the general care patients may receive as practitioners would have to offset increasing costs elsewhere.[18]

5.28 The Royal Australian College of General Practitioners (RACGP) even suggested that the freeze could force some general practices to close, if they could not meet costs and weren't willing to charge a gap payment to their patients.[19] However, this was highlighted as only anecdotal in follow-up information provided to the inquiry.[20]

5.29 However, the RACGP also highlighted:

> The Department of Health's report on Medicare statistics shows that 97.3% of general practice health assessments, chronic disease management, mental health care and medication review services were bulk billed in 2014-15.[21]

5.30 This statistic only further serves to highlight that reform is required in the way that chronic disease care is funded in Australia. To this end, the Practice Incentive Payments system is just one element of the current health care system encouraging better practice.

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17 Dietitians Association of Australia, *Submission 148*, p. 8.

18 Rural Doctors Association of Australia, *Submission 17*, p. 10; Royal Australian and New Zealand College of Psychiatrists, *Submission 31*, p.4; Optometry Australia, *Submission 59*, p. 9; Victorian Healthcare Association, *Submission 78*, p. 2; Silver Chain Group, *Submission 97*, p. 2; Australian Medical Association, *Submission 107*, p. 2; Australian Nursing and Midwifery Federation, *Submission 110*, p. 17; Royal Australian College of General Practitioners, *Submission 135*, p. 6; Aboriginal Medical Services Alliance Northern Territory, *Submission 153 – Attachment 1*, p. 2; Queensland Government, *Submission 167*, p. 18.

19 Royal Australian College of General Practitioners, *Submission 135*, p. 6.

20 Royal Australian College of General Practitioners, *Submission 135.1*, p. [2].

21 Royal Australian College of General Practitioners, *Submission 135.1*, p. [2].

## Practice Incentive Payments

5.31 The Practice Incentives Program (PIP), introduced in 2001, is aimed at supporting general practice activities that 'encourage continuing improvement, quality care, enhance capacity, and improve access and health outcomes for patients'.[22] It is administered by the Department of Human Services on behalf of the Department of Health, and consists of Practice Incentive Payments for eleven different areas:

- Asthma Incentive;
- After Hours Incentive;
- Cervical Screening Incentive;
- Diabetes Incentive;
- eHealth Incentive;
- General Practitioner Aged Care Access Incentive;
- Indigenous Health Incentive;
- Procedural General Practitioner Payment;
- Quality Prescribing Incentive;
- Rural Loading Incentive; and
- Teaching Payment.[23]

### Overview of the Practice Incentive Program

5.32 The Asthma Incentive encourages GPs to better manage the clinical care of people with moderate to severe asthma. There are two components to the incentives. The first is a one-off sign-on payment to the practice of $0.25 per Standardised Whole Patient Equivalent (SWPE). A practice must use a patient register and a recall and remind system, and implement a 'cycle of care' for their patients with asthma. The second component is a service incentive payment to the GP of $100 per patient per year for each completed cycle of care.[24]

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22 Department of Human Services, 'Practice Incentives Program', https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program, viewed 11 April 2016.

23 Department of Human Services, 'Practice Incentives Program', https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program, viewed 11 April 2016.

24 Department of Human Services, 'Practice Incentives Program Asthma Incentive Guidelines – October 2013', https://www.humanservices.gov.au/sites/default/files/documents/asthma-pip-guidelines.docx.

5.33 The Diabetes Incentive similarly has sign-on and service incentive payments, as well as an outcomes payment for practices reaching a target level of care for patients with diabetes.[25] The Cervical Screening Incentive likewise has sign-on, service incentive and outcomes payments, with a target of 'at least 70 per cent of eligible patients' screened within a 30 month period.[26] The Indigenous Health Incentive also has the same three components.[27]

5.34 The GP Aged Care Access Incentive aims to encourage GP services in Residential Aged Care Facilities, with the service incentive payment based on a required number of services provided.[28]

5.35 The Procedural GP Incentive encourages GPs in rural and remote areas to provide non-referred procedural services which would normally be specific referral-based specialty services in urban settings, including obstetric deliveries and certain general anaesthetic and surgical services. There are four tiers of payments provided to GPs according to the type and number of services provided.[29] Rural practices also benefit from the Rural Loading Incentive, which recognises the difficulties of providing care in rural and remote areas by providing a loading for practices according to the population of the locality.[30]

5.36 The After Hours Incentive gives an incentive payment for practices that provide access to care after hours, considered to be outside 8am to 6pm on weekdays, 8am to noon Saturdays, and on Sundays and public holidays.

