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The new Australian after-hours general practice incentive payment mechanism: equity for rural general practice?

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ABSTRACT

In July 2015, a national scheme for after-hours incentive funding for general practices was re-introduced in Australia, 2-years after funding was transferred to regional primary health care organisations (Medicare Locals). The re-introduction was recommended in a 2014 review of after-hours primary care reflecting the "overwhelming desire" among general practice. Given the centrality of after-hours care provision in rural and remote practices identified in the review, we compare and contrast the current and historical after-hours incentive funding mechanisms focussing on fairness towards rural general practices.

While there are similarities between the current and historical mechanisms, significant differences exist. The comparison is not straightforward. The major consistency is utilisation of practice standardised whole patient equivalents (SWPE) as the basis of funding, inherently favouring large urban general practices. This bias is expected to increase given a shift in focus from practices with no option but to provide 24/7 care to any practice providing 24/7 care; and an associated increased funding per SWPE. Differences primarily pertain to classification processes, in which the realities of rural service provision and recognition of regional support mechanisms are given minimal consideration.

Rapid introduction of the new general practice after-hours incentive funding mechanism has led to inconsistencies and has exacerbated inherent biases, particularly inequity towards rural providers. Impact on morale and service provision in non-urban areas should be monitored.

1. Introduction – policy background

The need to divert inappropriate or non-urgent visits away from emergency departments (ED) is an international concern [1]. The availability of out-of-hours primary care services has been identified as a potentially critical factor leading to non-urgent ED demand. For example, in Sweden, a reduction in ED presentations arose subsequent to an increased availability of out-of-hours care [2]. After-hours clinics have also been identified as minimising on-call demand in Australia, although only viable in urban areas [3].

In Australia, after-hours primary health care, the provision of care by general practitioners outside normal office hours (8am–6pm weekdays and between 8am and 12pm on Saturdays) has been the subject of a number of supply

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side initiatives commencing in the late 1990s. The After Hours Primary Medical Care Trials (AHPMCT) comprised five trials that sought to redress the issue of after hours (AH) general practice care provision in areas of high need from a local perspective [4,5]. Increased ED usage for non-urgent general practitioner (GP)-type presentations was an underlying concern [4,5]. Additionally, a national after-hours general practice incentive payment was introduced as a foundation component of the Australian Government's Practice Incentives Program (PIP) [6].

The PIP after-hours incentive payments were introduced to "help resource a quality after hours service and compensate practices that make themselves available for longer hours, in recognition of the additional pressures this entails" [7]. The intention was to provide the maximum payments to support those practices with unavoidable burden, i.e. no option but to provide 24/7 care [7]. Further, "[f]or quality and safety reasons" practices were "encouraged to explore alternative approaches to providing 24 hour care, seven days a week themselves".

On 1 July 2013, responsibility for after-hours funding was transferred from the Australian Government to 61 Medicare Locals. Medicare Locals were established between July 2011 and July 2012 under the Council of Australian Governments' (COAG) National Health Reform Agreement (2011) by the previous Labor Government [8]. The objective of these organisations was to improve coordination and integration of primary health care delivery in local communities, support health professionals and improve access to primary care [8,9]. A timeline of after-hours-related policy developments and supply-side initiatives is outlined in Fig. 1.

Through their after-hours programs Medicare Locals had the opportunity to develop and/or implement the most applicable and relevant after-hours funding/provision mechanism for their locale. Most Medicare Locals continued with incentive payments equivalent to the PIP payment [6]. However, these payments were associated with significant additional (unfunded) administrative imposts necessitated by the Australian Government [6]. Administrative burden was recently identified as a crucial determinant of the viability of general practice incentives [10]; and was an identified issue with the acceptability of the Medicare Local schemes [6]. Furthermore, the imposts were made under less than ideal circumstances [8], including implementation under tight timeframes whilst the Medicare Locals were being established and replacing the longstanding Divisions of General Practice [6]. Together these elements provided strong foundations for potential ill-feeling by general practitioners towards Medicare Locals. Medicare Locals had been handed the proverbial 'poisoned chalice'.

2. The new national after-hours PIP mechanism

2.1. Purpose of reform

On 1 July 2015, a national after-hours PIP payment was reintroduced. As per the information released in the Budget [11] and subsequently by the Department of Human Services [12], the overarching objective of the new after-hours PIP payment appears to be the implementation of a national scheme to ensure that all practices are treated the same by having access to the same funding process, and with funding directed towards practices providing their own 24/7 care. 'Continuity of care' thus the major focus.

2.2. Political context of the reform

In September 2013, the Liberal and National Coalition were elected to power in Australia after almost 6-years of Labor government. Their election platform promised a review of Medicare Locals [13], with ill-feeling towards Medicare Locals by general practice a major factor [8]. This Review ultimately led to the replacement of the Medicare Locals by 31 Primary Health Networks (PHNs), as announced in their first Budget (May 2014). Also announced at this time was the introduction of new co-payments for attendances at general practices [14]. This proposal that led to considerable ill-will between the government and the medical profession over the ensuing year [15–18].

In the interim, a national review of after-hours service delivery, the Jackson Review, was held to determine "the most appropriate and effective delivery mechanisms to support ongoing after-hours primary health care service provision nationally" [19]. This review, released publicly in May 2015, recommended the adoption of a national approach to after-hours incentive funding in response to an "overwhelming desire to return incentivising after-hours service arrangements back to a PIP payment" among general practice [6]. This recommendation was adopted in the May 2015 Federal Budget [12]. The commencement of the new after-hours PIP to coincide with the replacement of Medicare Locals by the PHNs on 1 July 2015. The new PIP mechanism was to be funded through the cessation of the national After Hours GP Helpline (AHGPH) and the Medicare Locals' after-hours program [11].

The AHGPH was used as a second stage to the national nurse triage service Healthdirect Australia in most jurisdictions. In the Jackson Review, the AHGPH was specified as having mixed reviews, and an unknown cost-benefit ratio [6]. It was noted as particularly relevant to rural and remote communities and residential aged care facilities, although potential benefits were offset by a lack of local knowledge and a lack of integration. The Review argued for the consideration of the "future role of the AHGPH and how it may be targeted in future to increase its efficiency and effectiveness". On 2 July 2015 after the commencement of the new PIP mechanism, the Department of Health reinstated the AHGPH for areas where there was no face-to-face services [20]. This was a quiet reversal, not becoming widely publicised until July 15 [21].

The re-introduction of the after-hours PIP was thus implemented during a period of considerable turmoil in primary health care policy. Two major medical bodies the AMA and the RACGP being particular vocal in the context of this turmoil [22,23]. With the re-instatement of the AHGPH the changes will also have been implemented with significant, unanticipated costs.