Understanding general practice funding models in Australia and beyond

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Background
Australia is undergoing general practice funding reform, with recent changes to Medicare and the introduction of MyMedicare voluntary patient registration.

Objective
Within this context, we provide general practitioners (GPs) with an explainer on health economic concepts relevant to current funding reform debates. This article outlines different funding model types, discusses the theoretical advantages and disadvantages of each funding model, and reflects on past experiences of reform.

Discussion
Common GP funding models across the world include fee for service, capitation, pay for performance and bundled payments. Each funding model has its potential advantages and disadvantages. Blended funding models can minimise undesired consequences of individual funding models but can introduce additional complexity. The challenge remains to design funding models that enable access to quality care, adequately pay providers and are sustainable into the future.

GENERAL PRACTITIONERS (GPs) are often the first point of contact in the Australian healthcare system, with nearly nine out of 10 Australians visiting a GP at least once a year.[1] First established in 1984, Medicare is Australia's public health insurer. Patient attendances at general practices are subsidised by Medicare patient reimbursements, according to the Medicare Benefits Schedule (MBS).[2,3] The MBS provides fee-for-service (FFS) payments to healthcare providers for agreed services. MBS payments might constitute the full payment for a service ('bulk billing'), or providers might charge fees greater than the MBS rebate, in which case the patient bears additional out-of-pocket costs. Medicare turns 40 this year. This milestone has brought into sharp focus discussions and debates around the financial viability of practices, increasing out-of-pocket costs for patients, a gap in remuneration for GPs versus other specialists (contributing to workforce shortages) and other related funding concerns.

General practices currently receive approximately 6.5% of the total health expenditure.[4] Over several decades, the MBS has been criticised for not reflecting contemporary clinical practice and for insufficient rebates that have not kept pace with inflation.[3,5–7] Although the Medicare FFS system incentivises a high volume of care, the funding model does not encourage integrated care, continuity or preventative health.[8–11] Thus, there is interest from funders and policymakers to explore alternative funding models to both improve quality of care and manage increasing healthcare costs.[3,8,12–14]

To achieve the aims of implementing effective primary healthcare in Australia,[15] the 2022 Strengthening Medicare Taskforce Report highlighted a need to review and reform current funding models.[8] Within this context, we aim to equip Australian GPs with health economic concepts relevant for participating in current funding reform debates. We begin with an overview of funding model types, discuss the theoretical advantages and disadvantages of each funding model, reflect on past experiences of reform, and conclude with a discussion on recent changes to Medicare.

What funding models are used to pay GPs?

Funding models are methods to remunerate healthcare providers. More than that, funding models are also key policy levers to achieve broader health system objectives such as improved quality, efficiency and equity.[16,17] This occurs when funding models generate financial incentives for the provider that align with the best interests of the patient to access high-quality care. In a tax-based healthcare system such as Medicare, the patient is also a taxpayer and therefore has an interest in optimising efficiency of healthcare funds.

Across different countries, GPs are paid via FFS, salary, capitation and pay-for-performance (P4P) methods.[16,17] In FFS, GPs receive reimbursements for completion

of itemised services. This applies to most GPs in Australia whereby patients receive MBS rebates for GP visits. Salaried GPs receive a fixed payment for hours worked. Salaried arrangements for GPs have been relatively uncommon in Australia other than for GPs employed in underserviced populations (eg remote government-funded clinics and Aboriginal Community Controlled Health Organisations [ACCHOs]).[18] Under capitation, GPs receive a prospective payment for providing care to a population, with payments calculated based on the number of registered patients and their demographic factors. Capitation is the main funding model for GPs in countries such as the UK.

Table 1 compares the potential advantages and disadvantages of each of these funding models. The main advantage of FFS is that payment changes with activity; thus, GPs have greater autonomy over their workload and are rewarded for an increased volume of services.[17] However, FFS can encourage overservicing and funders bear the financial risk of budget overspends. Maintaining a relevant fee schedule is administratively burdensome, and highly political.[19] In Australia, some critics highlight that the MBS prioritises procedures over cognitive tasks and inadequately incentivises prevention.[3]

In contrast to FFS, capitation has the advantage of ensuring predictable costs for the funder and allows greater flexibility to deliver team-based care.[20,21] With a fixed budget for their registered patient population, practices are incentivised to increase efficiency (eg by reducing unnecessary care and encouraging prevention). In contrast, capitation can result in underprovision of services and selection of healthier patients ('cream skimming').[12,17,19] As with capitation, the salaried model does not incentivise increased service provision and caps provider earnings. However, salaried payments are not dependent on the number of registered patients or the volume of services; hence, costs and revenue are predictable for both providers and funders.[22]

