



Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

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

Amanda L. Neil^{a,*}, Mark Nelson^{a,b,1}, Andrew J. Palmer^{a,2}^a Menzies Institute for Medical Research, University of Tasmania, Private Bag 23, Hobart, TAS 7001, Australia^b Discipline of General Practice, University of Tasmania, Private Bag 23, Hobart, TAS 7001, Australia

ARTICLE INFO

Article history:

Received 24 August 2015

Received in revised form 30 April 2016

Accepted 10 May 2016

Keywords:

Reimbursement

Incentive

After-hours care

Health care reform

Rural health services

Equity

Australian health system

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.

© 2016 The Authors. Published by Elsevier Ireland Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

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

* Corresponding author. Tel.: +61 3 6226 4640.

E-mail addresses: Amanda.Neil@utas.edu.au (A.L. Neil),

Mark.Nelson@utas.edu.au (M. Nelson), Andrew.Palmer@utas.edu.au (A.J. Palmer).

¹ Tel.: +61 3 6226 4734.

² Tel.: +61 3 6226 7729.

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.

1998	National Practice Incentives Program established. After-hours incentive funding a foundation component.
1999	Australian Medical Care Practice Trials, including: GP Assist in Hobart and surrounds, Tasmania GP Access in the Hunter region, New South Wales – triaged after hours clinics and phone triage service late at night Healthdirect Australia in Perth, Western Australia – nurse triage service.
2003	GP Assist established as an integrated statewide after-hours service, utilizing local nurse then GP triage
2007	Healthdirect Australia (HDA) commenced as a 24-hours advice/triage line in most Australian states and territories, including Tasmania, excluding Victoria and Queensland.
2010	Audit of PIP Program. After-hours incentive payments found to have the highest levels of non-compliance.
2011	July: National After hours GP Helpline commenced, not used in Tasmania
2011-2012	Introduction of Medicare Locals replacing Divisions of General Practices.
2013	July: Healthdirect became the 'gatekeeper' to telephone triage in Tasmania July: Responsibility for after-hours funding transferred to Medical Locals September Liberal Party elected to power, election platform included a review of Medicare Locals. December Review of Medicare Locals announced
2014	May: announcement of replacement of Medicare Locals with Primary Health Networks (Federal Budget) May: announcement of new co-payments (Federal Budget) August: Tenders for new PHNs called. August: National review of after-hours service delivery announced
2015	28 January: Tenders for new PHNs closed. 3 March: Co-payments withdrawn. 11 April: Initial 28 PHNs announced. 12 May: announcement of reintroduction of national after-hours incentive (PIP) payment (Federal Budget) 12 May: announcement that funding for new after-hours PIP to be derived through cessation of the national After Hours GP Helpline and Medicare Locals After Hours programs (Federal Budget) 22 May – GP Access After Hours in the Hunter secures an additional year of funding 22 May – Basic structure of new after-hours PIP mechanism released 5 June – Detailed structure of new after-hours PIP mechanism 5 June – Final three PHNs announced 30 June – Last day of Medicare Locals 1 July – PHNs commenced 1 July National after-hours PIP payment re-introduced. 2 July national After Hours GP Helpline re-instated

Fig. 1. Timeline of major Australian policy developments and supply side initiatives impacting general practice after-hours service provision.

2.3. Content of reform

The new after-hours PIP funding structure released in overview on 22 May 2015 [24], and in detail on 5 June 2015 [12], pays for five levels of service provision although funding is equivalent for two of the categories (Fig. 2). Payments are based on a practice's standardised whole-patient equivalents (SWPEs), capped at 20,000 SWPE, with 1000 SWPE considered equivalent to the annual workload of the average full-time general practitioner [25].

SWPE are the sum of the fractions of care provided to practice patients weighted for their age and gender. Fractions of care are assessed as the proportion of care, the number of GP and non-referred consultations, a given general practice provides an attending patient during a 12-month reference period, based on their total number of

claims made through Medicare, Australia's universal health scheme and Department of Veterans' Affairs [26,27]. The SWPE calculation process is illustrated by the formula presented in Textbox 1.

Payments under the reform range from \$1.00 per SWPE per annum for Level 1 practices to \$11.00 per SWPE per annum for Level 5 practices. Rural practices are also eligible for rural loading of up to 50%.

