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FUNDHOLDING IN AUSTRALIAN GENERAL PRACTICE

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TABLE OF CONTENTS

Title Page	i
Abstract	ii
Signed Statement	v
Acknowledgments	vi
Abbreviations	vii
 CHAPTER ONE	
THE AUSTRALIAN HEALTH CARE SYSTEM WITH PARTICULAR REFERENCE TO GENERAL PRACTICE	1
<i>Introduction</i>	1
<i>Section One:</i> The Current Funding Structure of the Australian Health Care System	3
1.1.1. Introduction	3
1.1.2. Breakdown of expenditure	4
1.1.3. General medical services	9
1.1.4. Pharmaceuticals	16
<i>Section Two:</i> Current and Future Dilemmas for the Financing of the Australian Health Care System	19
1.2.1. The ageing population	19
1.2.2. The growth in the use of health technologies	23
1.2.3. The shift to primary care	25
1.2.4. The change in consumer expectations	27
1.2.5. The plurality of funding sources	28
1.2.6. Efficiency in the Australian Health Care System	33
<i>Section Three:</i> General Practice	38
1.3.1. Introduction	38
1.3.2. Remuneration	40
1.3.3. Workforce	42
1.3.4. Deskilling and lack of integration	45
1.3.5. Quality of general practice and of health care	47
1.3.6. Consumers and general practice	50
1.3.7. Other Issues	52
1.3.8. General practice and fee-for-service	55
1.3.9. Changes in primary care world wide	58
 CHAPTER TWO	
MANAGED CARE, MARKET REFORM AND THE ROLE OF FUNDHOLDING	60
<i>Section One:</i> Managed care and market reform	61
2.1.1. Introduction	61
2.1.2. The failure of the best possible market in health care	64

2.1.3	Why consider managed care	69
<i>Section Two:</i>	Fundholding in other countries	71
2.2.1	United Kingdom fundholding	71
2.2.1.1.	Introduction	71
2.2.1.2.	Establishing a budget	74
2.2.1.3.	Data collection systems	77
2.2.1.4.	The role of the general practitioner under fundholding	78
	(a) Administration	79
	(b) The GP-patient relationship	80
	(c) General practitioner clinical behavior under fundholding	82
2.2.1.5	Quality of health care	89
2.2.1.6.	Equity	93
2.2.1.7.	Efficiency	95
2.2.1.8.	Recent developments under the new Labour Government	99
2.2.1.9.	Conclusion	102
2.2.2.	Fund holding in New Zealand	103

CHAPTER THREE

THE STUDY METHODS including AN ANALYSIS OF PREVIOUS RESOURCE USAGE BY THE PARTICIPATING GENERAL PRACTITIONERS	107
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<i>Section One:</i>	The Study Methods. The Overview	107
3.1.1.	Overall aim	107
3.1.2.	The primary hypothesis	108
3.1.3.	The Objectives of the thesis	109
3.1.4.	Background	111
3.1.5.	Assessment of technical and allocative efficiency	117
<i>Section Two:</i>	The Study Practices	118
3.2.1	The general practitioners and their practices	118
3.2.2.	Historical analysis of available practice information on resource utilisation and people attending	124
3.2.3.	Summary	140
<i>Section Three</i>	The Prospective Study Methods	143
3.3.1.	Qualitative methods	143
3.3.1.1.	Reflective participatory observation	145
3.3.1.2.	Interviews	146
3.3.1.3	The systematic review	148
3.3.2.	Quantitative methods	149
3.3.2.1.	Introduction	149
3.3.2.2	The data collected	150
3.3.2.3.	Data collection instruments	150
	(a) Consultations	150
	(b) Pharmaceuticals, pathology and diagnostic imaging	151
3.3.2.4	The data collection periods	151
	(a) First data collection period - July-September 1995	151
	(b) Second data collection period – January-March 1996	152

(c) Third data collection period – April-June 1996	152
3.3.2.5 Data entry and coding	152
3.3.2.6 Development of costing models	156
(a) Costing of ordered items	156
(b) Total costings per specified groups	157
3.3.2.7. Data adjustment	157
3.3.2.8. Data validation	161
3.3.2.9. Analysis across the age and sex profile of the practices	164
3.3.2.10. The development of a predictive costing model	165
3.3.2.11. The development of practice budgets	165
3.3.2.12. Comparison with the approximate budget for the first half of 1996	166

