Primary care funding and organisational policy options and implications: a narrative review of evidence from five comparator countries

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ABSTRACT

Objective: To review innovative models of primary care in different countries in order to identify potential mechanisms for reforming primary care policy in Australia.

Methods: We conducted a narrative review and synthesis of evidence about models of primary care from four English-speaking comparator countries (New Zealand, Canada, the United Kingdom and the United States) and one European country (The Netherlands), with a particular focus on the relevance and applicability of these models to Australia.

Results: We identified four key mechanisms for bringing about reform in primary care: flexible funding, quality frameworks, regional-level primary care organisations, and primary care infrastructure. These mechanisms are interdependent.

Conclusion: There are tensions and tradeoffs involved in balancing professional and bureaucratic control and in linking quality and accountability mechanisms. Enhanced linkage between researchers, policymakers and professional groups could assist in exploring options for effective primary care reform.

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To strengthen primary care in Australia, policymakers need evidence about potential reforms that is sensitive to local contexts, in order to understand what works, for whom and in what circumstances. Internationally, innovative models of primary care exist, including Primary Care Trusts in the United Kingdom, Primary Health Organisations in New Zealand, transmural care in The Netherlands, Family Health Groups in Canada and Health Maintenance Organizations in the United States.[1-10] These represent a move to a more collaborative provision of primary care. Each contains mechanisms designed to achieve change through influencing the relationships between and behaviour of funders, providers and consumers of primary care services. The set and arrangement of these mechanisms in any country reflects the unique local historical context of these relationships.

Within Australia, there has been no systematic analysis undertaken of these models and mechanisms and their potential for promoting primary care reforms locally. In 2005, the Australian Primary Health Care Research Institute commissioned us to conduct a systematic literature review on innovative models for comprehensive primary care delivery. The review was commissioned within a "linkage and exchange" structure,[11] in which commissioned research teams link throughout the review process with policymakers. The term "primary care" here refers to the system of health care workers (predominantly general practice, nursing and allied health professionals) providing locally based first-contact care in the community setting. We considered models in which general practice was included.

Methods

Our review appraised literature from four English-speaking countries (New Zealand, Canada, the UK and the US) and one European country (The Netherlands).[12] Our review questions included the following:

- What innovative mechanisms exist within the primary care system of each country?
- What contextual factors influence the development, implementation and sustainability of these mechanisms?
- What has been the impact on the primary care system?
- What is known about costs and benefits?
- What policy levers are available within Australian primary care to implement such mechanisms?

We electronically searched literature and country databases, including published and ongoing systematic reviews, general databases, Google Scholar and primary care organisation websites. We also undertook hand searches of references listed in journal articles. Grey literature consulted included international and Australian government policy documents, commissioned reports, position papers and policy statements of professional bodies and associations.

We aimed to identify, describe and summarise evidence about innovative mechanisms. We adopted a "knowledge-support review" approach[13] in contrast to a "decision-support review" approach that requires analysis and evaluation to contribute to a specific decision in a particular policy context. Rather than adopting specific evaluative criteria, such as access, quality and efficiency, we used a descriptive and interpretive narrative synthesis approach.[14] This entailed producing descriptive text about country-specific primary care reforms and innovative mechanisms developed and used. Synthesis involved describing common themes, issues and reform mechanisms, highlighting their potential tensions and trade-offs.

Results

Our search retrieved 780 documents, of which 318 were reviewed. We identified four key areas for potential primary care policy reform:

- Flexible funding of general practitioners;
- Quality frameworks at the practice level;
- Regional-level primary care organisations (PCOs); and
- Primary care infrastructure.

We discuss the first three of these and their implications, as there is interest within Australia in reforming primary care funding and organisational arrangements at the systems level, with quality of care an important consideration. Importantly, these areas for potential reform are not independent and, in particular, are dependent on the fourth policy option.

The full report on our review, with a more in-depth discussion of findings, is available at http://www.anu.edu.au/aphcri/Domain/PHCModels/index.php.

Flexible funding of GPs

Supply-side mechanisms, which focus on how regulatory and funding policies influence the organisation, type and level of services available, are more effective in changing the primary care system than demand-side strategies such as patient subsidies or copayments.[15-17] Supply-side mechanisms are usually managed by third-party payers (eg, government and insurance agents) on behalf of consumers. Three main features of these funding arrangements alter the relationship between third-party payers and GPs.

1. Funding general practices rather than individual GPs. Funding groups of GPs and primary care teams, which encourages local joint decision making and teamwork and discourages solo practice, is likely to result in efficiency and quality gains. In Australia, there are examples of payments to practices rather than individual GPs, such as the Practice Incentives Program.

Reform could involve expansion of the Practice Incentives Program to a wider range of quality improvement initiatives. With such reform, GPs and practices could have a choice of funding arrangements, including choice regarding the extent to which practices continue with fee-for-service arrangements, the range of services and activities covered by the funding, and the size and breadth of the GP and primary care provider group included. Service Incentives Payments, chronic disease management payments and other specific payments, which are based on the number of services provided of a specific standard, are currently paid through the Medicare Benefits Schedule to individual GPs. Such payments could be made to practices rather than GPs and could be extended to other disease areas, as in the UK Quality and Outcomes Framework.[18]

2. A plurality of funding mechanisms. Different funding arrangements can accommodate variations in GPs' working practices and styles and may improve recruitment, retention and local service provision. In the UK, GPs can choose General Medical Services or Personal Medical Services contracts, with the latter including salaried and practice-level contract options. GPs (or practices) could opt in or out of different funding options, depending on circumstances. This can enhance recruitment and retention of GPs, who may prefer to control working hours and/or not own a business. This is important, given the feminisation of the medical workforce, and could help provide services in remote and rural areas. Community health services in Victoria are an example of a model in which GPs are offered alternative funding arrangements, including salaried options. Funding arrangements could be negotiated locally between the practice and a regional primary care organisation or health authority.

