

**GP Budget Holding for Australia:
Panacea or Poison?**

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October, 1997
ISSN 1325-0663
ISBN 1 875677 84 4

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ACKNOWLEDGMENTS

The Health Economics Unit of the CHPE receives core funding from the National Health and Medical Research Council and Monash University.

The Program Evaluation Unit of the CHPE is supported by The University of Melbourne.

Both units obtain supplementary funding through national competitive grants and contract research.

The research described in this paper is made possible through the support of these bodies.

AUTHOR(S) ACKNOWLEDGMENTS

The authors would like to express their gratitude to Professor Richard Scotton and Ms Leonie Segal of the HEU for providing comments on earlier drafts of this paper. Needless to say, the usual disclaimer applies.

ABSTRACT

Australia has a lot in common with other OECD nations in its experience of health care expenditure and provision over the last decade. It has experienced many problems and concerns similar to those of other OECD nations, including upward pressure on health care costs, potential reductions in service quality and growth of waiting lists, particularly for public patients. In addition, Australia has experienced problems which might be considered unique due to its system of funding and geographical dimensions, such as the potential for cost shifting across levels of government and between public and private sectors, as well as a potential maldistribution of GPs across urban and rural areas.

Whilst many nations, such as the UK and NZ, have pursued some variation of managed competition and the purchaser-provider split to address these problems, and the USA has moved down the managed care reform path, the common element has been the focus on budget holding for primary care. In contrast, Australia has been relatively unusual in not moving down a budget holding route, but has instead chosen incremental reform, such as through coordinated care, restrictions of doctor supply and the General Practice Strategy.

The central issue, given this divergence of reform strategies to tackle similar problems, is to establish the likely success of each in achieving its objectives. Given the similarity of many of the core issues of concern, would we expect that the piecemeal Australian reform strategy will produce a more effective and efficient outcome than the more widescale reform of budget holding as pursued by other nations? In particular, with the introduction of the Australian coordinated care trials and the implicit budget-holding responsibilities that these imply, it is useful to examine whether wider GP budget holding for Australia would be a panacea or poison.

This paper reviews the likely effectiveness and efficiency of the Australian reform strategy in light of experience and evidence of budget holding in achieving similar objectives: principally to stem upward cost pressures, reduce reliance on FFS remuneration, improve coordination of care, reduce the incentive for cost-shifting, reduce waiting lists and tackle the issue of rural-urban imbalance in distribution and access to GPs. Within each of these areas budget holding would appear to offer a more effective, or cost-effective, achievement of the desired objective than piecemeal reform; in theory at least. It is clear, however, that in practice numerous issues pertinent to the Australian context would need to be tackled, such as the requirement for enrolment, or registration, of populations with specific GPs.

In conclusion, the authors recommend that budget holding for general practice be considered further as a viable, and potentially more efficient, alternative to the current piecemeal reform of the primary care sector.

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GP Budget Holding for Australia: Panacea or Poison?

1 Introduction

General Practitioners (GPs) have an important role within the wider health care system as, in many countries, they are the initial point of contact for patients in their use of health care services. As gatekeepers, GPs have a central role in determining the future use of health care resources by patients, and, with increasing health care costs, there has been an increased emphasis on incentives for GPs to ensure provision of the most cost-effective care possible, while maintaining quality standards. There has been a world wide trend towards the strengthening of primary care (Harris and Richardson 1994, Van de Ven 1996), with an important motivation being to 'extend' the role of the primary care physician, in order to reduce reliance on more expensive inpatient and specialist care and to reduce waiting lists. In other cases, the main objective is to curb unnecessary interventions and excessive billing practices (OECD 1994). In particular, adjustments in the payment and organisation of primary care physicians is used to help achieve these goals.

In both the United Kingdom (UK) and New Zealand (NZ) organisational and financial reforms along the lines of a purchaser provider split and the introduction of budget holding responsibilities for GPs have been introduced (Maynard 1994). In the United States of America (USA), primary care provision through Health Maintenance Organisations (HMO) is of a budget holding nature (Navarro 1991, Robinson and Casalino 1996) and while these countries have achieved different levels of success in terms of cost-effectiveness, quality and consumer-empowerment goals (Wilton and Smith 1997), Australia has chosen a different path for reform of primary care. The more recent 'political acknowledgment' of general practice (with the General Practice Strategy) and the establishment of divisions of general practice being some of the more significant Australian changes to primary care provision in recent years (Webster 1996). In particular, with the introduction of the Australian coordinated care trials (Department of Health and Community Services 1995) and the implicit budget-holding responsibilities that these imply, it is useful to examine whether the Australian primary care environment warrants such treatment.

This paper has four aims. First, to briefly identify the reasons for the introduction of primary care budget holding arrangements overseas. Second, to assess what difficulties the Australian primary care environment currently faces and the reform initiatives taken to address these. Third, from this to provide an assessment of the Australian primary care reform agenda and, fourth, given the problems that Australia faces, whether any overseas budget holding initiatives are of relevance.

2 Why Budget Holding?

It is useful to review briefly the reasons for the introduction of budget holding arrangements in the UK, NZ and USA. While it is difficult to separate the objectives of budget holding from the wider reforms introduced simultaneously in the health care sectors in some countries (eg the UK and NZ), nevertheless an emphasis on primary care has been a common feature.

2.1 Background to the GP Fundholding Scheme in the United Kingdom

The origins of the GP fundholding scheme are historical and pre-date the 1989 Thatcher review of the National Health Service (NHS). For most of this century, and certainly since the inception of the NHS, general practice has increasingly been 'losing ground' to the hospital sector. Before 1948, consultants operating within the hospital system were reliant upon GP referrals for their livelihood, with the incentive to respond to GP's demands. However, after the establishment of the NHS, hospitals became directly funded by the state, removing the incentive for hospital consultants to respond to the demands of GPs, creating a hospital (consultant) led NHS. (Glennister *et al* 1994)

Within this arrangement, GPs became increasingly frustrated by their lack of influence within the wider NHS and, in particular, their lack of ability to secure timely treatment for their patients (Levitt *et al* 1995, Pritchard and Beilby 1996). For years, GPs had accepted the hospital services provided by the District Health Authorities (DHAs) and the services with which the GPs were presented were on a 'take-it-or-leave-it' basis (Maxwell 1995). In particular, waiting lists for elective surgery remained a significant problem despite more government funding to tackle this issue (Department of Health 1989).

In addition, reform in the UK was against a backdrop of increasing health expenditure costs in most developed countries (OECD 1994). While the UK had been relatively successful in containing costs leading up to the reforms (McAvoy and Ashton 1997, forthcoming), there was evidence to suggest that health care resources were not being used in the most cost-effective way (Levitt *et al* 1995). For instance:

"... [There was] clear evidence of a wide variation in performance up and down the country. In 1986–87, the average cost of treating acute hospital in-patients varied by as much as 50% between different health care authorities, even after allowing for the complexity and mix of cases treated. Similarly, a patient who waits several years for an operation in one place may get that same operation within a few weeks in another ... And, at extremes, there is a twenty-fold variation in the rate at which GPs refer patients to hospitals." (Department of Health 1989)

There was concern that GPs were not fully responsible for the resource implications of care prescribed. For instance, in the UK prescriptions dispensed were the largest single element of the family health services authorities' budget, and in the decade prior to reform there had been a rise, after inflation, of 56% in the net cost of ingredients and in the number of items prescribed (Chew

1991). The government viewed these escalating drug costs as a priority to be addressed in the reorganisation of the NHS and the introduction of prescribing budgets for GPs was seen as a method of addressing this problem (Department of Health 1989).

