Australian Health System (Primary care)

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Overview

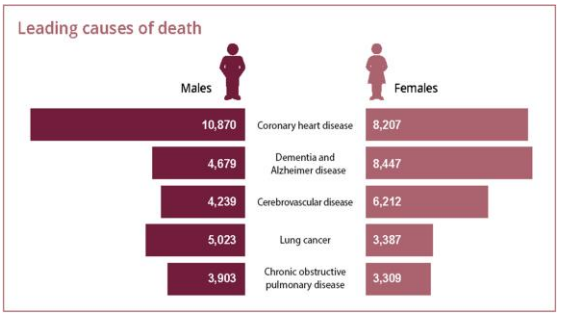
Australia is a Federation of 6 states and 2 territories:

~ 25 million

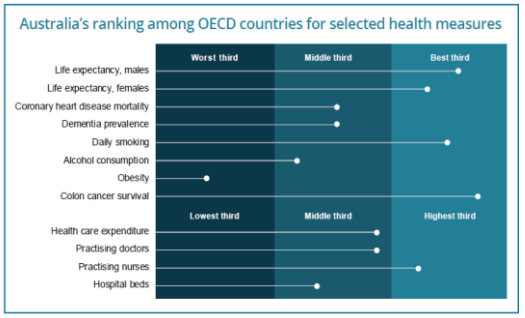
15% aged 65 and over

Life expectancy: M (80.4) and F (84.5)

Leading causes of death



Australia and the Organisation for Economic Co-operation and Development (OECD) countries



Selected indicators

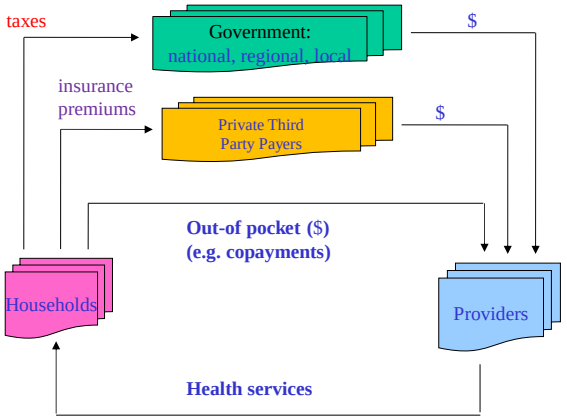
	Publicly funded coverage for a core set of services (%)	Total health care spending per capita	Doctors per 1,000 population	IMR (per 1,000 live births)	Asthma and COPD hospital admissions (per 100,000 population)	Obesity among adults (% of adult population who are obese)
UK	100	$4,192	2.8	4	303	26.9
Australia	**100**	**$4,700**	**3.1**	**3**	**310**	**27.9**
Canada	100	$4,753	2.7	5	250	25.8
USA	31.8	$9,892	2.6	6	262	38.2

Ref: The Organisation for Economic Co-operation and Development (OECD). *Health at a Glance 2017: OECD Indicators*, 2017, OECD Publishing.

Health system

- Taxation-funded universal health insurance with incentives for private insurance
- Mainly run by federal government
- A mix of public and private service providers

- Choice of participation: Compulsory
  - Every resident is (to some extent) mandated to contribute to health care financing (e.g. via taxes)
- Coverage: Universal
  - Every resident is entitled to access a uniformly predefined set of services



Health system

- Total health expenditure (2016-2017): $181 billion (10.2% GDP)
- Health expenditure:
  - Government funding (69%)
    - Commonwealth: 42%
    - State/Territories: 27%
  - Non-government (e.g. private health insurance and out of pocket): 31%
- Household spending on medical care is 5% of household expenditure on all goods and services
  - 40% private health insurance
  - 30% outpatients services
  - 27% pharmaceuticals
  - 3% other including hospitals

(Ref: 2016-ABS Household Expenditure Survey)

Health System: Finance

- Out of hospital services (Federal via Medicare), E.g.
  - Private GP or Specialist practices
- Hospitals
  - Public hospitals (co-funded by federal and state governments): Free public hospitals for all Aus
  - Private hospitals: Federal via Medicare + private insurance
- Subsidized private health insurance (Federal)
- Public health and community health (State government)
  - Aboriginal health services
- Subsidized residential Aged Care (Federal)

- Australia's universal health insurance scheme
- Ensures all Australians have access to free or low-cost medical, optometry and hospital care according to clinical need
- Individuals are free to choose private health services
- Provides coverage for the costs of medical services for citizens, as well as coverage for people from countries with whom Australia has reciprocal arrangements

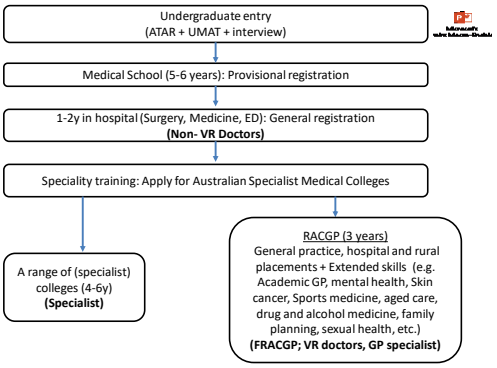
Medicare: Source of fund

- Medicare levy: A percentage levy on taxable incomes
  - Currently 2%
- Medicare levy surcharge:
  - If your income is above a certain threshold, and you don't have appropriate private hospital cover
  - The surcharge is in addition to the Medicare levy (1-1.5% depending on income)

Medicare rebates

- Medicare Benefits Schedule (MBS)
  - Primary care visits (GPs): Gatekeeping/ point of entry to system
  - Specialist visits
  - Services such as medical procedures, optometry services, dental services for people with chronic conditions
  - Other outpatient services (e.g. imaging services, blood test, etc.)
  - Some private hospital services (e.g. doctor fees)

How to become a GP?