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25 Department of Human Services, 'Practice Incentives Program Diabetes Incentive Guidelines – October 2013', https://www.humanservices.gov.au/sites/default/files/documents/diabetes-pip-guidelines.docx.

26 Department of Human Services, 'Practice Incentives Program Cervical Screening Incentive Guidelines – July 2012', https://www.humanservices.gov.au/sites/default/files/documents/cervical-screening-pip-guidelines.docx.

27 Department of Human Services, 'Practice Incentives Program Indigenous Health Incentive Guidelines – February 2014', https://www.humanservices.gov.au/sites/default/files/documents/indigenous-health-pip-guidelines.docx.

28 Department of Human Services, 'GP Aged Care Access Incentive Guidelines – September 2013', https://www.humanservices.gov.au/sites/default/files/documents/gp-aged-care-pip-guidelines.docx.

29 Department of Human Services, 'Practice Incentives Program Procedural GP Payment Guidelines – October 2013', https://www.humanservices.gov.au/sites/default/files/documents/procedural-gp-pip-guidelines.docx.

30 Department of Human Services, 'Practice Incentives Program Rural Loading November 2013', https://www.humanservices.gov.au/sites/default/files/documents/rural-loading-pip-guidelines.docx.

The rate of payment is based on SWPE and depends on the level of participation.[31]

5.37 The eHealth Incentive provides a payment of $6.50 per SWPE for practices meeting five requirements for adopting eHealth technology.[32] The Quality Prescribing Incentive aims to encourage GPs to 'keep up-to-date with information on the quality use of medicines', rewarding participation in certain activities which promote more effective, quality use of medicines, based on the practice's SWPE.[33]

5.38 Finally, the Teaching Incentive encourages practices to train undergraduate and graduate medical students by giving them experience working in general practice. The payments are to compensate for the reduced number of consultations due to the presence of the student.[34]

## The Role of the Practice Incentive Program

5.39 A number of submissions and witnesses outlined the role the Practice Incentive Program has in encouraging efficiency and quality care. For example, the Consumer Health Forum supports PIPs as a way of improving coordination and integration of care for people with complex and chronic health needs, and emphasised:

> …the need for a system of practice incentive payments that recognises the complexity of their case load and provides financial incentives to manage people with chronic diseases in a more holistic way.[35]

5.40 The Australian Medical Association stated that the Practice Incentives Program is the 'best place to do those pay for performance' payments, but that it needs to be expanded 'just a little bit so that not just the practice

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31 Department of Human Services, 'After Hours Incentive', https://www.humanservices.gov.au/health-professionals/enablers/after-hours-incentive, viewed 12 April 2016.

32 Department of Human Services, 'Practice Incentives Program eHealth Incentive – January 2016', https://www.humanservices.gov.au/sites/default/files/documents/ehealth-incentive-guidelines.v0.3.docx.

33 Department of Human Services, 'Quality Prescribing Incentive Guidelines – October 2013', https://www.humanservices.gov.au/sites/default/files/documents/quality-prescribing-pip-guidelines.docx.

34 Department of Human Services, 'Practice Incentives Program Teaching Payment Guidelines – December 2014', https://www.humanservices.gov.au/sites/default/files/documents/teaching-pip-guidelines.docx.

35 Consumers Health Forum of Australia, *Submission 159*, p. 5.

gets the performance payment but also the actual doctor that does the work'.[36]

5.41 The Improvement Foundation stated that:

> …using a Quality PIP, the Government could gradually increase requirements by focussing on payment for improvement as opposed to payment for performance.[37]

5.42 There were several suggestions about expanding the PIPs. For example, the joint submission from the Primary Care Collaborative Cancer Clinical Trials Group, the Clinical Oncology Society of Australia and Cancer Council Australia recommended including the breast and bowel cancer screening programs in addition to the current Cervical Screening Incentive.[38]

5.43 Lung Foundation Australia proposed introducing a PIP for patients who have been admitted to hospital with an exacerbation of their lung disease to ensure they are 'discharged with a follow-up plan to ensure appropriate linkage to primary care to manage their condition'.[39]

5.44 A number of submissions proposed the use of Practice Incentive Payments (PIPs) to encourage and facilitate the use of Integrated Health Checks (IHCs).[40] The IHC approach is outlined in the submission from the National Vascular Disease Prevention Alliance,[41] and discussed in Chapter 4.

5.45 Arthritis Australia stated that an Arthritis Incentive could assist in implementing the Musculoskeletal Primary Health Care Initiative (PHCI) across all Primary Health Networks. Arthritis Australia stated that rolling the PHCI out has 'the greatest potential achieve to improvements and cost savings in [osteoarthritis] care in the short term'.[42]

5.46 Other suggestions for additional incentive payments included an optometry incentive[43] and a nutrition care incentive.[44]

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36 Dr Brian Morton, Chair, Council of General Practice, Australian Medical Association, *Official Committee Hansard*, Sydney, 23 October 2015, p. 30.