A central part of the reform process in the UK was also to address consumer concerns in health care (Drummond 1995). In particular, the reforms aimed to give patients better health care and choice of services available, irrespective of where they might live (Department of Health 1989). Waiting lists for many consumers were of prime concern and many people faced little choice about where, when and at what time services were to be provided, particularly through the hospital system (Le Grand 1994). Much of the reason given for lack of choice stemmed from the decisions which GPs were making, and there was widespread acknowledgment that GPs lacked incentives to offer patients a choice of hospital (Lerner and Claxton 1994).

The various policy initiatives embraced by the reforms (eg the purchaser provider split, the introduction of hospital and community trusts, GP fundholding and the development of contracting with hospital trusts) were all described, in the various White Papers, in terms of their ability to promote the quality of health care services in response to the needs and preferences of consumers (Mahon *et al* 1994).

2.2 Background to Reforms in NZ (the introduction of a purchaser provider split)

Prior to the introduction of a purchaser provider split in NZ, 14 area health boards were responsible for the provision of hospital services, public health services and some community services for regional populations funded from a population based global budget.¹ Following management reforms and the setting of national priorities and targets (Clark 1989), some productivity improvements were noticeable in the provision of care; however, many problems remained (Ashton 1993). The 'Green and White' paper (Upton 1992) documented a number of key reasons for reforms with the strengthening of primary care in NZ of importance.

As with many countries, there was recognition in NZ that GPs had an important part to play in containing wider health expenditure costs. Primary care expenditure was increasing steadily and could not be directly controlled (Upton 1992, Jacobs and Barnett 1996), with escalating and open-ended fee-for-service (FFS) payments to GPs largely responsible. For instance, government expenditure on primary care increased at approximately 6% per annum (adjusted for inflation) during the 1980s (Malcolm 1993).

Separate funding for primary and secondary care also meant that patient care was poorly integrated (Ashton 1993) and that cost shifting was occurring. In particular, by the late 1980s, as budget constraints became tighter, the area health boards responded by partly shifting the cost of care to primary care and other parts of the health sector. For instance:

¹ For a concise summary of arrangements before and after the 1991 reforms, see Borrem and Maynard (1994).

“Funding pressures meant that in areas like continuing care — where multiple sources of funding were involved — considerable energy was spent by agencies on policies that shifted costs from one public sector agency to another or alternatively, shifted costs from the public sector to private individuals.” (Scott 1994, p. 30)

There was clearly scope for improved coordination and more appropriate definition of the roles and responsibilities of different health care providers.

This was combined with increasing dissatisfaction by GPs with respect to access and choice for patients in terms of hospital treatment. Despite the fact that throughput of hospital patients between 1987 and 1990 increased by 10% (while spending remained constant) (NZ Treasury 1990), waiting lists and waiting times remained unacceptably long (Upton 1992). As Cooper (1995) claimed:

“The mounting ‘waiting list’ for elective surgery (it grew 61% between 1981/91) was argued to be proof positive that [the public health sector] was a fatally flawed system”. (p. 800)

These concerns were also combined with inconsistent productivity improvements for some hospitals, and some area health boards struggling with debt (Ashton 1993). Additionally, consumers were increasingly vocal in their criticism of the lack of equity in the health scheme (eg with rising consumer co-payments for GP services) and a lack of consumer control in respect of health choices (Borren and Maynard 1994, McAvoy and Ashton 1997 forthcoming).

2.3 Background to Reforms in the USA (the growth of HMOs/managed care)

In 1993/94, the Clinton administration attempted a comprehensive restructuring of the health system. The reforms proposed were similar to the Dutch reform package and promised a core benefit package available to all Americans. Competing insurers would have to accept all those who insured with them, with the ultimate aim of the proposals being the introduction of competition in the insurance market, thereby ensuring incentives for cost control (Street 1994).

The Clinton plan could be described as ‘managed competition within a global budget’ (Scotton 1995). The reforms proposed that total premiums for insurance cover should not exceed a specified budget cap as it was believed that competition alone could not control costs. In addition, the system was designed to reduce (or certainly not increase) government expense by ensuring that individuals and employers would purchase health care, rather than being financed through taxation (Aaron 1994, White 1995).

There were two fundamental reasons for the proposed introduction of health reform in the USA:

- a desire for a more egalitarian distribution of health care (Reinhardt 1996). For instance, there is no universal coverage, with the majority of citizens opting for private health insurance (either taken out individually, or, more commonly, as part of their employment) with the elderly and poor covered by Medicare and Medicaid respectively. In particular, in 1993, 18.1% of the

non-elderly population (or 40.9 million people) were not covered by health insurance (increasing from 17.8% or 39.9 million in 1992) (EBRI 1995); and

- concern with increasing health care costs. Despite cost-containment efforts in the 1980s, health care expenditure was increasing (Fuchs 1988, 1990) and predictions suggested that health spending would rise from about 12.1% of GNP in 1990 to about 45% of GNP by the year 2050 (Reinhardt 1996). This was clearly viewed as unsustainable with health care costs in the USA exceeding those of other developed nations (Rosenman 1996).

After the demise of the Clinton reform option, many believed that health reform would stall. While reform to ensure universal access to health care is widely acknowledged as 'dead and buried', the spectacular growth in the managed care sector has meant that cost-containment 'reform is not dead, not even half dead' (Reinhardt 1996). Indeed, reform has become very much market oriented and Richardson (1997) has commented that the 'managed care revolution in the USA represents the first time in the post war period that a medical market has resembled the competitive market of economic theory' (p. 2) Hardly the signs of stagnating reform!

One of the main reasons for the spread of HMOs, and managed care more generally (and related to increasing health care costs), is the great variation in medical practice procedures which cannot be explained by health status or socio-economic factors (Reinhardt 1996, Richardson 1997). For instance, Welch *et al* (1989) examined spending per enrollee by the Medicare program in 1989 by physicians in various American cities and found that enormous variations in medical treatment procedures were occurring. For instance, Miami and Ft. Lauderdale had much more resources intensive patterns of practice than in Minneapolis, San Francisco or New York City.² Similar results have been reported by Holahan *et al* (1990), Ham *et al* (1988) and Wennberg and Gittlesohn (1982).

In particular, the spread of the managed care market (with its HMOs and budget holding responsibilities) has been an important factor in containing costs, as well as ensuring a major shift in market power from producers of health care services to purchasers (and, hopefully, therefore consumers) (see Wilton and Smith 1997 for a summary).