P4P and bundled payments are typically added on to the above funding methods, to encourage specific activities.[16] P4P involves financial reward for achieving predetermined care measures. The Australian Practice Incentives Program (PIP), where eligible practices can receive additional funding for participating in quality improvement activities, is an example of P4P.[12,14]
In bundled payments, payment is made for a defined package of care over time, which encourages innovation, efficiency and integration.[13,19] The Diabetes Care Project is an example of a bundled payment piloted in Australia.[13] The disadvantages of both P4P and bundled payment models are that they encourage measured and remunerated activities, potentially decreasing internal motivation of providers and shifting the focus away from unmeasured patient priorities. 'Cream skimming' behaviour on the part of

Table 1. Potential advantages and disadvantages of different funding models

Funding model	Advantages	Disadvantages	Financial risk
FFS	• Increase activity • Encourage competition on quality and cost • Provider autonomy	• Potential for overprovision • Does not incentivise value • Uncapped health expenditure • No incentive for prevention • Potential to contribute to inequitable access (eg in remote areas)	Funder
Capitation	• Contains costs • Incentivises prevention • Predictable costs for funder	• Under provision • 'Cream skimming' • Does not incentivise quality	Provider
Salary	• Predictable costs • Incentivises time with patients • Predictable income for provider	• Low productivity • Does not incentivise quality	Predictable costs and income for both provider and funder
P4P	• Rewards targeted activity • Can encourage increased quality (at least in the short term)	• Has typically focused on measurable processes over health outcomes (in primary care) • Decreases unincentivised activity • Decreases internal motivation • 'Cream skimming'	Funder, unless payments are capped
Bundled payments	• Offers greater flexibility in care provision • Encourages innovation efficiency • Encourages coordination	• Does not encourage initial prevention • Decreases unincentivised activity • Under provision • 'Cream skimming'	Provider bears financial risk within the bundled payment; funder bears risk on total volume of bundles paid

FFS, fee for service; P4P, pay for performance.

providers is a further potential unintended consequence of both funding models.[13,19,23–25]

The above discourse on advantages and disadvantages of these funding models has continued for many decades.[26,27] Yet, there remains limited robust evidence to quantify the extent to which funding models influence patient outcomes.[28–31]

Learning from previous experience

To mitigate the negative effects of any single model, many countries use blended funding models to address the undesired consequences of each funding model. Blended funding models can also introduce complexity and require additional resources to permit appropriate monitoring.[32] Here, we discuss several case studies of GP funding reforms and reflect on lessons learnt from their evaluations (Table 2).

Quality and Outcomes Framework (UK)

The UK Quality and Outcomes Framework (QOF) was a nationwide implementation of P4P funding introduced alongside an existing capitation funding model in 2004, and continues to contribute to approximately 10% of general practice income in the UK.[24,33] The QOF includes scoring for over 100 clinical and service metrics, which corresponds to practice funding received. QOF has some evidence of short-term clinical improvements and prioritisation of QOF objectives.[34–36] For example, quality of care metrics for asthma and diabetes initially improved (between 2003 and 2005), but subsequently rates of improvements slowed between 2005 and 2007.[34] Qualitative interviews with GPs reported unintended consequences in which 'pop-up boxes' of targets had the potential to crowd outpatient agendas.[35] The QOF experience highlights challenges in developing quality measures in primary healthcare where single-condition indicators might not be appropriate for GP contexts where there is complex multimorbidity.[33,36]

Diabetes Care Project (Australia)

The Diabetes Care Project was a large Australian randomised controlled trial involving 7781 people across 184 general practices.[37,38] Intervention group 1 received digital tools, whereas group 2 received both digital tools and additional funding – bundled payments ($130–$350 per year, depending on risk stratification) and P4P payments (up to $150 per year) for integrated diabetes care. The group with additional funding demonstrated modest but statistically significant clinical improvements at 18 months (eg improvements in haemoglobin A1c [HbA1c], blood pressure, lipid targets), whereas the group using digital tools only did not.[38] The costs of implementing the program were partially offset by hospitalisation costs, but the program was not deemed to be cost-effective.[38]

Health Care Homes (Australia)