37 Improvement Foundation, *Submission 179*, p. 5.

38 Primary Care Collaborative Cancer Clinical Trials Group, Clinical Oncology Society of Australia and Cancer Council Australia, *Submission 63*, p. 8.

39 Lung Foundation Australia, *Submission 66*, pp 9-10, 12.

40 Australian Health Promotion Association, *Submission 49*, p. 12; Diabetes Australia, *Submission 102*, pp 3-4; National Stroke Foundation, *Submission 113*, p. 8; National Vascular Disease Prevention Alliance, *Submission 121*, pp 8-9; Kidney Health Australia, *Submission 126*, pp 6-7; Heart Foundation, *Submission 131*, pp 8-9;

41 National Vascular Disease Prevention Alliance, *Submission 121*, pp 7-16.

42 Arthritis Australia, *Supplementary Submission 141.1*, pp 1-2.

43 Optometry Australia, *Submission 59*, p. 10.

5.47 Ultimately, practice incentives are intended to encourage practitioners to coordinate and plan care for chronic disease patients in the longer term, rather than treating their illness on a transactional basis.

## Other Funding Models

5.48 Along with comments on the current Medicare system and its fee-for-service structure, many submissions and witnesses discussed alternative payment models.

5.49 One model that was raised numerous times in submissions and at public hearings is known as capitation. Capitation was defined by the Adelaide Primary Health Network:

> Capitation is a way of paying an annual fee to a single practice for the complete care of each patient they have enrolled at their practice. It means that practices can benefit from ensuring that their patients remain healthy and well.[45]

5.50 Capitation is used in various jurisdictions around the world. According to the Consumers Health Forum of Australia:

> Patient enrolment models are a standard feature of many international healthcare systems including countries such as UK, the Netherlands, Norway, Denmark, New Zealand, Spain and Italy.[46]

5.51 Capitation is often discussed in connection with 'bundled' or 'blended' payment models. For example, a funding model may include capitation along with a pay-for-performance system or pay-for-service, or both. Medibank Private supported such a system, stating:

> A model that considers blended funding, combining fee-for-service, block funding and performance based payments could be implemented to better support people with chronic disease.[47]

5.52 The Adelaide Primary Health Network described how a bundled system might work:

> For the prevention and management of chronic disease, a bundled care package can be paid to one entity who then hold the funding and apportions it among the participating care providers for a patient. A care coordinator from that entity, working in

44 Dr Lauren Ball, *Submission 5*, p. 2.

45 Adelaide Primary Health Network, *Submission 119*, p. 38.

46 Consumers Health Forum of Australia, *Submission 159*, p. 5.

47 Medibank Private, *Submission 43*, p. 12.

> partnership with the patient, allows for a cost-effective approach to the implementation of the package.[48]

5.53 Support for capitation or a bundled payment funding model has been common through the inquiry in both submissions and at public hearings.[49] The Western Australia Primary Health Alliance commented that there needs to be more flexibility around bundling payments which better link and incentivise collaboration for people with recurring chronic illnesses, particularly those with multiple co-occurring illnesses.[50] This was supported by Professor Alistair Vickery at the Perth hearing.[51]

5.54 The Centre for Primary Health Care and Equity at the University of NSW (PHCE) notes that bundled payment models 'provide flexibility to develop innovative ways to deliver care including through other providers and modalities'.[52]

5.55 The Australian College of Nursing stated that it supports trialling mixed models of capitation, grants, and outcomes-based payments, and that such models 'deliver a range of incentives that would better support the ongoing, multidisciplinary care that much of the community requires'.[53]

5.56 Dr Louisa Hope, a GP in the Castlemaine area of Victoria, suggested a model blending fee for service for some procedures with funding 'per head of patient' or for chronic health patients:

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48 Adelaide Primary Health Network, *Submission 119*, p. 39.

49 Rural Doctors Association of Australia, *Submission 17*, p. 9; National Rural Health Alliance, *Submission 67*, p. 12; Royal Australasian College of Physicians, *Submission 81*, pp 4-5; Dr Paul Burgess, *Submission 92*, p. 6; Alzheimer's Australia, *Submission 98 – Supplementary*, p. 6; Australian Nursing and Midwifery Federation, *Submission 110*, pp 17-18; South Eastern Melbourne PHN, *Submission 123*, p. 5; Australian Primary Health Care Research Institute, *Submission 124*, pp 8-9; Arthritis Australia and Australian Rheumatology Association, *Submission 141*, p. 14; Primary Health Tasmania, *Submission 142*, pp 11-12; Department of General Practice, University of Melbourne, *Submission 151*, pp 4-5; NSW Health, *Submission 152*, p. 5; Sydney North PHN, *Submission 155*, p. 2; GMHBA, *Submission 157*, pp 3-4; Consumers Health Forum of Australia, *Submission 159*, p. 5; Queensland Government, *Submission 167*, p. 7; Brisbane North PHN, *Submission 182*, p. 3.