² These trends were noticed after adjusting for inter-city differences for age and gender and after allowing for variation in allowable charges to Medicare paid physicians.

3 Primary Care in Australia: Practices and Problems

3.1 General Practice in Australia

For most Australians, general practice is the first point of contact with the health care system. In each year, approximately 80 per cent of people visit a GP at least once (Macklin 1992). While there is no consensus on the 'exact' role of GPs in Australia (NCEPH 1991, Buetow *et al* 1995), they nevertheless deal with a broad range of medical, and social, conditions. These may include the diagnosis and initial treatment of 'undifferentiated' illness, and chronic as well as acute conditions. Not only do GPs have a central role in patient care management and continuity of care, but are also viewed as responsible for long-term health maintenance (Commonwealth Department of Health and Family Services 1996).

Most GPs are private medical practitioners whose services are funded largely through Medicare, a Commonwealth Government program, which provides universal health insurance that provides benefits to consumers on a FFS basis. At present, benefits represent 85% of the schedule fee set by the Commonwealth Government, although approximately three-quarters of GPs 'bulk-bill' whereby the GP absorbs the 15% which would be charged to the patient. Importantly, there is no limit placed on total government outlays on Medicare benefits. This means that the cost of GP services funded under Medicare to the Commonwealth Government is determined entirely by the volume of patients (adjusting for consultation length) seen by individual GPs. For instance, in 1994/95, an average of 5.5 consultations per head of population (98 million in total) were conducted by GPs. This cost the Commonwealth Government approximately \$2.2 billion and accounted for approximately 52.5% of services funded under Medicare FFS arrangements. (Commonwealth Department of Health and Family Services 1996)

While data are not always consistent³, data from the Better Practice Program suggests there are approximately 5,500 practices in Australia, with an average of 3.3 individual (or 2.5 full-time equivalent) GPs in a practice. Although the size of general practices and their organisational arrangements differ (about one-third of general practices are solo), each of these practices is responsible for treating, on average, just over 3,800 individual patients which is equivalent to approximately 16,000 consultations per year (Commonwealth Department of Health and Family Services 1996).

3.2 The Problems of General Practice in Australia

While health care provision in Australia is relatively efficient compared to international standards (Richardson 1994, 1995), there is widespread recognition that there are many problems to be addressed. Recent inquiries into the Pharmaceutical industry and Private Health Insurance by the Industry Commission (1996, 1997), the prevalence of hospital waiting lists, calls for reform of Medicare, either incrementally (Duckett 1995b) or more wide-ranging (Richardson 1995, Scotton

³ There are a number of different data bases which can be used to obtain information about Australian medical workforce and general practice organisation patterns and these include: Medicare data from the Health Insurance Commission (HIC), Australian Institute of Health and Welfare (AIHW) statistics, data from the Australian Bureau of Statistics (ABS) and the Royal Australian College of General Practitioners (RACGP) and data from the National Centre for Epidemiology and Population Health.

1995, Cunningham 1997), are all pressures for change. Given that primary care is such an integral part of health care in Australia, it too has not been isolated from the wider reform agenda. Some of the more important problems of general practice are discussed briefly below.

Increasing costs

Total health expenditure (from all sources) as a proportion of GDP in Australia has increased from 7.7% to 8.5% between 1984/85 and 1993/94. While these growth rates are relatively minor in comparison with international trends, of importance is that the *composition* of health expenditures has been changing. In particular, expenditures on medical services⁴ (of which GP services are a component) and pharmaceuticals have been increasing not only in absolute terms but also as a proportion of total health expenditure⁵ (from 24% in 1984-85 to 28% in 1992-93). In comparison, the 'public hospital' category of expenditure has experienced large decreases over this same period (declining from 36% in 1984/85 to 30% in 1991/92. (Commonwealth Department of Health and Family Services 1996).

Growth in GP Attendances

Expenditure on non-specialist attendances⁶ as a proportion of total health expenditures has also increased, from 5.6% in 1984/85 to 6.5% in 1994/95. This represented a 3% average annual growth in total *per capita* expenditure on Medicare-funded non-specialist attendances. In particular, growth in per capita expenditure increased rapidly in the early 1990s and this can be partly explained by the GP transition to vocational registration and the associated entitlement to higher Medicare benefits. However, over the 11 year period, it is clear that most growth in per capita expenditure is attributable almost entirely to the growth in the *quantity* of services consumed per capita, rather than increases in the *prices* of those services (Commonwealth Department of Health and Family Services 1996).

In general there is no consensus about what is causing overall increases in these per capita expenditure trends. Different authors have suggested different reasons, for instance, increases in technology (for a review see Doessel 1987, Richardson 1986, Walsh and De Ravin 1995), an aging population (NCA 1996), cost-shifting (see below) and supplier induced demand (Richardson 1981).⁷

In addition, Rosenman and Mackinnon (1992) have suggested that increased costs in the provision of medical services may in part be explained by bulk-billing practices. This analysis used Medicare claims data from the Health Insurance Commission for the years 1984 to 1990

⁴ Medical services encompasses services provided by GPs and specialists. For a more detailed description see Butler (1994) and Connelly and Doessel (1995).

⁵ Total health expenditure includes total expenditure on health from all sources on public and private hospitals, other institutions, medical services, pharmaceuticals and all others.

⁶ 'Non-specialist attendances' are non-referred attendance services that currently attract a benefit through Medicare for private medical services. Although the majority of non-referred attendances since 1984 are of GP type, a variety of medical practitioners use these terms (Commonwealth Department of Health and Family Services 1996).

⁷ Note: there is no consensus on this view (see Doessel 1997).

and implied that bulk-billing by GPs may increase service rates, with this increase not directed to improving access to medically *necessary* services.⁸ However, this approach has been criticised by Richardson (1993) on statistical and policy grounds and earlier research by Richardson (1993) found that bulk-billing had little impact on total service use and service use per patient (Richardson 1991).

Growth in Flow-on Costs

GPs also have further 'flow-on' cost considerations through referral to specialists, allied health professionals, hospitals, other health-care services (eg pathology and imaging) as well as associated prescription costs. Data suggest that, in general, the Commonwealth Government spends as much on non-specialist ordered tests (pathology, diagnostic imaging) and pharmaceuticals as it does on the actual non-specialist attendances (ie: \$2,710m and \$2,277m respectively, in 1994/95). In particular, over the last four years, Commonwealth Government expenditures on non-specialist attendances increased by 23% while expenditure on non-specialist ordered tests and drugs increased by 50%. As the Commonwealth Department of Health and Family Services (1996) reports:

"It is this trend that is at least partly responsible for the growing interest in 'coordinated care' and 'budget holding' arrangements in the funding of medical services in Australia". (P. 163)

Cost-shifting

Through Medicare, all Australians are provided with access to medical and hospital services without a significant cost impediment. However, one of the most important problems of the Australian health care system is that there is a significant degree of overlap and lack of articulation between both Commonwealth and State government and public and private sectors. Many of the services are close substitutes for each other and not only are provided on different terms to patients, but are also financed through different sources. For instance, severely ill patients are treated in either state/territory public hospitals, to which the Commonwealth Government provides hospital grants, or in specialised state psychiatric facilities which do not receive Commonwealth support. In particular, there is obvious overlap between FFS general practitioner care and state/territory provided (hospital) services in two major areas:

- FFS general practitioner care funded under Medicare and outpatient services provided by state public hospitals⁹; and
- GP pharmaceutical referrals (with Commonwealth benefits for private dispensing) and public hospital dispensing.

