

Keep up to date with new Australian primary health care research

ISSN 1839-6348

Issue 43
May 2015

Jodie Oliver-Baxter

This *RESEARCH ROUNDup* explores the application of blended funding models in primary health care. It presents a snapshot of examples and evaluations of effects and consequences of implementing blended funding models in Australia, New Zealand and Canada and the impact of these approaches on organisations, care delivery for chronic conditions and patient experience.

Most developed countries have moved to, or are continuing to move towards, some mixture or blend of funding models in their health systems.¹ Funding models around the delivery and quality of primary health care has been in the spotlight in recent times (Table 1). Instances of blended funding in primary health care occur when payment for services undertaken by a GP for a patient are calculated and paid in a variety of ways from multiple payers. For example, there has been recent discussion of changes to Medicare's universal 'fee-for-service' approach with an annual payment which pays GPs a lump sum per patient, rather than for each visit².

Policy Context

In 2009 the National Health and Hospital Reform Commission reported that there was considerable confusion, uneven access, variation in the quality of care received, cost blaming and service shifting due to the complex division of funding responsibilities, performance and accountability across government levels in Australia.³ Since then substantial investments have been implemented through incentives to GPs to enroll, deliver and coordinate primary and allied health services for people with diabetes. This involves the creation of blended funding models. For example grant payments to support multidisciplinary clinical services and care coordination as well as outcomes payments to incentivise good performance, and episodic or bundled payments.⁴ The use of different payment systems for hospitals, GPs and other providers has also discouraged integration and cooperation within the health system.^{5,3}

Blended funding models often occur where there are gaps in service availability. For example, integrated payment models, referred to as bundled or capitated contracts-integrated funding, have been utilised since the 1970s for the primary care of Indigenous populations through Aboriginal Community Controlled Health Services. Similarly, the pooling of federal and state or territory government funding into 'Multi-Purpose Services' provide a range of health and aged care services to defined populations in some rural areas. Such hybrid models are

often used to address weaknesses associated with single-base funding models.^{6(p.30)}

In Australia, the **Diabetes Care Project**^{7,8} began enrolling eligible practices and people with diabetes across regions in Queensland, Victoria and South Australia in 2012. At the GP practice level (N = 150), amongst other things this programme trials new funding models. Capitation funding will be received by intervention arm of 50 GP practices along with pay-for-performance payments. Practices receive up-front payments plus additional performance bonuses for achievements on relevant clinical indicators (i.e. HbA1c levels)⁹. Outcomes from this project have not yet been released.

New Zealand

Since 2009, New Zealand has moved towards a blended payment system that combines a universal capitated general medical subsidy, patient copayments, and targeted fee-for-service payments for specific items such as comprehensive free reviews for patients with diabetes, care of other chronic conditions, and immunizations.¹⁰ The benefits of capitation have been found to include **better use of provider mix** (services that GPs previously had to provide to claim benefits can now be delivered by other team members, usually practice nurses); patient enrolment (the relationship between patient and provider is more explicit, allowing greater accountability for provider behavior); and accurate demographic information. This also provides a rich data platform for individual and population care, quality improvement activities, planning, and research.¹¹ However, the impact of blended payment changes is not well researched. Moving to capitated funding has not changed the transactional nature of GP consulting because patient fee-for-service payments remain a significant portion of income¹¹.

Canada

Canadian examples of blended payments have been evolving over the past 10 years¹²⁻¹⁴, with voluntary capitation introduced

Table 1 Examples of blended funding models

Blended capitation	Capitation based on a defined basket of primary care services provided to enrolled patients. Reimbursement is age and sex of adjusted capitation payments each patient. Fee-for-service paid for other services. Additionally, GPs receive a monthly comprehensive care capitation payment for all enrolled patients.	e.g. Family Health Network, Canada
Enhanced fee-for-service	GPs receive the majority of payment through fee-for-service billing. Voluntary patient enrolment. Enrolled and Patient Fees (i.e. New Patient Fee) and some incentives, premiums and bonuses, chronic disease management and preventive care are paid for eligible services to enrolled patients.	e.g. Family Health Group, Canada
Blended salary model	Physicians are salaried employees of community or mixed governance practice teams. Salary based on the number of enrolled patients, plus benefits and/or incentives.	e.g. Aboriginal Health Services, Australia

Blended funding models in primary health care

in 2007. Health care in Canada is organised at the provincial level resulting in a natural, ongoing experiment in new models of care.¹ Several programmes implemented in Ontario and based on blended funding, have been evaluated. These include examination of the impact of funding approaches on populations with multimorbidity, complex mental health conditions as well as reported patient experience under different models.

The **Diabetes Management Incentive (DMI)** is a C\$60 per patient annual bonus that physicians receive for planned, ongoing management of patients with diabetes according to elements from the Canadian Diabetes Association's Clinical Practice Guidelines. These include tracking and monitoring of HbA1C, health promotion counselling and patient self-management support.¹⁵ Comparisons between physicians practicing in an enhanced fee-for-service model and a blended capitation model have indicated that physicians in a blended capitation model are more responsive to the Diabetes Management Incentive than physicians in an enhanced fee-for-service model.¹⁵ Similar findings have been reported whereby patients assigned to a traditional fee-for-service physician were least likely to receive optimal monitoring compared to those enrolled in a blended fee-for-service model.¹⁶ This study identified that Ontarians with diabetes enrolled in a capitation model were more likely than those enrolled in an enhanced fee-for-service model to receive the optimal number of recommended monitoring tests.