50 Professor Learne Durrington, Chief Executive Officer, Western Australia Primary Health Alliance, *Official Committee Hansard*, Perth, 11 March 2016, p. 19.

51 Associate Professor Alistair Vickery, Primary Health Care, School of Primary Aboriginal and Rural Health Care, University of Western Australia, *Official Committee Hansard*, Perth, 11 March 2016, pp 20, 23.

52 Centre for Primary Health Care and Equity, University of NSW, *Submission 6,* p. 3.

53 Ms Kathleen McLaughlin, Acting Chief Executive Officer, Australian College of Nursing, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 38.

> If they were then registered with your clinic and the care stayed within your clinic, you would have a per capita payment for each patient that you were looking after over that year. [54]

5.57 Some submissions did raise caution about the capitation or enrolment-based models. The PHCE cautioned that enrolment must be available to all and to ensure that disadvantaged patients do not fall through the cracks.[55] The Australian Primary Health Care Research Institute also emphasised that cherry picking must be avoided and equitable access to service for high-need individuals must be ensured.[56]

5.58 Pay-for-coordination (PFC) is another funding model, used in some countries in Europe. The model:

> …consists of payments to one or more providers to coordinate care between certain care services. It seeks to provide an incentive for the extra effort required by stakeholders to cooperate with one another, share organized, transparent information on healthcare delivery and health outcomes, often set to predefined standards.[57]

5.59 The experiences of this type of funding model in European countries is discussed further below.

5.60 Pay-for-performance (PFP) offers incentives based on certain performance indicators. It is used in the United Kingdom of Great Britain (UK), introduced in 2004 in the Quality and Outcomes Framework (QoF), in which GPs receive financial rewards if they reach certain targets in quality, process, and outcome. This scheme is discussed further below.

## International Experiences of Alternative Funding

5.61 Many submissions and witnesses raised examples of international health care funding models Australia should examine. Most commonly discussed were the systems in the Netherlands, the UK, the United States of America (USA), New Zealand, and the Canadian province of Ontario.

5.62 At the public hearing in Perth, Dr Jodi Graham spoke about different systems being used in Europe, tabling an article from *Health Policy*

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54 Dr Louisa Hope, General Practitioner, Mostyn Street Clinic, *Official Committee Hansard*, Bendigo, 18 November 2015, p. 25.

55 Centre for Primary Health Care and Equity, University of NSW, *Submission 6,* p. 3.

56 Australian Primary Health Care Research Institute, *Submission 124*, p. 9.

57 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), pp 297-8.

discussing integrated chronic care in Europe.[58] The article examines several European countries employing pay-for-coordination, pay-for-performance and bundled payment systems. Austria, France, England, the Netherlands, and Germany 'have implemented payment schemes that were specifically designed to promote the integration of chronic care'.[59]

5.63 Dr Graham said these European systems 'are basically all pay for coordination and pay for performance', and that they are having 'a lot more success than Australia and the US at the moment'.[60]

5.64 The *Health Policy* article described pay-for-coordination schemes in Austria, France, and Germany, and pay-for-performance schemes in England and France, as well as discussing the bundled payment system in the Netherlands.

## The Netherlands

5.65 As discussed in Chapter 3, the Netherlands has a public-private hospital system. Dutch residents are required to purchase statutory health insurance from private insurers. The system is financed 'through a nationally defined, income-related contribution, and through community-rated premiums set by each insurer'.[61]

5.66 The Dutch system has GPs as the central figure in primary care, with other providers including dentists, midwives and physiotherapists. Hospital and specialist care, other than emergency care, is accessible upon referral from a GP. All citizens are registered with a GP of their choice. [62]

5.67 When a Dutch resident with the requisite insurance is diagnosed with a chronic disease, their care can be met by a bundled-payment system. Under the bundled-payment system:

> …insurers pay a single fee to a contracting entity, the care group, to cover all of the primary care needed to manage a chronic condition. The care groups are often exclusively owned by general

58 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), pp 296-304.

59 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 296.

60 Dr Jodi Graham, *Official Committee Hansard*, Perth, 11 March 2016, p. 6.

61 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 9.