2.3.1. Overview of rurality in the PIP program

Within the PIP program practices in rural locations are eligible for a rural loading based on the practice location's Rural Remote and Metropolitan Area (RRMA) classification [28]. The RRMA is a seven level categorisation: Capital city; Other metropolitan centre; Large rural centre; Small rural centre; Other rural centre; Remote centre; Other remote area. For non-metropolitan locations, defined as locations

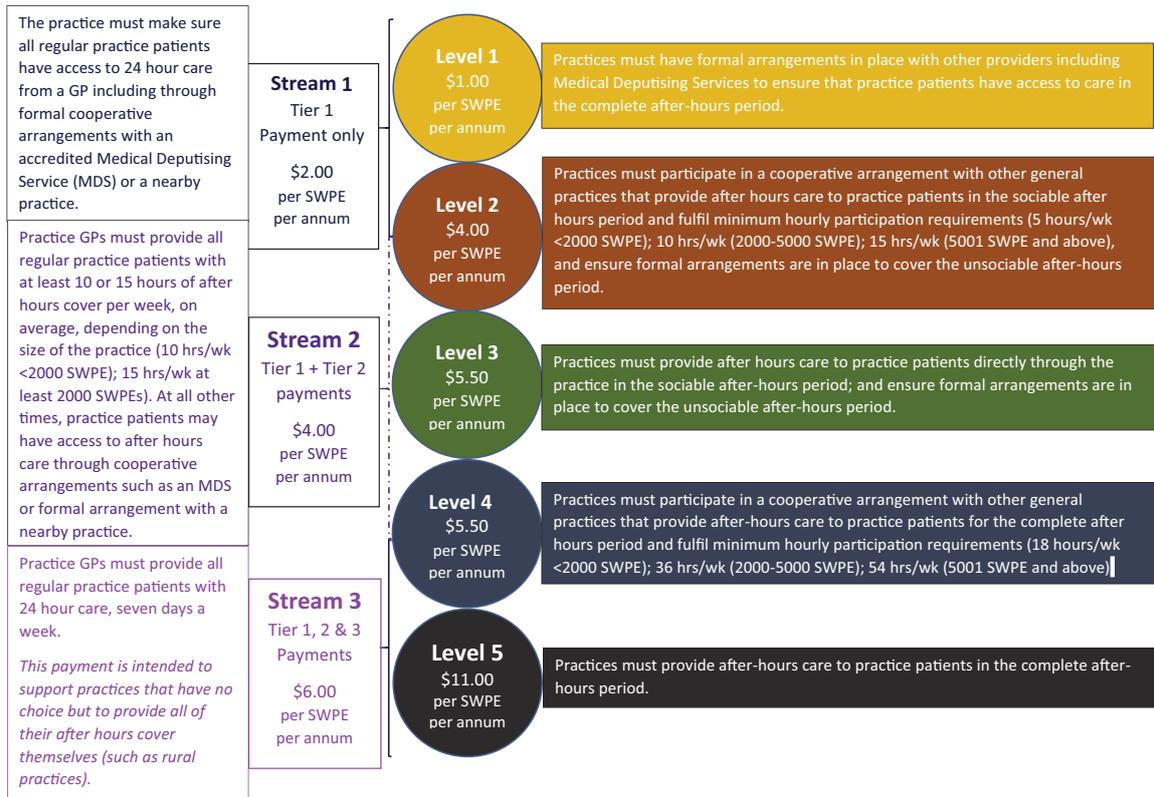


Fig. 2. Relationships and comparative payments under 3 streams of pre-July 2013 and 5 levels of post-July 2015 after hours PIP mechanisms. 8am to 12pm Saturdays; and all day Sundays and public holidays
Sociable after-hours period: 6pm to 11pm weeknights
Unsociable after-hours period: 11pm to 8am weekdays, hours outside of 8am and 12pm Saturdays and all day Sundays and public holiday.