GP activities

- GPs visit 30 patients/day
- 85% of the Australian population see a GP at least once a year
- More than 137 million GP services delivered by 37,000 GPs
- General practice spending: ~ 10% of total health expenditure (primary care: 36%)
- The mean length of consultation: 14.9 minutes (median: 13m)
- GPs make 16 referrals per 100 visits
  - 82 prescriptions, 48 lab test orders, 11 imaging service orders/ 100 visits

Common GP MBS items

	MBS Group A1 (Vocationally registered GPs)	**MBS Group A2** (Non VR)
Level A- Brief	$17	$11
Level B- Standard	$37	$21
Level C- Long	$72	$38
Level D- Prolonged	$107	$61

Common GP MBS items

- Proactive GP Management Plan: $145 (once a year)
  - A comprehensive written plan describing patient needs, management goals, health promotion activities, and treatment
  - Team Care Arrangements (develop and coordinate team care): $114
  - Review and revisions of the plan (every 3 months): $72
- GP mental health plan: $105 ($134 for GPs who have undertaken mental health skills training)

Common GP MBS items

- Practice Incentive Programs
  - Aim: to improve quality of care and health outcomes (e.g. Diabetes Incentive Program)
    - $1/patient: Payment to practice for the use of recall/reminder system for patients with diabetes
    - $20/diabetic patient: Payment to practice if GPs have completed a diabetes cycle of care for at least 50% of their patients
    - $40/diabetic patient: Payment to GPs for each annual cycle of care completed

Annual diabetes cycle of care

Activity	Frequency and description
Assess diabetes control by measuring HbA1c	At least once.
Carry out a comprehensive eye examination	The patient must have had at least 1 comprehensive eye examination over the current and previous cycle of care. The examination isn't needed if the patient is blind or doesn't have both eyes.
Measure weight and height and calculate Body Mass Index (BMI)	Measure height and weight and calculate the BMI on the patient's first visit and weigh them at least twice more.
Measure blood pressure	At least twice.
Examine feet	At least twice. This isn't needed if the patient doesn't have both feet.
Measure total cholesterol, triglycerides and HDL cholesterol	At least once.
Test for microalbuminuria	At least once.
Measurement of the patient's estimated Glomerular Filtration Rate (eGFR).	At least once.
Provide self-care education	Provide patient education about diabetes management.
Review diet	Review the patient's diet and give them information on appropriate dietary choices.
Review levels of physical activity	Review the patient's physical activity and give them information on appropriate levels of physical activity.
Check smoking status	Encourage the patient to stop smoking.
Review medication	Review patient's medicine.
Note: practices must perform activities needed twice in a cycle of care at least 5 months apart.	

Quality prescribing incentive

- $1/patient paid to practices that
  - participate in a clinical audit of prescribing for high cost medicines
  - Case-based distance learning, presenting common clinical scenarios with a set of questions designed to help refine GP clinical decisions and management plan
  - practice visits by an independent pharmacist

"My Health Records"

- All Australians have a "My Health Record" (storing an individual health information) unless they opt out
  - A shared health summary
  - Medicare claims history, hospital discharge information, diagnostic imaging and lab reports, and details of allergies and medications

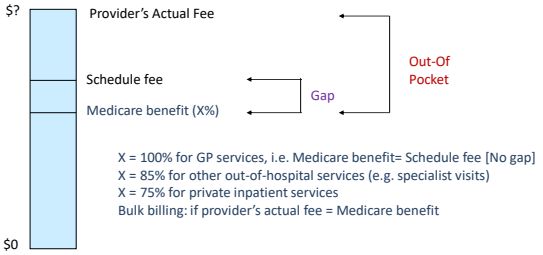
How does the MBS work?

- For each listed medical service, there is a unique item number, a description of the service, along with a fee set by government (Schedule fee)
- Medicare benefit is the amount a patient can claim per service which is a fixed % of schedule fee (75% to 100%)
- Private health care providers can set own fees (provider's actual fee)

How does the MBS work?