> practitioners who assume both clinical and financial responsibility on the basis of bundled-payment contracts.[63]

5.68 These care groups either deliver the care themselves or subcontract to other care providers.[64]

5.69 The University of Wollongong (UoW) notes that the service bundles are negotiable by insurers and care groups, and subcontracted services are negotiable by care groups and providers. This allows for flexibility in developing different models, but has also resulted in price variations.[65] These price variations may challenge the community rated basis for insurance costs in the Netherlands, but have continued to work up until now.

5.70 The Dutch system is 'disease specific', and started with diabetes, but is being rolled out 'to all chronic diseases'.[66]

5.71 The positive effect of this system has been highlighted, for example, by the Australian College of Rural and Remote Medicine.[67]

5.72 Studies have found improvements in diabetic care through this system, as well as positive patient experience.[68]

5.73 This positive impact was also reported by *Health Policy*:

> …the bundled payment scheme was perceived as having a positive structural impact on financing and process delivery of chronic care, increased provider cooperation within the primary care sector, and promoted the integration of financing of different care sectors.[69]

5.74 In addition to these benefits, the scheme was seen to have 'improved protocol adherence and record keeping, and promoted competition between health care providers', although it was also reported to have

63 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 10.

64 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 10.

65 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 10.

66 Dr Jodi Graham, *Official Committee Hansard*, Perth, 11 March 2016, pp 5-6.

67 Australian College of Rural and Remote Medicine, *Submission 76*, p. 8.

68 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 10.

69 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 302.

introduced new financial constraints and failed to decrease the growth of health care expenditure.[70]

## Other European Countries

5.75 Austria, France, and Germany have implemented variations of pay-for-coordination (PFC) systems, aiming to promote the use of Disease Management Programs (DMPs) for specific chronic conditions. Austria created 'financial pools' by 'combining 1-2 per cent of the budget of social health insurers with that of regional governments. France initiated 'a negotiation between the social health insurance and the association of GPs'. German health insurers receive a 'fixed fee per patient per year for costs in primary and secondary care', with remuneration for enrolling patients with chronic conditions in DMPs.[71]

5.76 Implementation of PFC models has been perceived as 'successful with relatively high uptake in Germany and France', while in Austria it has been seen as less effective, 'as actors did not respond to the incentives with which they were provided'.[72]

5.77 France has a PFP scheme in which GPs are rewarded, 'not for specific disease treatments but rather for adequately registered patient records and for following evidence based guidelines'.[73]

## Canada

5.78 Ontario, Canada had a fee-for-service system similar to Australia's until it began shifting to a blended model incorporating capitation and pay-for-performance.[74] According to the UoW, Canada over the last decade has had movement towards group practices, with:

70 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 302.

71 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 299.

72 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 301.

73 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 300.

74 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 1.

> …a shift from unitary physician payment methods (mainly fee-for-service) to payment arrangements that include blends of fee-for-service, capitation, salary, or payments per session.[75]

5.79 The blended model in Ontario is:

> …an interdisciplinary team essentially paid almost completely – all but 10 per cent – by capitation, and there are incentives for quality primary care management.[76]

5.80 Patients in Ontario belong 'to a group of doctors… [who] work with allied health professionals and practice nurses'.[77]

5.81 The UoW's Graduate School of Medicine stated that Ontario's experience suggested that blended models 'can provide a favourable balance between productivity and quality in CDM measures in primary care'.[78]

5.82 The UoW also reported that 'population-based bonuses provide incentives' for services including 'Pap smears', flu immunisations, and cancer screening:

> A growing, but still limited, body of evidence suggests that the payment models and incentives introduced in Ontario are improving preventive care delivery, chronic disease management, physician productivity, and access to care.[79]

5.83 The UoW report also found that pay-for-performance incentives have improved care in Ontario.[80]

## United Kingdom of Great Britain

5.84 The UK introduced the 'Quality and Outcomes Framework' (QOF) in 2004, offering pay-for-performance contracts to GPs, who are rewarded based on performance indicators across four domains: clinical standards,

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75 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 10.

76 Professor Grant Russell, Director, Southern Academic Primary Care Research Unit, Monash University, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 29.

77 Adjunct Professor Michael Moore, Chief Executive Officer, Public Health Association of Australia, *Official Committee Hansard*, Canberra, 21 August 2015, p. 30.

78 Graduate School of Medicine, University of Wollongong, *Submission 16*, p. 1.

79 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 11.