Deeble (1991) comments on substitution behaviour as follows:

⁸ The Rosenman and Mackinnon (1992) analysis does, however, acknowledge that it is not possible to decide whether the observed effects represent an improvement in health care or whether they are more appropriately viewed as representative of service overuse or demand inducement by practitioners. This is because there are no adequate measures of treatment outcome.

⁹ Alternatively, hospital outpatient departments have been privatised (Duckett 1995a).

“There is anecdotal, and sometimes documented evidence of the closing of some public hospital out-patient departments in most states and/or their conversion to fee-for-service operation under Medicare, as well as a host of marginal adjustments in areas like university health services, industrial services, public programs for screening and immunisation, etc. The Medicare hospital agreements prohibit such devices for cost-shifting but they are difficult to identify”. (Deeble 1991, p. 59)

Given the nature of Australia’s heterogeneous health care system, the question of service substitution cannot easily be viewed in a global fashion (Sax 1984, Doessel 1994). However, Doessel (1994) provides some insight into the level of substitution between FFS care and outpatient hospital use for Queensland. Using Queensland Public Hospital statistics over the period 1982/83 to 1989/90, this analysis suggests that the use of ambulatory medical services provided by Queensland public hospitals has changed since the introduction of Medicare. Per capita use of medical services¹⁰ in public hospitals over the period 1984/85¹¹ to 1989/90 declined by approximately 12% while per capita use of care provided through private medical practice increased by 21.5%. Doessel (1994) attributes the shift from public to private ambulatory care as follows:

“With bulk-billing under Medicare the net price to the consumer/patient is zero, as is the net price for attending a recognised public patient as an outpatient. However, non-pecuniary queuing costs (travel costs, time spent waiting in hospital queues etc) may be the explanation. Given that public hospitals have budget allocations, and that more in-patients are exercising their Medicare hospital rights given the decline in proportions holding private hospital insurance cover, hospitals may have decreased their allocations for ambulatory care, thus increasing the queuing costs.” (p. 14)

Although cost-shifting has an immediate and obvious effect on the budget of the party incurring additional costs, opportunity costs are a further consequence of cost-shifting (Duckett 1995b). For instance, devising ways to shift costs between different jurisdictions means less time will be dedicated to devising more efficient ways of providing care.

Waiting Lists

Public hospital waiting lists for elective surgery have long been an area of potential concern in Australia’s health care system (Patterson 1996), although, until fairly recently, there were little available national data concerning waiting for surgery in public hospitals (AIHW 1996). However, a recent study using data on waiting times for elective surgery obtained from a six month survey of Australian public hospitals (January to June 1995) indicated that performances of Australian Public Hospitals varied significantly across jurisdictions (Moon 1996, SCRCSSP 1997). More specifically:

¹⁰ This data includes expenditure on outpatients, casualty, radiography, pathology etc (Doessel 1994, p. 12) It covers non-inpatient occasions of service in Queensland Public Hospitals (excluding nursing homes).

¹¹ In 1984, Medicare was introduced.

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- NSW recorded the lowest clearance time¹² (2.1 months) while the NT recorded the highest clearance time of 6.1 months. The national average was 2.7 months;
 - 27% of all category 1 patients¹³ in Australia at the time of the survey had been waiting longer than 30 days with the proportion ranging from 3% in Victoria to 83% in the NT;¹⁴ and
 - 11% of all category 2 patients had at the time of the survey been waiting for longer than 12 months with the proportion varying from 5% in NSW to 36% in the NT.

It should also be noted that clearance times for elective surgery in both categories 1 and 2 were consistently high for orthopaedic surgery, plastic surgery, urology and ear, nose and throat surgery (SCRCSSP 1997).

A study by Baume and Wolk (1995) investigated the difficulties in public hospital admissions from the perspective of referring medical practitioners. Referring surgeons, physicians and GPs were randomly selected from three metropolitan (Sydney) health areas and while the problems raised in this study may be region specific, they potentially affect a sizeable proportion of the population of Sydney (31.3%). The following findings were noted:

- for *non-elective* admissions, GPs had difficulties in arranging admissions and often experienced rudeness from medical officers and received limited feedback about the outcomes of admission requests. In particular, GPs often sent patients directly to accident and emergency departments without notice as this made it difficult to reject patients, if after assessment, admission was necessary; and
- for *elective* admissions, GPs referred most patients to specialists, who were sometimes chosen on the basis of the length of their waiting lists.¹⁵ In particular, concern was noted from all referring medical practitioners about the greater difficulties in finding beds for patients with greater social needs (eg the elderly).

It was further indicated that although the concerns of surgeons, physicians and GPs are different, common themes emerged: (i) there is a mismatch between public hospital beds and pressures for admissions; (ii) this results in longer waiting times for patients, with elective surgery often deferred (sometimes repeatedly); and (iii) patients electing to have the procedures completed

¹² Clearance time is defined as the length of time that it would take to provide services to all those on the elective surgery waiting lists, assuming that the rate of servicing remained constant and that no patients were added to the list. It is a prospective measure of the capacity of the system to remove patients from waiting lists not the average waiting time.

¹³ Patients were classified into two groups based on the clinical urgency of the procedure: (i) Category 1 where admission is desirable within 30 days, and (ii) Category 2 which includes all other patients with no desirable time set for admission (AIHW 1996).

¹⁴ Note: 11% of all category 1 patients in Australia admitted from elective surgery waiting list had been waiting over 30 days.

¹⁵ Long waiting times are noted in the following areas: cardiothoracic, general medical specialties, neurosurgery, ENT surgery, plastic surgery, paediatric neurology, immunology, ophthalmology, orthopaedic and prostate/urology (Baume and Wolk 1995).

privately at their own expense. Despite reports to the contrary (eg Pritchard and Beilby 1996) Baume and Wolk (1995) further concluded:

*“GPs seem to be particularly powerless. They reported liaison experiences with public hospitals which on an **ex parte** basis, seemed inappropriate behaviour between professional colleagues.” (p. 405)*

These issues are even more remarkable given that the clearance time for elective surgery by clinical specialty for NSW public acute care hospital patients was significantly below the national average in 1995 (eg 2.1 months as opposed to the 2.7 months for the national average¹⁶ (SCRCSSP 1997)).

Additionally, further recent studies have highlighted the decline in coordination and integration between hospitals and GPs (Goldman 1986, Schattner *et al* 1989, Harris *et al* 1993) with Isaac (1997) commenting that this lack of involvement is potentially problematic for ongoing patient care. In particular, Isaac (1997) further reiterated that GPs perceive difficulty in gaining access to public hospitals for their patients, particularly those requiring non-urgent or semi-urgent care and have no clear strategy about how to achieve this.