Box 1: Calculating standardised whole patient equivalents (SWPE)

$$SWPE_P = \sum_{i=1}^n \omega_{asi} \alpha_{iP}$$

where:

SWPE_P = Standardised whole patient equivalents for a given general practice, P

ω_{asi} = age and sex adjusted weighting factor applicable to patient *i*

α_i = Proportion of GP and non-referred Medicare & Veterans Affairs claims (count) for patient *i*, undertaken in general practice P, during a rolling 12-month reference period

Weighting factors (ω_{as}) as at February 2016 (Calculating the SWPE value).

Patient age (years)	<1	1–4	5–14	15–24	25–44	45–64	65–74	75+
Female	0.5556	0.8399	0.5229	0.8333	1.0229	1.1046	1.4771	2.2157
Male	0.6078	0.915	0.5327	0.5392	0.6797	0.9052	1.3333	2.0392

Sources: Derived from information presented in [26,27].

with a population less than 100,000 people, remoteness is categorised on the basis of population size/density of a Statistical Local Area (SLA) and the straight-line distance from the geographical centre of the SLA to the nearest urban centre within each of four population categories [29]. The RRMA has historically been employed to influence general practice policy [30], although its use is considered problematic [29–32].

The PIP rural loadings are 0% for Levels 1 (Capital cities) and 2 (Other metropolitan centres); 15% for Level

3 (Large rural centres); 20% for Level 4 (Small rural centres); 40% for Level 5 (Other rural centres); 25% for Level 6 (Remote centres) and 50% for Level 7 (Other remote areas). As loading for remote centres (RRMA-6) is markedly less than for other rural centres (RRMA-5), anomalies can also arise in the operationalisation of the rural loading through the PIP. For example, practices in Mareeba, an RRMA-6 location, on the Atherton Tableland in Far North Queensland, will receive significantly less funding per SWPE than practices in Atherton classified at RRMA-5. The respective

populations of these locations are 8449 and 7226; and they lie 70 km and 90 km from the nearest population hub of Cairns (RRMA-3; population 146,758) [33,34]. Both locations have a hospital with a 24/7 accident and emergency department, although Atherton Hospital has the largest referral centre on the Tablelands.

Rural general practitioners may also be eligible for State-based payments to ensure the availability of medical practitioners at local hospital facilities, hospital provision being a State responsibility. However as reflected by arrangements pertaining in the State of Tasmania, while specific locations may be identified as eligible for support, the agreement is between the State Government and individual general practitioners, and not all general practitioners within a designated location may be eligible [35].

2.4. Comparison of new and historical mechanisms

Historically, the PIP after-hours mechanism was comprised of three effective streams based on an accumulation of Tier payments; Stream 1 comprising Tier 1 payment only, Stream 2 comprising Tier 1 and Tier 2 payments, and Stream 3 comprising Tier 1, 2 and 3 payments (Fig. 2). Each Tier was funded on the basis of SWPE. Practices in rural locations were further eligible for rural loading as detailed above.

The highest payments (Stream 3) were intended for those practices with no option but to provide around the clock care, i.e. 24 hours/day, 7 days/week [7] and thus experiencing unavoidable burden. Overall, funding under the model was primarily influenced by practice size based on SWPE and then stream, with rurality having the least impact [36,37]. The re-introduced after-hours PIP mechanism thus has several commonalities with the historical mechanism with funding based on a practice's categorisation according to the type and extent of after-hours services provision and payment per funding category based on the practice's size (SWPE). Differences arise in the categorisation process, the funding per category and the capping of SWPE overviewed in Table 1.

2.4.1. The categorisations

Comparing categorisations (Levels – new scheme; Tiers – historical scheme) the greatest commonalities appear at the extremes. There appears to be a direct correlation between Level 5 criteria and Tier 3 (Fig. 2), and a partial correlation between Level 1 and Tier 1. Level 1 comprising the subset of Stream 1 practices that ensured care through alternate providers, or who would not meet requirements for Level 2. The major differentiation thus pertains to Levels 2, 3 and 4 (new scheme) and Tier 2 (historical scheme).

Level 2 (new scheme) appears to have less stringent requirements than for Tier 2 (historical scheme) (Fig. 2). This is true in relation to hourly participation requirements. For example, practices with less than 2000 SWPE were required to provide 10 h per week cover to achieve Tier 2 status as compared with the 5 h per week currently required to achieve Level 2 status. However, under the new scheme practices must operate in a cooperative with other practices to provide care from a GP from within the cooperative during the sociable hours (6pm to 11 pm weeknights,

Table 1

Overarching changes between the Historical and New PIP Mechanisms, and the Impacts Thereof.