80 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 11.

organisational standards, patient experience, and additional services.[81] The QOF rewards practices for 'delivering quality targets and improving data capture'. The funding enables practices to employ nurses to implement the quality initiatives identified, while the data collected contributes to the development of innovative approaches.[82]

5.85 The University of Melbourne calls the QOF 'the largest and most highly developed pay for performance… system in primary care in the world', noting that it contains important lessons for using PFP to 'target clinical need associated with socioeconomic disadvantage'. The University of Melbourne stated that an evaluation of the QOF suggests that PFP schemes 'can contribute to the reduction of inequities in the delivery of clinical care'.[83]

5.86 The uptake of PFP was reported as 100 per cent in England, and 30 per cent initially in France before climbing to 90 per cent within three years. The PFP schemes in both England and France led to 'positive structural changes in chronic care financing and chronic care delivery'.[84] The Better Care Fund was established in 2013 to encourage integrated health and social care. It was established as a single pooled budget to encourage the UK's National Health Service to work more collaboratively with local government around people, with a focus on reducing hospital admissions and improving financial savings.[85]

5.87 The King's Fund, a UK health policy think tank, was referenced by several submissions.[86] Professor Jeffrey Fuller called the King's Fund 'an informative clearing house of research and best practice exemplars' whose research substantiates the need for long-term thinking.[87]

5.88 A 2013 King's Fund report titled 'Co-ordinated care for people with complex chronic conditions' investigated five UK programs of care coordination for people with chronic conditions, identifying key success factors at personal, clinical and service, community, functional, organisational, and system levels.

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81 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 300.

82 Sydney North PHN, *Submission 155*, pp 1-2. See also the Royal Australasian College of Physicians, *Submission 81*, p. 5.

83 Department of General Practice, University of Melbourne, *Supplementary Submission 151.1*, p. 5.

84 Tsiachristas, A et al, 'Exploring payment schemes used to promote integrated chronic care in Europe', *Health Policy* 113 (2013), p. 302.

85 Cohealth, *Submission 88*, pp 11-12.

86 Professor Jeffrey Fuller, *Submission 22*, p. 2; National Rural Health Alliance, *Submission 67*, p-17-18; South Eastern Melbourne PHN, *Submission 123*, Attachment B; Queensland Government, *Submission 167*, p. 6.

87 Professor Jeffrey Fuller, *Submission 22*, p. 1.

5.89 These factors highlighted the importance of a holistic patient focus and dedicated care coordinators. Other key factors included tailored care plans, multidisciplinary care teams, localised care coordination programs and local leadership, and a single source of funding.[88]

5.90 One key observation of the report was that 'success in care co-ordination appears to be the result of a long-term process, facilitated by key local leaders'.[89] Another observation was the importance of context: highlighting this observation in the report, South Eastern Melbourne PHN commented, 'an approach that works in inner Melbourne would need to be effective on the city outskirts or in a rural area'.[90]

## United States of America

5.91 In the United States, the Kaiser Permanente (KP) health care system is held up as an 'exemplar' system that has 'achieved good outcomes in chronic disease management'. The key feature is:

> …defined populations for which organisations have overall responsibility for health care with a funding model that provides a suite of care that is planned and continuous rather than reactive and episodic.[91]

5.92 The KP system is a 'closed-group model', and has about eight million members across nine American states and Washington, D.C. It is described as being different from other programs with its strong emphasis on preventive care. The system uses a shared electronic health record system which patients can access. Doctors are salaried rather than paid for service, reducing incentives for unnecessary procedures, and KP also aims to minimise the amount of time spent in hospital.[92]

5.93 Studies of the KP model compared to other systems found lower rates of hospitalisation, particularly for 'preventable hospitalisations and readmissions associated with chronic conditions'.[93]

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88 Goodwin, N et al, 'Co-ordinated care for people with complex chronic conditions', King's Fund (2013), pp 25-27.

89 Goodwin, N et al, 'Co-ordinated care for people with complex chronic conditions', King's Fund (2013), p. 27.

90 South Eastern Melbourne PHN, *Submission 123*, Attachment B.

91 Professor Jeffrey Fuller, *Submission 22*, p. 2.

92 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, pp 11-12.

93 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, pp 12, 27.

5.94 The 'Kaiser Permanente Pyramid' attempts to target scarce resources towards those most in need by segmenting populations 'into groups to which interventions can be targeted'.[94]

5.95 The KP model has a positive reputation outside of the US and was broadly held up in this inquiry as a noteworthy model in submissions and public hearings.[95] South Eastern Melbourne PHN highlighted the early identification of lifestyle risk factors and the role of a 'designated care coordinator'.[96]

5.96 It must be acknowledged that the KP system is essentially a coordinated health care commissioner, provider and insurer within the US 'user pays' system, however many of the coordinated care and funding principles that are used by KP can help inform chronic disease care in Australia.