Fee-for-Service Remuneration

One of the most obvious implications of FFS is that it rewards provision of extra services and this occurs through allowing GPs to keep direct control over their incomes, through varying the number of services provided. In particular, this is more likely where services on the MBS are more 'profitable' (Langwell and Nelson 1986). In some situations, extra provision of services may be desirable, for instance, where there are unmet needs or when the provision of GPs is under-supplied. However, when an excess supply of doctors exist, this form of payment is disadvantageous as it can lead to supplier-induced demand (Richardson 1990b, Newhouse 1992¹⁷, Mooney 1994).

A further disadvantage of FFS is that physicians may wish to maximise incomes by seeing as many patients as possible. In particular, FFS methods of remuneration provide relatively little financial incentive for doctors to provide longer consultations to ensure that the underlying problems that patients brought to the consultation are addressed.¹⁸ More particularly, Broom (1991) commented:

“Consumers identify the fee-for-service method of remuneration as containing incentives that do not encourage quality care.” (p. 1)

¹⁶ This excludes data for Queensland.

¹⁷ Note: Newhouse (1992) has documented that it is not the basis of payment (ie FFS) that is potentially responsible for inducement, it is payment above marginal cost.

¹⁸ Note: this has been partially addressed through the Better Practice Program (discussed later).

Additionally, FFS remuneration encourages GP to keep patients to themselves, rather than referring them to other more appropriate care (such as specialists or allied health professionals). A further disadvantage is that activities which are not reimbursed through the payment schedule are not encouraged. For instance, as Macklin (1992) documents:

“It is difficult in a fee for service system to pay doctors for system-wide activities such as continuing medical education, quality assurance and liaison with other health professionals” (p. 119)

Coordination of Care

At present in the Australian community, there are over sixty discrete government programs for health and community services, each with its own organisational, management and funding boundary. In many instances there are insufficient linkages between services delivering care in institutions and in the community, and between health care services and community care services (COAG 1995, Paterson 1996).

This lack of integration means that it is often difficult for consumers of health services to get adequate continuous care. It also means that care is often ‘uncoordinated’ and poorly planned with plenty of scope for overlap in service provision, and, often, ineffectual follow-up between the many providers of care. This problem is more likely when care is of a long-term nature and/or when chronic conditions are involved (eg diabetes).

Duckett (1995b) has suggested that the present uncoordinated arrangements stem from when Medicare (and Medibank) were being developed (and most probably prior to this), with most of the policy focus being on medical practitioners (outside of hospitals). In particular, the role of other allied health professionals (eg podiatrists and physiotherapists) were largely ignored. For instance, existing Commonwealth Medicare arrangements only provide reimbursement for certain services through the Medical Benefits and Pharmaceutical Benefits Schedules. This means that the services of many other health professionals fall outside this ambit and as a consequence ‘it is easier for a person with diabetes to get access to a consultant physician than to a podiatrist or a dietitian’. (Duckett 1995b, p. 123).

While a move towards an open-ended FFS payment schedule for *all* health professionals may not be acceptable, a move towards better coordinated care is desirable. In simple terms, coordinated care involves the provision of a *mix* of services over long periods of time which are difficult to arrange effectively through self-management (COAG 1995). In particular, persons with chronic diseases would benefit from programs which not only stabilise their condition but also ensure access to appropriate allied care as required.

Moving to more coordinated care has the advantage of reforming a current health care system which is often viewed as ‘complex and unfriendly’ for consumers as well as being inefficient for governments responsible for funding it.

Maldistribution

There is a significant maldistribution of GPs between urban and rural areas. For instance, the Australian Medical Workforce Advisory Committee suggests that the GP workforce is in oversupply in metropolitan areas with significant under-supply in rural and remote areas. This urban oversupply is estimated to be approximately 4,400 GPs (or 2,900 full-time-equivalents) with an undersupply in rural areas of approximately 500 (or 445 full-time-equivalents). (AMWAC 1996) This is despite the fact that the health status of rural Australians is worse than those of urban people (Harrison 1997) and that the rate of avoidable deaths in country areas is 40% higher than those in capital cities (AIHW 1994).

There is also great disparity between rural and urban GPs. Not only do rural GPs have a higher workload (153 encounters per week as compared with 116 for urban areas), the conditions managed differ (eg respiratory and cardiovascular problems are managed less with skin disorders of greater significance), rural GPs prescribe less, with little difference between country and metropolitan areas in the frequency of specialist referrals (Britt *et al* 1994). In addition, the inaccessibility of the GP remains one of the greatest disadvantages for rural residents (Humphreys *et al* 1997).

Change in the Role of GPs

Since the late 1970s, the role of general practice has greatly changed and the combination of more effective medical care and reduced financial barriers increased demands on, and for, GPs. This pressure, combined with increased entry to specialist colleges, encouraged GPs to refer to specialists more often and give up much procedural work that they had completed previously (especially in obstetrics and elective surgery). In the 1980s, with the increase in numbers of GPs, the 'decline' of the GP role continued and by the early 1990s, many were predicting the demise of general practice (Pegram *et al* 1995).

Many problems were inherent, including: (i) a 'lack of voice' in health planning; (ii) GPs in many instances were effectively 'excluded' from any role in local issues; (iii) the inadequacy of links between GPs and other health professionals; (iv) the diminishing role of GPs in hospitals and many other areas of care; and (v) the profession's lack of consensus about how to rectify these problems (Pegram *et al* 1995). Douglas (1991) summarised the situation in the following terms:

"... [M]any GPs are feeling demoralised and impotent to change a system which is not making best use of their skills ... They have been pushed out of hospitals by their specialist colleagues; they are under intense competitive pressure from their 24 [hour] clinic colleagues and from community health professionals; and they often feel isolated in their difficult primary care task" (General Practice Evaluation News 1991, p. 2)

4 Reform of Primary Care in Australia

Due to problems of increasing cost, growth of GP attendances, growth of 'flow-on' costs, potential cost-shifting, rising waiting lists, problems associated with FFS remuneration, lack of coordination of care, maldistribution of GPs and a decline in the role of GPs, various reform initiatives have been proposed and implemented in recent years.

4.1 Recognition of General Practice and Development of the General Practice Strategy (1991)

In 1989, vocational registration for GPs was introduced with entry in to general practice requiring specific training, qualifications and commitment to ongoing education. This was in recognition of general practice being a distinct professional discipline in its 'own right'. For instance, the World Health Organization had already accepted that general practice is a specific scientific discipline and not merely a sum of information from other specialties (Bollen 1996).

In part, this move arose as the 'generalist' nature of the discipline was in 'retreat', as the role of the GP had been changing over time with 'other' skills growing in importance. For instance, during the 1980s, the prime focus of primary care had been on the well-being of individual patients but there was a growing recognition of the need to promote wider community health. Implicit in this was an emphasis on additional skills, namely the importance of doctor-patient communication, anticipatory medicine, continuing care and practice management (Commonwealth Department of Health and Family Services 1996).