CHAPTER FOUR

QUALITATIVE METHODS – RESULTS AND DISCUSSION 167

<i>Section One:</i> Qualitative Results	167
4.1.1. Reflective participatory observation	168
4.1.1.1. The practices overall	168
4.1.1.2. The practice staff	169
(a) Reception staff	169
(b) General practitioners	171
4.1.1.3. Software considerations	172
4.1.1.4. Data collection	174
4.1.2. General practitioners – pre intervention interviews	175
4.1.3. General practitioners questionnaire responses - pre and post intervention	182
4.1.4. General practitioner interviews - the value of the information on the resulting costs of their management decisions	191
<i>Section Two:</i> Discussion regarding the qualitative results	197
4.2.1. The practices overall	198
4.2.2. The role of the general practitioner in fundholding	203
4.2.3. The key issues for a general practitioner to become a fundholder	205
4.2.4. Computers and the general practitioner	213
4.2.5. Data and the general practitioner	215
4.2.6. Behaviour change and the general practitioner	218
4.2.7. Quality of care	221
4.2.8. Regulations	223
<i>Section Three:</i> Summary and clarification of the Objectives	224

CHAPTER FIVE

QUANTITATIVE DATA COLLECTION - RESULTS AND DISCUSSION 228

<i>Section One:</i> Quantitative Results	229
5.1.1. Overall data set	229
5.1.1.1 First data collection period July-September 1995	230

5.1.1.2	Second data collection period January-June 1996	241
5.1.2.	Analysis of the effect of age and sex on costs	252
5.1.2.1	Stage 1	252
5.1.2.2	Stage 2	256
<i>Section Two:</i>	Discussion of quantitative results	268
5.2.1.	Accuracy of data collection	268
5.2.2.	Resource allocation by practice and by general practitioner	275
<i>Section Three:</i>	Results and Discussion of the Regression Models	281
5.3.1	Examination of the interaction of all variables on mean cost per item ordered	281
5.3.2	Discussion of the results from the modelling	285
<i>Section Four:</i>	Summary	286

CHAPTER SIX

THE DEVELOPMENT OF THE PRACTICE BUDGETS AND THE FUNDHOLDING FRAMEWORK 288

<i>Section one:</i>	The Development of Practice Budgets	
6.1.1.	Budget approximation	288
6.1.2.	Budgetary predictions	297
6.1.3.	Summary	301
<i>Section Two:</i>	The Development of the fundholding framework	302
6.2.1.	Introduction	302
6.2.2.	The role of the general practitioners	303
6.2.3.	The role of other practice staff	306
6.2.4.	The methods required to develop a practice budget	308
6.2.5.	The responsibilities of the Commonwealth and State Governments and the private sector	310
6.2.5.1	Commonwealth Government responsibilities	310
6.2.5.2	State Government responsibilities	311
6.2.5.3	Private sector responsibilities	312
6.2.6.	The role of the consumers	312
<i>Section Three:</i>	Summary	313

CHAPTER SEVEN

THE APPRAISAL OF THE FUNDHOLDING FRAMEWORK AND AN ASSESSMENT OF THE TECHNICAL EFFICIENCY OF A FUNDHOLDING GENERAL PRACTICE 314

<i>Section One:</i>	Appraisal of the Fundholding Framework	315
7.1.1.	Analysis of costs	315
<i>Section Two:</i>	Assessment of technical efficiency	327
7.2.1.	Base case model and sensitivity analyses	327
7.2.1.1	Base case	332
7.2.1.2.	Variation of practice size and total budget	335
7.2.1.3.	Variation of practice infrastructure costs	335
7.2.1.4.	Variation of anticipated savings	336

7.2.1.5.	Variation of Commonwealth Government transaction costs in the pre-fundholding year	337
7.2.1.6	Variation of discount rates	338
7.2.2.	Graphical comparison of the sensitivity analyses	338
7.2.3.	Which scenario is likely?	343
CHAPTER EIGHT		
ASSESSMENT OF ALLOCATIVE EFFICIENCY		346
8.1.	Introduction	346
8.2.	Assessment of allocative efficiency	347
8.3.	The effect of the proposed fundholding framework on the health system overall	351
8.4.	The effect of the proposed fundholding framework on consumers	357
8.5.	The effect of the proposed fundholding framework on general practitioners	363 368
8.6.	GP fundholders as part of a regional managed care model	371
8.7.	Conclusion	
References	376

ABSTRACT

This thesis examined the hypothesis that fundholding in Australian general practice could be more efficient, in both technical and allocative terms, than fee-for-service for consultations, pharmaceuticals, pathology and diagnostic ordering. The research indicates that there may be a place for fundholding in Australian general practice, if general practice fundholders were integral members of a regional managed care model. There is now a need for a larger trial where actual monies are managed within a "real" budget or a limited introduction within a carefully structured development and evaluation framework.