## New Zealand

5.97 The Canterbury Model was developed to focus on integrating health and social care as a way of stemming the growing demand for hospital care.[97] The model was developed by the Canterbury District Health Board, in the South Island of New Zealand, and has attracted international attention for achieving better client care pathways.[98]

5.98 The focus in the region has been on 'purposefully building up general practice to be able to look after people with complex chronic conditions'. The aim is to keep people out of hospital if they do not need it, to treat them quickly when they do need it, and to discharge them to good community support.[99]

5.99 The system has reportedly saved 'more than a million days of waiting for treatment in just four clinical areas in recent years', with fewer patients entering care homes, better and quicker care with less need for hospital

94 Royal Australian College of General Practitioners, *Submission 135*, p. 4.

95 Metro North Hospital and Health Service, *Submission 9*, p. 1; Graduate School of Medicine, University of Wollongong, *Submission 16*, p. 1; Australian Healthcare and Hospitals Association, *Submission 40*, p. 21; Victorian AIDS Council, *Submission 47*, p. 13; Australian College of Rural and Remote Medicine, *Submission 76*, p. 11; WA Primary Health Alliance, *Submission 180*, p. 10;

96 South Eastern Melbourne PHN, *Submission 123*, Attachment B.

97 The Kings Fund, 'Case study 5: Canterbury District Health Board, New Zealand', <http://www.kingsfund.org.uk/time-to-think-differently/publications/reforming-nhs-within/case-study-5-canterbury-district-health-board-new-zealand>, viewed 19 April 2016.

98 Professor Jeffrey Fuller, *Submission 22*, p. 2.

99 South Eastern Melbourne PHN, *Submission 123*, Attachment B.

visits, and a budget that went from NZ $17m in deficit in 2007 to a NZ $8m surplus by 2010-11.[100]

5.100 While not strictly a funding model, the impact of improved care coordination and avoiding unnecessary treatment and hospital admissions has had a profound impact on the cost of chronic disease care, as outlined above.

5.101 One feature of the Canterbury Model is its 'HealthPathways', described as 'local agreements on best practice':

> They are created by bringing together hospital doctors and GPs in order to hammer out what the patient pathway for a particular condition should be. They spell out which treatments can be managed in the community; what tests GPs should carry out before a hospital referral; where and how GPs can access such resources…[101]

5.102 This feature has been used as a model for similar approaches in Australia, as discussed in a number of the public hearings and submissions[102] and as highlighted in Chapter 4.

## Concluding Comment

5.103 Funding of chronic disease prevention and management in Australia is a complex web of responsibilities, performance measures and outcomes.

5.104 At the core of primary health care is the MBS fee for service (FFS) model, delivering episodic care to the vast majority of Australians in an adequate manor to manage their minor health issues, or ongoing care for simpler health issues. However, the adequacy of the FFS model for coordinated prevention and care of chronic disease/s is clearly lacking.

5.105 The Committee acknowledges the moves made in introducing chronic disease management items to the MBS in recent years, but the

100 Timmins, N and Ham, C, 'The quest for integrated health and social care: A case study in Canterbury, New Zealand', The King's Fund, p. 6.

101 Timmins, N and Ham, C, 'The quest for integrated health and social care: A case study in Canterbury, New Zealand', The King's Fund, p. 21.

102 Mr Matthew Jones, Chief Executive Officer, Murray Primary Health Network, *Official Committee Hansard*, Melbourne, 1 October 2015, pp 55-56; Mr Jason Trethowan, Chief Executive Officer, Western Victoria Primary Health Network, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 57; Professor David Ashbridge, Chair, Western Alliance Academic Health Science Centre, *Official Committee Hansard*, Bendigo, 18 November 2015, p. 19; Ms Megan Clark, Benefits Manager, GMHBA Health Insurance, *Official Committee Hansard*, Bendigo, 18 November 2015, pp 29-31; Centre for Primary Health Care and Equity, University of NSW, *Submission 6*, p. 2; Kidney Health Australia, *Submission 126*, p. 9.

overwhelming opinion expressed in this inquiry is that these MBS items do not go far enough to encourage and incentivise care models that deliver the best outcomes for patients.

5.106 The international examples outlined above show that similar international jurisdictions to Australia have either evolved into coordinated, bundled payment systems, or are in the process of doing exactly that, based on the overwhelming evidence that the models of care outlined in Chapter 4 deliver better outcomes, and ultimately better return on investment in care for chronic disease.

## Health Care Homes

5.107 The Prime Minister and Health Ministers' joint announcement of the trials of Health Care Homes for chronic disease patients, commencing in July 2017, combines many of the elements of care reform and funding models outlined in Chapter 4 and this chapter. The work of the Primary Health Care Advisory Group (PHCAG), culminating in its *Better Outcomes for People with Chronic and Complex Health Conditions* report, is an indication that the intended improvements from the 'Healthier Medicare' reform agenda is achieving outcomes.