Change	Potential impacts
Categorisation	Practices may find it more difficult to fulfil requirements to provide care within a co-operative or alone across the entire sociable hours (Levels 2 and 3) or within a co-operative across the entire 24 h period 7 days per week (Level 4) as compared with Tier 2 (historical) requirements. Regional specificity has been given superficial consideration as reflected by the operationalisation of the mechanism for Tasmanian general practice.
Funding per category	There is the potential for halving to almost doubling of payments per SWPE from the lowest to highest categories. Given that funding based on SWPE favours larger practices, the benefits to larger practices will be enhanced. Payments to most Tasmanian general practices are expected to decrease given the operationalisation of the categorisation process.
Capping of SWPE	An attempt to limit the impact of practice size on payment with the utilisation of SWPE. However, the cap is only expected to affect the very largest urban practices in the major metropolitan cities. Thus, unfairness previously identified within Tasmania will not be addressed.

25 h over a week). Face-to-face contact is expected to occur where clinically appropriate and deemed safe and reasonable, so practices appear to need to be conveniently located to facilitate patient access. This is difficult for more rural and remote practices so Level 2 is implicitly of greater relevance to locations with sufficient density of practices to ensure viability, i.e. urban locations.

Level 3 (new scheme) distinguishes those practices who provide their own care during the 25 sociable hours period, as compared with 10 h across the after-hours period for practices with less than 2000 SWPE and 15 h for practices with at least 2000 SWPE under Tier 2 (historical scheme). In rural settings (RRMA 3–7) “the provision of GP care through local arrangements outside of the practice, such as local hospital arrangements, will be acceptable as long as practice patients have access to a practice GP.” During the unsociable hours alternate providers, including other practices and Medical Deputising Services may be utilised. Level 3 is thus being primarily directed at more rural practices. However, as this Level allows for ‘sharing of the load’ during the unsociable hours, there is still an implicit expectation of a degree of proximity between providers.

Level 4 is for practices that operate in a co-operative over the complete after-hours period, 365 days of the year subject to minimum levels of service provision by three size bands (e.g. 18 h/week for practices with <2000 SWPE). The ability to act within a co-operative arrangement again indicates an implicit level of accessibility across practices to enable face-to-face contact, as for Level 2. As indicated above Level 5 is focussed on provision of 24/7 care by a given practice and thus appears to have direct correlation with Stream 3. Local arrangements are allowed for Level 5 rural practices; although no alternate provider provision is

allowed during the unsociable hours for any practice. There may thus be an expectation that this Level will be of particular relevance to the most remote and isolated practices, although this is not definitive.

2.4.2. Funding per category

Funding per SWPE for general practices within Stream 1 of the historical mechanism at \$2.00 per SWPE per annum may be either reduced by reclassification to Level 1 (\$1.00/SWPE/annum) or increased by reclassification as Level 2 (\$4.00/SWPE/annum). For historical Stream 2 (meets Tier 2 criteria, and receives Tier 1 and 2 payments) general practices payments per SWPE may be maintained by reclassification as Level 2 at \$4.00 per SWPE per annum or increased through reclassification as Level 3 or 4; and for Stream 3 (meets Tier 3 criteria, and receives cumulative Tier 1, 2 and 3 payments, \$6.00/SWPE/annum), payment may be either decreased or increased by reclassification as Levels 3 or 4 (\$5.50/SWPE/annum) and Level 5 (\$11.00/SWPE/annum) respectively. Notably, there is the potential for an almost doubling of payment received by practices classified at Level 5, relative to Tier 3.

3. Expected outcomes: Is the new after-hours PIP scheme fairer to rural practices?

In the national after-hours review after-hours care provision was noted as central to the care provided by rural and remote practices [6]. In this section, the fairness of the new after-hours PIP scheme to rural general practice is examined with reference to its impact on Tasmanian general practice.