In December 1991, the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGPs) and the Commonwealth Government entered into discussions on general practice (around key themes of workforce and standards of care) and to examine more generally proposals to enhance the status and quality of general practice. These discussions formed the foundation of the *General Practice Strategy* (1991)¹⁹ which is primarily concerned with developing a framework for helping general practice reassert its role in Australia's health system and ensure the highest quality of care for patients. More particularly, it is concerned with (Bollen 1996, Commonwealth Department of Health 1996):

- the *Divisions and Projects Grants Program*²⁰ which provides corporate funding infrastructure, and project funding for GPs to become involved in cooperative activities and projects to improve integration with other elements of the health care system and meet identified local health needs. In particular, Divisions were conceived to provide GPs with a 'strong voice' in their interaction with other local and regional bodies and provide support at the local level for

¹⁹ The General Practice Evaluation Program is part of the General Practice Strategy and its purpose is to: (i) evaluate the changes made to general practice, and (ii) to determine whether they have improved the quality and financial value of care in general practice and the wider health system.

²⁰ The Support and Evaluation Resource Units (SERUs) were set up as part of this program with a role to assist the Divisions in project development and evaluation. There are four SERUs in the following areas: Public Health and Health Promotion, Access, Education and Integration .

other GP Strategy initiatives, such as education (for vocational registration), better practice guidelines and accreditation;

- the *Rural Incentives Program*²¹ which seeks to address the maldistribution of GPs and provides incentives for the recruitment and relocation of GPs to rural areas. This was based on the belief that there are too many GPs in metropolitan areas with too few being in rural or remote areas (Douglas *et al* 1991);
- the *Better Practice Program*²² which provides a supplement to FFS income to GPs who meet certain eligibility criteria by providing a comprehensive range of services. This policy initiative represented an attempt by Government to 'move away' from FFS as the predominant form of payment to GPs; and
- support for the *development of standards and accreditation for practices* to address quality of care initiatives. The accreditation system has two major components: (i) setting acceptable minimum standards for general practice, and (ii) an effective and objective process for assessing practices against these standards.

More recently the Commonwealth Government has made further policy announcements concerning the restriction of Medical Provider numbers, the restriction of numbers of overseas doctors working in Australia, the introduction of the Coordinated Care Trials and an announcement that the General Practice Strategy is to be reviewed in 1997.

²¹ There are five principle elements of the General Practice Rural Incentives Program which are: (i) relocation grants to assist in relocation from well-served to under-served areas; (ii) training grants to allow GPs to upgrade their rural practicing skills; (iii) remote area grants for GPs in remote areas where the economic viability of the practice may be in question; (iv) continuing education/locum grants; and (v) rural undergraduate support grants which aim to encourage students to select a rural career. (Commonwealth Department of Health and Family Services 1996)

²² Payments under the Program are available to practices that apply and satisfy certain eligibility criteria with the formula determined by the Commonwealth Department of Health and Family Services. It particularly aims to foster better continuity of care with practices in rural and remote areas eligible for a separate loading.

5 Assessment of Reform

It is difficult to assess the reforms to date as many are recent and there have been no economic evaluations assessing their efficiency. Analysis of reforms will therefore focus on whether or not they have the *capacity* to improve the problems they seek to address and, in particular, where deficiencies are identified whether budget holding models have any relevance.

5.1 Rising Costs

As documented in section 3.2, costs associated with general practitioner services have been increasing, specifically in relation to flow-on costs (such as pharmaceuticals) as well as the number of GP consultations which have increased significantly over the past decade.

Pharmaceuticals

With respect to the increasing use of pharmaceuticals, analysis is suggestive that no matter how rigorous the listing process, it is the actual use of drugs that determines the total costs of the Pharmaceutical Benefits Scheme (PBS). While some increase in cost is expected (ie ageing population etc), it is also recognised that inappropriate prescribing accentuates the problem. Analysis of the drugs which have contributed most significantly to the current rise in PBS costs are the top 35 drugs (in terms of annual cost and volume of prescriptions) which are mostly used to treat common conditions.²³ The main factor appears to be the preferences of GPs for prescribing newer and more expensive drugs (Hill, Henry and Smith 1997).

At present there is little restriction on the ability of GPs in their prescription endeavours. In particular, the current PBS scheme exerts only limited control over drug use, mainly by channeling use to an appropriate target population (by the Authority system) or by not listing the drug at all. However, in the 1997 Commonwealth Budget, there have been moves to delist some drugs and introduce a premium paid by patients for some brand name products. It is not clear however that this will lead to a reduction in pharmaceutical costs as the high-cost prescribing drugs are unlikely to be targeted.

It is useful to draw upon the experiences of the UK and NZ in dealing with these same issues. Both countries have implemented budget holding initiatives and one of the central reasons for this was to stem the increase in pharmaceutical costs (Bradlow and Coulter 1993, Crump *et al* 1995, Jacobs and Barnett 1996). Budget holding introduces incentives to encourage the most cost-effective care possible through making GPs responsible for the wider flow-on costs of any care prescribed and providing an effective 'cap' on the level of overall expenditure (Malcolm and Powell 1996). For pharmaceuticals, this means that GPs will more carefully consider which drug is most appropriate, and in which circumstance, and, thus, prescribing of the most expensive 'flavour of the month' drug is unlikely to be sustained (Wilson *et al* 1995).

²³ These include antiulcer/antireflux treatments, cholesterol-lowering, antidepressants, and ACE inhibitors.

Growth in GP Attendances

While there has been no *single* effort to stem the increase in GP attendances, the Commonwealth Government has introduced a number of strategies to counter this effect.

One of the most important initiatives undertaken by the Commonwealth Government has been to restrict Medicare Provider numbers and restrict the numbers of overseas doctors practicing in Australia. These strategies, among other things, were introduced to specifically address the oversupply of general practitioners in urban areas. However, they are also predicted to help stem the increase in GP attendance patterns by: (i) by restricting the number of practitioners who are able to claim benefits from the Medical Benefits schedule and (ii) encouraging improved quality of care (through reductions in unnecessary visits).

Butler (1994) has questioned the link between supply restrictions and reductions in expenditure, and it is not clear that these arrangements are likely to produce greater impetus for the provision of more cost-effective care. Restricting the supply of new GPs is unlikely to encourage practicing GPs to be more efficient. This is because at present, there are few incentives in the system which reward parsimonious use of health resources (without compromising standards of care).

In contrast, budget holding provides a useful set of financial incentives through which more cost-effective care is encouraged. These have been prime reasons for the establishment of budget holding schemes in the UK and NZ (Maynard 1994, Borrem and Maynard 1994), while also accounting for the enormous spread of managed care (and HMOs more generally) in the USA (Reinhardt 1996, Rosenman 1996). Importantly, cost-effective care is encouraged through two central characteristics of budget-holding: (i) financial risk, and (ii) enrollment. Through financial risk-sharing, GPs have an incentive to ensure that services are funded within the constraints of their budget (Wilton and Smith 1997) and this eliminates the need for excessive numbers of consultations. Enrollment not only enhances the bargaining capacity of GPs through 'force of numbers' (Reinhardt 1996) but also ensures that GPs are better able to provide 'continuity of care' (Macklin 1992) while counteracting the potential of patients to involve in 'doctor-shopping'.