Blended funding models and the primary care of patients with **complex mental health conditions** has also been explored. In Ontario, primary care practitioners are offered \$1000 per year for enrolling five patients with bipolar disorder or schizophrenia, and an additional \$1000 for rostering another five such patients (i.e. maximum incentive \$2000).¹⁷ Three new types of medical homes have evolved, distinguished primarily by mode of physician remuneration: enhanced fee-for-service, blended capitation, and team-based blended capitation.¹⁸ The major distinction between the blended capitation models is that team-based practices have non physician providers, often including mental health workers.¹⁷ Almost half of the capitation practices were team-based, many of them incorporating mental health workers in their multidisciplinary clinician teams. Despite physicians in all three types of medical homes receiving financial incentives for rostering patients with severe mental illness, people with mental illness were under-represented in Ontario's capitation-based medical homes.¹⁷

The influence of blended funding models on **patient experience** has also been investigated by measuring family-centred care (FCC), a holistic approach.¹⁹ The four service delivery funding models included salaried community health centers (n = 35), fee-for-service practices (n = 35), capitation-based health service organisations (n = 32) and blended remuneration family health networks (n = 35). Patient-reported FCC scores were high and did not vary significantly by primary care model. However a larger number of nurse practitioners and clinical services on-site were both associated with higher FCC scores and scores decreased as the number of family physicians in a practice increased and if practices were more rural.²⁰

Summary

Blending funding models in primary health care are complex, politically and professionally challenging and require well-integrated systems. Hybrid funding approaches must consider flexibility, accountability, adequacy and adjustment during payment reform.²¹

References

- 1 Phillips RL. (2012). International Learning on Increasing the Value and Effectiveness of Primary Care (I LIVE PC). *The Journal of the American Board of Family Medicine*, 25(Suppl 1), S2-S5.
- 2 Heath J. (2015). New funding model for GPs to replace co-pay, *Financial Review*. Fairfax Business Media: Australia.
- 3 Department of the Prime Minister and Cabinet. (2014). *Reform of the Federation White Paper: Roles and Responsibilities in Health*, Issues Paper 3. Canberra: Australian Government.
- 4 Commonwealth of Australia. (2010). *A National Health and Hospitals Network for Australia's future-Delivering better health and better hospitals for all Australians*. Canberra: Australian Government.
- 5 Bennett CC. (2013). Are we there yet? A journey of health reform in Australia. *MJA*, 199(4), 251-255.
- 6 Australian Government Productivity Commission. (2015). *Efficiency in Health: Productivity Commission Research Paper*. Canberra: Australian Government.
- 7 Fountaine T, Shaw JE, Zimmet PZ. (2012). Designing payments for GPs to improve the quality of diabetes care. *MJA*, 196(9), 568-568.
- 8 Scott A, Harris MF. (2012). Designing payments for GPs to improve the quality of diabetes care. *MJA*, 196(1), 24-26.
- 9 Leach M, et al. (2013). The Diabetes Care Project: an Australian multicentre, cluster randomised controlled trial [study protocol]. *BMC Public Health*, 13(1), 1212.
- 10 New Zealand Government. (2014). *Briefing to Incoming Minister: Health*. Wellington NZ: The Treasury.
- 11 Goodyear-Smith F, et al. (2012). International Learning on Increasing the Value and Effectiveness of Primary Care (I LIVE PC) New Zealand. *The Journal of the American Board of Family Medicine*, 25(Suppl 1), S39-S44.
- 12 Collier R. (2009). Shift toward capitation in Ontario. *Canadian Medical Association Journal*, 181(10), 668-669.
- 13 Hutchison B, et al. (2011). Primary health care in Canada: systems in motion. *Milbank Quarterly*, 89(2), 256-288.
- 14 Sweetman A, Buckley G. (2014). Ontario's Experiment with Primary Care Reform. *SPP Research Papers*, 7(11).
- 15 Kantarevic J, Kralj B. (2013). Link between pay for performance incentives and physician payment mechanisms: evidence from the Diabetes Management Incentive in Ontario. *Health Economics*, 22(12), 1417-1439.
- 16 Kiran T, et al. (2014). The Relationship between Primary Care Models and Processes of Diabetes Care in Ontario. *Canadian Journal of Diabetes*, 38(3), 172-178.
- 17 Steele L, et al. (2013). Inclusion of persons with mental illness in patient-centred medical homes: cross-sectional findings from Ontario, Canada. *Open Med*, 7(1), e9-e20.
- 18 Glazier RH, Redelmeier DA. (2010). Building the patient-centered medical home in Ontario. *JAMA*, 303(21), 2186-2187.
- 19 Hogg W, et al. (2008). Framework for primary care organizations: The importance of a structural domain. *Int J Qual Health Care*, 20(5), 308-313.
- 20 Mayo-Bruinsma L, et al. (2013). Family-centred care delivery: Comparing models of primary care service delivery in Ontario. *Canadian Family Physician*, 59(11), 1202-1210.
- 21 Miller HD. (2014). *Issue Brief: Making the Business Case for Payment and Delivery Reform*, Ed Network for Regional Healthcare Improvement, Center for Healthcare Quality and Payment Reform. Washington DC: Robert Wood Johnson Foundation.

Acknowledgement: Thank you to expert reviewer Adjunct Associate Professor Paresh Dawda for his comments on a draft of this paper.