

General practice: who's paying the piper?

Robert W Pegram

There are three points of conflict in how general practitioners receive income that are, I believe, at the centre of the internally inconsistent and often confused position in which we find ourselves.

The first is between how general practices receive their income and how general practitioners receive theirs. When the world was flat and most practices were the practitioners in them, this did not matter. Today it does, as the many income streams flowing into a practice form a pool from which, after being evaporated by costs, the practitioners receive fiscal sustenance. Provided the pool is sufficiently deep, it matters little — in purely financial terms — how the income stream flows (in ideological terms, this is another matter). I contend that, in the future, there will be a clear distinction between practice revenues and practitioner incomes. If one is determined to continue to drink from a diminishing pool, then so be it.

The second point of conflict is that society has chosen for primary care — a public good — to be provided largely through a private business model. Public goods are about accountability, resource rationing and managing public expectation at minimum cost. Private industry is about autonomy, providing what customers want and maximising profits within the constraints of business competition and legislation. Many of the funding incentives around population health and the GP workforce have been necessary to deal with market failures, and the need to support an essential private industry by means of various public subsidy regimens.

The third point of conflict is between the individual and society. The most important person for a GP at any given moment is the patient sitting opposite. Funders, on the other hand, are interested in populations. From their point of view, individuals may fare

worse, provided not enough of them do so to damage population averages. However, a GP cannot accept that any patient should fare worse.

So, who do GPs and practices serve — the patient, the business, or the funder (as the agent of society)? I would like to see:

- Practices commissioned to provide care for patients at a payment that is based on a true costed model for infrastructure costs plus a margin. This would target high care need groups where simple fee-for-service payments are not viable.
- Divisions of General Practice managing pools of resources on behalf of general practice for the mutual benefit of those working in those practices and the populations they serve.
- Less money and fewer resources devoted to managing the funding demilitarised zone between the federal and state governments.

Some will recognise that points one and two have already been achieved in some places — witness the Hunter Urban Division of General Practice After Hours Network for the first, and the Access to Psychologists program for the second. The Hunter Urban After Hours scheme provides realistic levels of funding from federal and state governments and Division(s) into a managed pool that allows total flexibility in how services are provided and paid for. The net result is an integrated regional after-hours service (including an after-hours telephone triage and advice service, five GP clinics located in hospitals and the community, patient transport where needed, and a home visit service) that is highly valued by all, yet allows choice.¹ The Access to Psychologists program, as part of the Australian Government Better Outcomes in Mental Health Initiative, allows GPs to refer patients to mental health professionals for focused psychological strategies. It allows flexibility in how the service is provided by specifying inputs (grants provided to each Division) and outcomes (patients requiring such interventions). The bit in between is delivered through local variation within an overall program framework.²

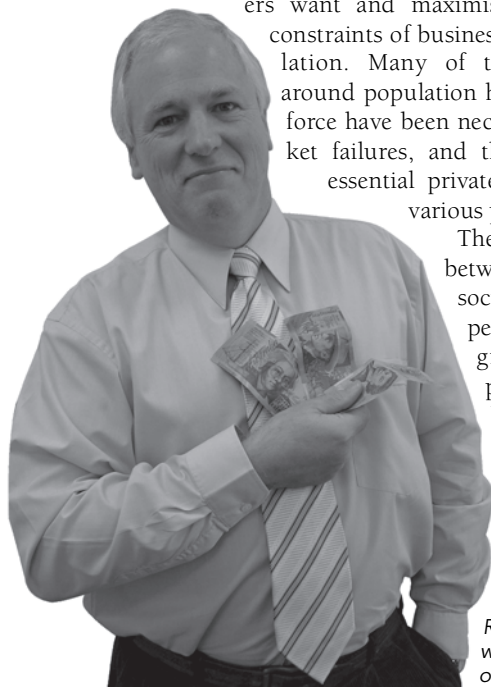
As for the third point, well, as Meatloaf once sang, “two out of three ain't bad”.

Competing interests

I am currently a part-time, contracted, percentage-of-fees-generated paid GP, as well as a salaried health service manager (having sampled full fee-for-service remuneration as a practice principal, salaried employment and mixed arrangements).

References

- 1 Hunter Urban Division of General Practice website. Available at: <http://www.hudgp.org.au/index.cfm?fuseaction=programs&fusesubaction=article&documentID=30&articleID=70> (accessed June 2005).
- 2 Australian Government Department of Health and Ageing. Requirements for general practitioner referral of patients for focussed psychological strategies. Available at: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-boimhc-require.htm> (accessed June 2005).



Robert Pegasus holding what is about the value of a GP consultation.

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