Commencing in 2017, the Health Care Homes trial was introduced to trial new models of providing coordinated chronic disease care.[37] Key components included voluntary patient registration, risk stratification of patients and tiered bundled payments to replace FFS payments related to the enrolled patient's chronic disease care, which operated alongside usual FFS MBS rebates for acute presentations.[39] Clinicians and patients alike welcomed the potential for improved continuity and team-based care.[40,41] Initially, there was widespread interest from practices to join the trial. Although the evaluation reported positive patient experiences, no evidence of improved clinical outcomes emerged. Importantly, a lack of clarity about the nature of the change resulted in implementation challenges and a large dropout from the trial by practices.[42] The Health Care Homes payments were calculated based on existing MBS expenditure, with the assumption that current levels of GP funding were sufficient for implementing the new model of care.

Table 2. Case studies of funding initiatives and lessons learnt

Initiative	Year	Type of change	Learning points
Quality and Outcomes Framework (QOF; UK)	2004 to current	P4P alongside a primarily capitation model in the UK	• Improvements in quality across some clinical indicators • Potential for cream skimming and overriding intrinsic motivation • P4P measures difficult in primary care setting
Diabetes Care Project (Australia)	2011–14	Bundle payment for care coordination and P4P payment, alongside FFS rebates	• Funding improved clinical outcomes for diabetes • Not found to be cost-effective • Difficult to attribute any change to different components of the intervention
Health Care Homes (Australia)	2017–21	Voluntary patient enrolment and bundle payment for chronic disease according to complexity tier alongside FFS rebates (for acute presentations)	• Positive patient experiences • Implementation challenges with lack of clarity about changes • Change perceived as primarily focused on cost-cutting • Needs robust risk stratification system

FFS, fee for service; P4P, pay for performance.

Providers described funding levels to be inadequate for highly complex patients, were concerned that the changes were primarily intended as a cost-cutting mechanism and questioned the appropriateness of the risk stratification tool among disadvantaged populations.[40–43]

In summary, primary healthcare funding reforms might improve patient outcomes. However, evaluation of the above initiatives showed that clinical effects tend to be mixed, and there might be undesirable consequences from focusing on specific payable outcomes. Furthermore, existing performance measures used might not reflect the longitudinal nature of primary care. Strong primary healthcare creates positive health outcomes,[44] but the evidence on optimal levels of funding and other primary healthcare characteristics that facilitate greater returns on investment in terms of health outcomes remains inconclusive.[45,46] Nevertheless, when considering reforming the payment method, reviewing the adequacy of the proposed funding cannot be ignored.[14,40,47] For funding reforms to achieve their desired goal of improving quality of care, the amount of proposed funding needs to reflect the cost of delivering high-quality services.

GP funding models and Medicare reform

In response to the Strengthening Medicare Taskforce recommendations,[8] the Australian Federal Government tripled bulk billing incentives for children and Commonwealth concession card holders from November 2023.[48] This increased the FFS rebate for targeted populations, for a select number of GP items on the MBS (eg time-based consults level B and above). Voluntary patient registration to MyMedicare also opened in October 2023, allowing patients to register with a preferred GP. Registered patients have access to MBS rebates for additional longer telehealth items (20 minutes and above for telephone consults) at their nominated practice. MyMedicare is the planned mechanism to increase blended funding arrangements in general practice.[49] Enrolments have the potential to improve continuity of care and to better target additional practice funding.[50] However, few details are available to date, and providers remain wary that patient enrolment represents a push towards capitation, reduced funding and reduced GP autonomy.[51] The impact of current Medicare changes remains to be seen and will require future evaluation.

Conclusion

GP funding reform is a topic of current debate in Australia, on a backdrop of broader discussions around improving the existing healthcare system. Understanding the strengths and limitations of funding model types is key to contributing meaningfully to these discussions. Previous funding reform attempts have highlighted that both the amount of funding and type of funding model are important, that quality measures need to be appropriate, and that funding changes are difficult without provider support. In future reforms, the challenge remains to design funding that enables access to quality care for patients, adequately pays providers and is sustainable into the future.

Key points

- Australia is undergoing changes to GP funding, including changes to Medicare and the introduction of MyMedicare.
- Each funding model has its potential advantages and disadvantages.
- Blended funding models can minimise undesired consequences of individual funding models but can introduce additional complexity.
- The challenge remains to design funding models that enable access to quality care, adequately pay providers and are sustainable into the future.

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Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

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