The study was completed in three urban general practices. A mixture of qualitative and quantitative methods were initially used to develop a framework for fundholding. The qualitative methods included the use of reflective participatory observation and interviews. A series of questionnaires complemented these techniques. The quantitative methods included the gathering of information on consultation, pharmaceutical, pathology and diagnostic ordering costs for the general practitioners (GPs) based within the practices. These costs were then used to develop budgets for the three practices. A method was created for the documentation and comparison of mean cost per ordered item across the GPs and practices. A final multiple regression model which included GP variables, conditions treated and the age and sex of the patients allowed a more focussed examination of the effect of the GP on mean cost.

Following the development of the framework a series of economic models were developed. A systematic review was completed to identify strategies that could be integrated into a fundholding practice to produce gains in efficiency within these models. The economic models examined the conditions where fundholding could be more efficient than fee-for-service general practice.

There are a number of conditions that would need to be satisfied within this model for gains in efficiency to occur. They include:

(a) at a general practice level:

Improvement in resource management would be required among GPs. In this thesis, a 14% variability in mean cost per ordered item for the GPs involved was identified in the multiple regression model. Secondly, there would need to be the adoption of strategies that have been proven to change behaviour to bring about gains in efficiencies. The systematic review identified a number of feasible strategies including academic detailing and computerised feedback of the costs of ordered tests and prescriptions. Thirdly, an appropriate budget of at least \$5 million for a group of general practices with yearly group infrastructure costs of \$417,145 and group capital costs of \$215,000 would be required. The capital costs would mainly cover information technology needs. The group would need to have a minimum number of 34-36 full time GPs. The required budget would be reduced if the yearly infrastructure costs were lower. In the economic model created for the thesis, a group infrastructure cost of \$330,199 would decrease the budget to approximately \$4.5 million and the GP group size to 28-30 full time practitioners.

(b) At a regional health system level:

A method to link the fundholding practice to a regional funding pool that included Commonwealth and State Government monies, and the rapid development of capitation based budgets, with a decreased reliance on historical approximation would be important prerequisites. This study has developed a possible model based around conditions treated and the age and sex of the attendees. Models of risk sharing between the fundholding practices and the regional sponsors would be important.

The consequences of the adoption of fundholding would vary. For the health system overall, the adoption of this model within a region should create improved linkages in primary care, allowing GPs to be more easily integrated with all other providers. The current push to move patients to primary care would, theoretically be more easily managed, especially if gains in efficiencies

were used to fund new services. It is unrealistic to consider that GP fundholders might be able to control the costly tertiary sector which is the most expensive element in the health care system. Cost shifting would still be a significant problem, unless the regional managed care pool embraced all Commonwealth and State Government monies.

For general practice, fundholding would create new opportunities for innovation and re-skilling and allow more active linkage of quality care to financial rewards. GPs would be freed to pursue other roles, such as involvement in shared care and working in primary health care teams. Patient linkage would be a prerequisite and there is evidence that GPs are likely to find this a positive benefit.

The rapid implementation of the information technology required for budgetary management would be an important inducement for the profession. The data collection required by GPs, if they want to fundhold may be a substantial burden for them and methods need to be sought to manage this issue.

It is likely that the current growth in overall pharmaceutical expenditure would be slowed or even halted, if appropriate interventions were implemented within capped pharmaceutical budgets.

For consumers the actual consequences are unclear. It is likely that consumers would become active partners in a developing fundholding practice and this would be a welcome change. Consumer needs should be more appropriately met, particularly if fundholding practices were offering individualised packages of care. Theoretically, quality of care could improve, but the evidence is not convincing that this scenario would eventuate. Similarly, improved integration and service provision could flow from this model, providing important benefits for particular groups such as the elderly. Some form of patient linkage would be required, and the reaction of Australian consumers to this concept is unclear, even though it seems apparent that most GPs would welcome this change.