A further important element of budget-holding arrangements is that it restricts the ability of GPs to over service through open-ended FFS arrangements (see below).

5.2 Fee-for-Service Medicine

With respect to increases in FFS expenditures, the Commonwealth Government has chosen to work towards reducing the reliance on FFS expenditure, mainly through the introduction of a more 'blended payment system' with practice payments through the Better Practice Program, and through the Divisions of General Practice whereby GPs or Divisions are able to seek funding for projects. While this move towards alternative payment methods is laudable, nevertheless there are several problems with this approach.

For example, Better Practice payments are only made to approximately 32% of practices (1,084 in April 1996) with such payments only constituting approximately 7.7% of the revenue that those practices received at this time (Commonwealth Department of Health and Family Services 1996).

While this scheme should be recognised for the quality of care improvements that it is endeavouring to foster (particularly greater continuity of care), nevertheless these payments only represent a small proportion of total GP income. It is unlikely therefore, that this scheme will have much impact in *aggregate* on the over-servicing incentives currently created through FFS arrangements.

In contrast, expenditure on the funding of Divisional projects has been of greater significance, with program funding growing rapidly from \$18.9 million in 1992/93 to \$57.6 million in 1995/96 (Commonwealth Department of Health and Family Services 1996). In the November 1994 funding round, the average value of project grants per division was \$154,657 with the average size of each project grant at \$44,616. At this stage, few projects have been economically evaluated so it is difficult to consider their overall cost-effectiveness. Nevertheless, preliminary analysis of Divisional projects approved in 1993/94 by the Access Support and Evaluation Resource Unit (SERU) and the Public Health and Health Promotion SERU (1996) are suggestive that projects vary in quality. Although both these SERUs reported that Divisions may now be 'more experienced' in running projects, there is a need for urgent *economic evaluation* as to the overall efficiency of this initiative.

While expenditure on the funding of Divisional projects may be commended for encouraging activities previously not rewarded through FFS provision (for instance health education and promotion), and while the projects may encourage Divisions to better integrate health services, these same results could also be achieved through the incentives created by budget holding initiatives. For instance, budget holding encourages greater preventative medicine as GPs have an incentive to ensure that their patients remain as 'healthy as possible' to eliminate the need for more costly care, which may be avoidable (Pritchard and Beilby 1996). Within these arrangements, GPs are better placed to 'educate and promote' healthy lifestyles on a *continuous* basis without recourse to separate funding of 'once off' health promotion activities through the Divisions. In addition, through providing GPs with incentives to develop appropriate care for their patients, they are encouraged to shop around for alternative services and providers. This leads to the potential for greater integration of care.

In particular, it is useful to reflect on the experiences of NZ and the USA leading to the development of budget-holding arrangements. Escalating costs (particularly through open-ended FFS) arrangements led to inefficiencies in health care provision in these countries, becoming a significant factor leading to budget holding reform (Jacobs and Barnett 1996, Robinson and Casalino 1995).

5.3 Coordination of Care

The Commonwealth Government's coordinated care proposals have been designed to meet the needs of high quantity medical service users without developing an open-ended system, based on FFS to cover non-medical services (Duckett, Hogan and Southgate 1995). A total of 12 coordinated care trials from five states are currently in the development phase, with some of the features as follows: (i) Medicare entitlements are to be preserved; (ii) client (patient) participation is voluntary with exit allowed at any stage; (iii) enrollment offered only to defined populations in target groups expected to have high service use/needs; (iv) clients have access to a 'skilled

coordinator'; (v) funding provided from an 'envelope' of funds initially based on average client costs; and (vi) services covered by the trial include medical (both GP and specialist care), pharmaceutical, community support, allied health and hospital in-patient and outpatient services. (Commonwealth Department of Human Services and Health 1995).

While these trials represent an important step towards a more coordinated approach of health care provision, nevertheless a range of problems exist and some remain skeptical (Montalto 1997). For example, the coordinated care trials focus on 'high users or the chronically ill' and while this can be justified, as Medicare does not provide comprehensive services for this group and as there are significant cost savings to be made in this area (Jackson 1996), others have questioned the definition of 'high users' (Duckett 1996). For instance, chronically ill patients may be high users of medical services for one year and not another (ie the population is not static). Additionally, a focus on 'high users' emphasises the cost-savings objectives of health reform rather than targeting service enhancement (Henderson *et al* 1988, Duckett 1996).

Further, while coordination may be improved (which in itself represents a cost saving), it is not clear that coordinators will necessarily be encouraged to 'shop around' for services which are *most* cost-effective. This is because within the trialling arrangements there is no financial incentive to encourage this, as coordinators ultimately do not stand to benefit if savings can be made. This is a deliberate feature of the trials. Budgets are absolutely fixed, and must remain neutral, with no over or under spend in each year. Although this provides some incentive to discover less costly services, it does not match the incentives provided by explicit budget-holding where both profit and loss can be sustained. It is also not clear that quality of care (through continuity of care) will be enhanced as patients will be able to 'drop out', or receive additional services outside of the coordinated care trial if they so choose (although the trial will not pay for such additional care, clients are still eligible for all Medicare services and there is uncertainty over the impact of private insurance).

In contrast, budget holding not only improves coordination of care, but also introduces complementary cost-effectiveness incentives. In the UK and NZ, budget holding arrangements were introduced in-part to better facilitate and coordinate care (Department of Health 1989, Scott 1994) while in the USA, HMOs are popular with their enrolled populations for the coordinated, continuity of care type of approach that is taken (Davis *et al* 1995). However, a prime facilitator for the spread of budget holding reforms is the incentives that are created for GPs to prescribe quality care within budgetary constraints.

It is important that ultimate budgetary responsibilities are allocated as there is evidence to suggest that costs of operating practices in Australia may be significantly greater than in the UK. For instance, Gunning (1997) compared the processes and costs of managing chronic health problems (eg asthma, diabetes and depression) between two similar practices, one in the UK and the other in Australia. In particular, this pilot study was able to conclude that the UK practice was less costly in terms of drug costs and GP/specialist services whereas in the UK, hospital costs were higher. Additionally, patient review was considered more efficient in the UK.

While the results of this study would need to be replicated over larger samples, it is suggestive of the need to ensure that reform in Australia addresses the potential for cost-effective care, not only

those stemming from cost savings attributed to better coordinated systems. Indeed, further research (Baile *et al* 1997) has indicated that 22% of surveyed Australian GPs would like to expand their role in coordination of care and be involved in budget management.²⁴

5.4 Cost-Shifting

While cost-shifting between different jurisdictions or providers is unlikely to be eliminated until wholesale reform of the health system is undertaken (eg managed competition), some commentators have suggested that the COAG reform agenda represents a cooperative approach through which many of these issues may be resolved (Duckett 1995b). However, this approach puts great faith in bureaucracies being able to overcome their respective State/Territory/Commonwealth vested interests!