- If Medicare benefit does not cover 100% of schedule fee for a medical service, then
  - Gap= the difference between Medicare benefit and schedule fee (paid by patients)
- If the provider's actual fee is higher than Medicare benefit for a medical service, then
  - Out of pocket= Difference between the provider's actual fee and Medicare benefit (paid by patients)
- If the provider's actual fee = Medicare benefit, then
  - Bulk billing (i.e. zero out of pocket)

MBS: Fees, benefits & co-payments for medical services



X = 100% for GP services, i.e. Medicare benefit= Schedule fee [No gap]
X = 85% for other out-of-hospital services (e.g. specialist visits)
X = 75% for private inpatient services
Bulk billing: if provider's actual fee = Medicare benefit

Medicare safety net (out of hospital services)

Threshold	Threshold amount	Eligibility	What the benefit is
Original	$470 (based on gap amount)	All Medicare cardholders	100% of schedule fee for out of hospital services
Extended concessional	$680 (based on out of pocket costs)	Concessional cardholders (+ low income)	80% of out of pocket costs for out of hospital services
Extended general	$2,133 (based on out of pocket costs)	All Medicare cardholders	80% of out of pocket costs for out of hospital services

- **Schedule fee** is a fee for service set by the Australian Government
- **Gap amount** is the difference between the Medicare benefit and the schedule fee
- **Out of pocket costs** is the difference between the Medicare benefit and what your doctor charges you.

Pharmaceutical Benefits Scheme (PBS)

- Medicare covers or subsidises the cost of pharmaceuticals listed on PBS

	Patient contribution	PBS Safety net threshold	Contribution when PBS threshold is reached
General patient	$38.80	$1,494.90	$6.30
Concession card holder	$6.30	$378	Nil

Two key funding models

- Australia: Fee-for-service (FFS) + Gatekeeping (through financial incentives)
  - Paid for each individual service provided
  - The more services provided, the higher the income
  - Fees paid: Out of pocket or reimbursed by a third party
  - Supplier-induced demand (SID)?
- UK: Capitation
  - Each GP has a list of registered people
  - GP receives a fixed fee for each person registered (+ adjustment) regardless of the amount or level of services provided
  - Income is based on the number of patients registered
  - Breaks the link between income and number of services provided
  - Greater continuity of care
  - SID is less likely

Incentives

Payment method	Paying for what	Incentive to increase the number of patients treated (or listed)	Incentive to perform more preventive activities	Incentive to increase the number of services provided	Incentive to refer patients more often to specialists	Incentive to spend longer time with each patient	Potential impact on health care costs (Health system)
FFS	Volume of activity	High	Low	High (Over provision)	Low	Low (but it may vary)	Limited
Capitation	A fixed amount per enrollee	High (up to threshold)	High	Low	High	High	Good

Enhancing primary care: Investing and implementing cost-effective interventions

- Rising workload and growing pressures on GPs with adverse impact on health promotion activities
  - Shifting to practice nurses
    - Incentives to recruit more practice nurses
    - More involvement of practice nurses in preventive care (health promotion activities)
  - Example: PN involvement in diabetes, obesity, and depression
    - Afzali H, et al. A risk adjusted economic evaluation of alternative models of involvement of practice nurses in management of type 2 diabetes. Diabetic Medicine 2013; 30:855-863

Enhancing primary care: Investing and implementing cost-effective interventions

- Aging population and need for avoiding unplanned hospital admissions
  - Karnon J, Afzali, et al. A cost-effectiveness model for frail older persons. Applied Health Economics and Health Policy 2017; 15:635-645.
- Recent call for proposals to generate evidence for new or improved integrated models of care to manage older people within primary care to avoid hospitalisations

Enhancing primary care: Investing and implementing cost-effective interventions

- Need to develop more integrated (and efficient) care
  - GP super clinics (2011): Responding to community needs and focusing on multidisciplinary integrated team-based approaches for chronic disease prevention and management
    - GP services
    - Specialist services (consulting rooms for visiting specialists)
    - Practice nurses
    - Pharmacy services
    - Dental Services
    - Allied Health and Nursing – diabetes nurse educators, dietitians, social workers, physiotherapy, psychology
    - Linkage with hospitals (triage services)

Enhancing primary care: Investing and implementing cost-effective interventions

- Need to develop more integrated (and efficient) care
  - Establishing Primary Health Networks (PHNs)
    - Investigating local health care needs
    - Worforce (GP) modelling and prediction
    - Aligning general practices and community health care
      - Moving from traditional (dispersed general practice) towards an integrated primary and community care given local needs
    - Support for GPs, including continuing education (priorities such as diabetes, asthma, CVD, alcohol and drugs, mental health, aged care)
    - Regular GP round table (feedback from GPs on the direction of care in their area)

Summary

- Training and education
  - Appropriate skills of commutation skills
  - Addressing complex ethical situations
  - Understanding the importance of preventive medicine, and long-term condition management plans
  - Developing skills for working in groups/teams (team care management plans)
  - Understanding principles of economic evaluation and the impact of their clinical decisions on population health
- Health system
  - Primary care as a speciality and gatekeeping (GPs are much more than gatekeepers)
  - Using incentives to manage long-term conditions with GPs leading the coordination of care
  - Allowing for longer (GP) consultation time (payment system): Increased personalised care
  - PHNs
  - Specialists to collaborate with (and support) primary care
  - Sharing electronic care records
  - Research grants to help improve primary care (cost-effective models of care)