5.108 The bundling of payments for Health Care Homes into quarterly payments, to be coordinated and paid to the patients 'home' practice for all required medical, allied health and out-of-hospital services[103] is a welcome reform to the traditional FFS system for the care required by chronic disease patients.

5.109 The Committee congratulates the Australian Government for announcing this reform, and while the final detail of the trials is forthcoming, the development of such an initiative can only benefit chronic disease patients into the future.

5.110 The Health Care Home implementation advisory group outlined as part of the announcement to 'oversee the design, implementation and evaluation of the trials'[104] has an important job ahead to manage a watershed moment in providing best practice care to chronic disease patients in Australia.

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103 The Hon. Malcolm Turnbull MP, Prime Minister and The Hon. Sussan Ley MP, Minister for Health, Minister for Aged Care, Minister for Sport 'A *Healthier Medicare* for chronically-ill patinets', *Media Release*, 31 March 2016.

104 The Hon. Malcolm Turnbull MP, Prime Minister and The Hon. Sussan Ley MP, Minister for Health, Minister for Aged Care, Minister for Sport 'A *Healthier Medicare* for chronically-ill patinets', *Media Release*, 31 March 2016.

## Moving into the Future

5.111 While the Health Care Home trials are a welcome move, the Committee believes that the primary health care system in Australia can aim for more elements of the best practice care and funding models outlined in this report.

5.112 Ultimately, the model of care that brings together the best elements of all the theoretical and practical examples outlined contains:

- Blended payments – FFS for ordinary health care needs, bundled and capitation payment methods for ongoing chronic care, as well as salaried chronic care physicians;
- Pay for performance – rather than pay individual practitioners for a 'treatment', measure the outcome of the suite of care provided and pay based on outcome;
- Chronic Care Methodology and patient-centred care – bringing together the patient, their families, all their required health care providers and coordinating their care, in agreement with the patient themselves;
- Prevention of disease or progression – incentivise the care and education required of both the patient and their care providers to enable avoidance of, or slow the progression of, chronic disease; and
- Supported by well-funded and coordinated eHealth systems – expansion of the My Health Record to become the central repository of patient data, augmented by practice data and de-identified central government treatment data, that can be used for performance measurement, as well as research and outcomes-based improvement.[105]

5.113 The Australian primary health care system cannot change into a cohesive system of reformed care in a short period. Much like the long-term investment required for creating chronic disease prevention policies work, as outlined in Chapter 4, the time investment required to reform chronic disease management is long-term as well.

5.114 Long-term investment in improvements to chronic disease prevention and management is important. The rapid movement from Medicare Locals to Primary Health Networks has challenged the primary health care system to find stability and care continuity, so the continued investment and consolidation in the Primary Health Network model is imperative to measuring success and improving care into the future.

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105 Adapted from the 'Key Principles Underpinning Cost Effective Modles of Primare Care Funding' outlined in Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 29.

5.115 The Committee is also of the opinion that the Practice Incentives Program should be examined for potential expansion, along the lines of some of the payments for coordination outlined earlier in this chapter, especially the potential for a PIP for breast, bowel and skin cancer screening, as well as the Integrated Health Check outlined above and in Chapter 4.

5.116 These expanded Practice Incentive Programs can then be evaluated to identify improvements to associated chronic disease management.

5.117 Additionally, the Committee recommends that the Australian Government continue to fund the evolution and expansion of the My Health Record, managed by the Australian Digital Health Agency from 1 July 2016. The importance of patient-managed care information, as well as the resultant data that can be used to measure successes, failures and outcomes, as identified in Chapter 4, is essential to moving the primary health care system into the future.

## Recommendations

### Recommendation 11

5.118 **The Committee recommends that the Australian Government commit to providing consistent support and funding for the establishment of Primary Health Networks or similar into the future, to enable consistent development and support for chronic disease prevention and management.**

### Recommendation 12

5.119 **The Committee recommends that the Australian Government examine the current Practice Incentives Program with the aim that it be expanded to include programs for breast, bowel and skin cancer screening, as well as the Integrated Health Check developed by the National Vascular Disease Prevention Alliance; and**

**That these programs, as well as the existing Practice Incentive Programs, be evaluated and measured to identify improvements to management of chronic disease.**

### Recommendation 13

5.120 **The Committee recommends that the Australian Government continue to prioritise funding of the evolution and expansion of the My Health Record to support improvements in the prevention and management of chronic disease, as well as the wellness of all Australians.**

Steve Irons MP
Chair

3 May 2016