In particular, these problems were common to NZ and the UK, where significant cost-shifting occurred between different government entities as well as public and private organisations. The advantage of *total* budget holding is that it places financial responsibility for patient care within a single entity, the budget holding primary care provider. This limits the opportunity to shift the costs of care to other providers/organisations. In particular, fundholding GPs in the UK are beginning to move down this path toward 'total purchasing' (British Audit Commission 1995).

5.5 Waiting Lists

While there is some evidence to suggest that casemix funding of public hospitals will serve to increase hospital throughput (and achieve reductions in elective waiting lists) (Duckett 1995a), these achievements are likely to be restricted to the States which have taken the case-mix reform path. Additionally, although waiting lists may decline, other factors such as the more effective integration of primary and secondary care will not be affected by this reform agenda. Although direct collaboration between some Divisions and Hospitals have been successful in improving the interface between GPs and the hospital sector (for a case study see Pirkis *et al* 1996), evidence of widespread GP 'empowerment' remains patchy. Additionally, it will be of interest to ascertain whether such cooperative arrangements prove to be mere 'lip-service' over time.

In the UK, NZ and USA, the idea that primary care providers would be 'empowered' was a powerful incentive for many to become involved in budget-holding reforms (Pritchard and Beilby 1996). In the UK and NZ, waiting lists were extensive, and GPs faced little choice concerning the terms and conditions of health care provision for their patients (Glennister *et al* 1994, Malcolm and Powell 1996). Additionally, hospital providers had little incentive to be responsive to the needs of primary care physicians; however, the implementation of budget holding has caused a dramatic role reversal (especially in the USA) (Inglehart 1994, Rosenman 1996). Particularly through the presence of enrolled populations, GPs are able to bargain and secure cost-effective care from providers. Budget-holding has the ability to empower GPs through the threat of sanction. By being responsible for how patient budgets might be spent, GPs have the ability to

²⁴ A response rate to this survey was 14-18% with 30% indicating they did not want to expand their role with respect to coordination of care; 34% who did want to expand their role but did not want to take into account the costs of care; and 21% who wanted an expanded role in coordination of care and who thought costs should be taken into account, but were reluctant to be involved in budget holding responsibilities (Baile *et al* 1997).

seek care from providers which are more 'responsive' to their needs (Wilton and Smith 1997). It is not clear that supply-side reform (eg case-mix) *alone* has the potential to achieve this.

5.6 Maldistribution

Many difficulties have been raised concerning the introduction of GP budget holding and how this may impact on rural areas. For instance, budget holding may only be suitable for those areas with adequate numbers of GPs and hospitals, and careful prior assessment of local circumstances is required to ensure that already demanding workloads of GPs in rural areas are not significantly increased by additional budget holding responsibilities (Rosenthal 1996). While such claims require further attention, it is clear budget holding *alone* will not serve to counteract the current over-supply of GPs in metropolitan areas and the relative undersupply of GPs in rural areas. However, over time budget holding is likely to have an impact on both the numbers and distribution of GPs as one of the pre-requisites for an 'effective' budget holding scheme is patient enrollment (Wilton and Smith 1997).

In the UK, the first-wave budgets were allocated to practices with enrolled populations of no less than 9000 patients. If 'minimum' thresholds for budget allocations were to apply in Australia, some practices in both metropolitan and rural areas would not reach specified thresholds.²⁵ In particular, for GPs in metropolitan areas practices may no longer be lucrative (due to oversupply) and some will choose to: (i) merge or 'cooperate' with other practices; (ii) retire from general practice; or, alternatively, (iii) relocate in areas which have greater scope for achieving required enrollments. However, it is possible that many of these effects may not hold for rural areas as distances and lower populations may preclude realisation of minimum population thresholds.

²⁵ There is no reason to suppose that patient enrollment thresholds should be the same in both rural and metropolitan areas, however, the absolute size of the enrolled population will necessitate different stop-loss arrangements.

6 Discussion

Australia has a lot in common with other OECD nations in its experience of health care expenditure and provision over the last decade. It has experienced many problems and concerns similar to those of other OECD nations, and in particular to those of the UK, NZ and the USA. These include upward pressure on health care costs, potential reductions in service quality and growth of waiting lists, particularly for public patients. In addition, Australia has experienced problems which might be considered unique due to its system of funding and geographical dimensions, such as the large potential for cost shifting across levels of government and between public and private sectors, as well as a potential maldistribution of GPs across urban and rural areas.

However, whilst many nations, such as the UK and NZ, have pursued some variation of managed competition and the purchaser-provider split to address these problems, and the USA has moved down the managed care reform path, the common element in all has been the focus on budget holding for primary care. In contrast, Australia has been relatively unusual in not moving down a budget holding route, but has instead chosen incremental reform, such as through coordinated care, restrictions of doctor supply and the General Practice Strategy.

The central issue, given this divergence of reform strategies to tackle similar problems, is to establish the likely success of each in achieving its objectives. Given the similarity of many of the core issues of concern, would we expect that the piecemeal Australian reform strategy will produce a more effective and efficient outcome than the more widescale reform of budget holding as pursued by other nations? Put succinctly, the question is whether GP budget holding for Australia would be a panacea or poison.

This paper has reviewed the likely effectiveness and efficiency of the Australian reform strategy in light of experience and evidence of budget holding in achieving similar objectives: principally to stem upward cost pressures, reduce reliance on FFS remuneration, improve coordination of care, reduce the incentive for cost-shifting, reduce waiting lists and tackle the issue of rural-urban imbalance in distribution and access to GPs (see section 5). Within each of these areas the authors have briefly outlined the extent to which it appears that Australian reform will achieve the objectives set, and have indicated how this may differ from the expected impact of budget holding. Of importance is that in **each** case the argument proposed was that budget holding would be more effective, or cost-effective, in achieving the desired objective. That is, GP budget holding, these authors would argue, is more likely to be a panacea than a poison.

However, this is in theory. In practice there are numerous issues to be tackled in any proposal to implement such a budget holding system in the Australian context. For example, as outlined in a previous paper by the authors (Wilton and Smith, 1997), a prerequisite to budget holding would be the enrollment, or registration, of populations with specific GPs. This was already established in the UK for example which eased the transition to budget holding. In contrast, Australia has no such registration system and so a move to budget holding would involve this extra process of registration. On the other hand, information systems in Australia are far more progressed than

they were when GP fundholding was introduced in the UK which would facilitate such a scheme in Australia. In addition, the establishment of Divisions may be fortuitous in the management of budgets by a body other than the GP. However, these issues of practical implementation of such a scheme deserve further research (which is currently being undertaken by the authors) and cannot be covered here. A final point worth noting, however, is that such a scheme may be best reviewed in both the current context and in the likely event of more widescale managed competition reform, as proposed by Scotton (1995).

In conclusion, the authors recommend that budget holding for general practice be considered further as a viable, and potentially more efficient, alternative to the current piecemeal reform of the primary care sector.

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