3. Different funders. Funding arrangements could be between the general practice and a regional-level PCO or health authority, rather than central government (although government, either state or federal, would need to allocate funds and provide a governance and accountability framework). This would allow local flexibility in the service types funded and provided and would enhance the capacity of the system to directly plan for and address regional needs most effectively. An example is Primary Care Trusts in the UK, which are now responsible for negotiating funding arrangements with GPs under General Medical Services contracts. This includes funding for essential services that all practices need to provide, but also for additional services (eg, cervical screening, immunisation, maternity and minor surgery) and enhanced services (eg, specialised services for specific populations). Practices can opt in or out of these services, depending on their circumstances.

In the US, physicians may be funded by one or more Health Maintenance Organizations, in addition to the federal Medicare and Medicaid programs. Primary Health Organisations in New Zealand negotiate funding arrangements with local general practices directly. In Australia, community health services and GP Plus health care centres in South Australia are examples of states negotiating arrangements with the federal government for funding primary health care services. Funds could be pooled and managed by regional-level PCOs.

Quality frameworks at the practice level

Improving quality and consistency of care is a focus of reforms in all countries we reviewed. Various frameworks (eg, the Quality and Outcomes Framework in the UK) and sets of practice-level performance indicators (eg, quality indicators in The Netherlands) exist to measure clinical performance in prevention, disease management and patient experiences. In Australia, quality monitoring exists at the level of practices and Divisions of General Practice, although quality monitoring of clinical outcomes is not a major focus.

Quality measurement mechanisms act primarily at the level of the relationship between GPs and funders. Financial incentives do influence GP behaviour,[19-22] and linking these to adherence to clinical guidelines (as in the UK Quality and Outcomes Framework) is an important mechanism for improving quality, although it still needs careful evaluation. Performance measurement that links quality improvement with accountability can heighten conflict and tension between GPs and funders and needs careful consideration. The two areas may need to be managed by separate agencies. One option would be to link performance with incentives such as grants for practice infrastructure, equipment and facilities, rather than with individual GP financial incentives.

Regional-level primary care organisations

Strong and effective primary health care systems are characterised by a degree of devolution of governance[23-25] in the form of regional-level PCOs. Many manifestations of these exist, including Primary Health Organisations, community health organisations and independent practitioner associations in New Zealand, primary care groups and Primary Care Trusts in the UK, community health services and Family Health Networks in Canada, Managed Clinical Networks in Scotland, and Health Maintenance Organizations in the US.

Regionally based PCOs can play a critical role in implementing policy reforms in the areas of organisation, planning and service delivery. They can have a role in the management and delivery of primary care services, including planning, purchasing and performance management for their catchment; holding budgets; negotiating contracts and service agreements with general practices; bringing nursing and allied health workers together with GPs into joint governance arrangements; and engaging the community in planning and local service development. PCOs vary in the extent to which they are set within clear legislative frameworks, and have independent boards with community representation. Our review suggested that devolution needs to address issues of optimal size of PCOs (balancing local ownership with economies of scale), as well as integration with secondary care and other national health priorities.

Within Australia there are PCOs with varying roles, functions and responsibilities. These include Divisions of General Practice, Area Health Services, Primary Care Partnerships, Primary Health Partnerships, community health services and Multi-Purpose Services. These could be further developed. With legislated boards and multidisciplinary provider representation, such organisations could have a stronger and more effective role in financial management; service delivery and coordination; education and training; professional recruitment and support; systems management; and performance monitoring. Improved capacity and systems for monitoring, auditing and accountability would be required if this were considered.

Discussion

Our narrative review of innovative models for comprehensive primary care delivery provides a locally relevant evidence base for potential Australian primary care policy reform. However, the review highlighted tensions inherent in reform around issues of autonomy of players within the system. PCOs must inevitably balance sustained engagement of practitioners and clinical leaders with ensuring a focus on wider national health priorities. This balance between professional and bureaucratic control in reforms is inevitably a product of local historical relationships between players. Similar trade-offs exist in the way quality and accountability issues are brought together and in managing consumer choice.

Our review is limited. Narrative synthesis is a new and emerging methodology. Our limited time frame and focus on documentary evidence made it difficult to appreciate local contextual factors in depth. Lastly, our brief confined us to a knowledge-support approach and a limited linkage and exchange process. Thus, for example, it was not within our remit to explore in depth the trade-offs between professional and bureaucratic control.

The reform options are interdependent. Flexible GP funding options could be linked to a quality framework that rewards quality improvements. Arrangements need to be established under a national framework linked to adherence to minimum and quality standards, incentives to be cost-conscious, and appropriate management and monitoring of funds and performance by PCOs. Funding options could continue to be managed by the federal government, with GPs free to choose which option suited their circumstances, while pooling some resources at state or PCO level could help establish new funding models. Options exist in Australia, but on a small scale. Further work is needed to explore these and the interdependencies between them. While individual mechanisms could be pursued independently, this is less likely to produce significant change.

Competing interests

None identified.

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