Tasmania is an island state comprising 0.9% of Australia's landmass [38,39], and 2.2% of its population [38,39]. Tasmania's population is the most widely dispersed population of any Australian jurisdiction, and almost 60% of its general practices are located in rural areas (RRMA3-7), compared to the Australian average of 32% for general practices receiving PIP [40,41]. Tasmania has a long-standing history of innovation in after-hours care provision, including the introduction of the local GP telephone triage service, 'GP Assist', an alumna of the After Hours Primary Medical Care Trials, and most recently development and implementation of an incentive funding mechanisms through the then Tasmania Medicare Local [32].

3.1. The impact of practice size on funding

The major consistency between the current and historical after-hours PIP mechanisms is the utilisation of SWPE as the basis of funding, which leads to greater payments for larger practices [36,37]. However, under the new mechanism, there has been an attempt to limit the impact of SWPE (practice size) through the imposition of a 20,000 SWPE cap. As the average size of a practice in Tasmania is less than 4000 SWPE [36], this cap will only pertain to the largest urban practices in the major metropolitan cities.

Large practices reaching the SWPE cap will receive an annual PIP payment of \$220,000 (Level 5, 20,000 SWPE x \$11.00/SWPE/annum), \$100,000 more than they would have received under the historical mechanism. In contrast,

a practice with 1000 SWPE would receive \$5000 more per annum over historical funding levels (assuming both are in metropolitan locations). For a small remote practice (1000 SWPE, RRMA-7 location), the increase would be \$7500.

One therefore questions whether the expected "increase in the number of practices that are providing after-hours support" [42] will be more likely to occur amongst large urban practices, particularly given the potential to use such significant levels of PIP support strategically. For example, to employ a medical practitioner specifically for after-hours care, particularly given that fee-for-service for individual attendances would still be charged.

3.2. What value is placed on the unavoidable burden faced by rural practices providing around-the-clock care?

As noted previously, the historical mechanism was intended to preferentially support those practices with unavoidable burden. In contrast 'continuity of care' holds precedence based on rhetoric and funding priorities in the current mechanism. As illustrated in *Textbox 2*, the maximum value placed on unavoidable burden in remote locations under the new mechanism is \$15.90 per night, an increase of \$2.89 per night over the historical mechanism.

Meanwhile, as remoteness rather than practice size has been found to be a stronger independent predictor of after-hours service provision [36], the solo practitioner will likely be providing more care. Given the impacts of funding per SWPE noted above, the unfairness many rural practices have previously noted in regard to the historical after-hours PIP mechanism [36], will only be exacerbated under the new PIP mechanism.

3.3. Regional specificity under the new mechanism

Within Tasmania, the local GP telephone triage service 'GP Assist' has been an integral element of after-hours care for well over a decade. Under the new PIP mechanism GP Assist has been classified as a cooperative general

Box 2: What is the value of unavoidable burden under the New PIP mechanism?

A general practice with 20,000 SWPE has the workload equivalent to 20 full-time doctors. Assuming there are 20 doctors, each doctor in the practice would effectively have to be on-call for the equivalent of about one-night every 3 weeks (365 days/20 doctors). In contrast, a doctor in an isolated practice providing care to the equivalent of 1000 SWPE, i.e. a doctor in a solo practice without any ability to "share the load" would be on-call every night. On the basis of the PIP payments for a Level 5 practice, the value of the rural practitioner being on-call the extra 346 nights as a sole practitioner ((365/1) - (365/20)) in a remote location can be equated to \$15.90 per additional night on call (\$16,500-\$11,000)/346). This is a small incremental increase over historical payments. Under the historical mechanism, the value of a rural practitioner being on call the extra 346 nights as a solo practitioner was \$13.01 ((\$9000 - \$6000)/346).

Box 3: The impact of the Tasmanian GP triage service 'GP Assist' being classified as a cooperative practice.

In Tasmania any general practice that utilises the local GP telephone triage service 'GP Assist' is restricted to claiming at Levels 2 and 4 under the new PIP mechanism [43]. Even a solo practice in a remote area necessitating face-to-face provision by the local general practice at all times. Furthermore, practitioners are not able to claim practitioner time provided to the GP Assist service against hourly practice requirements for face-to-face provision under Levels 2 and 4. In turn, utilisation of GP Assist for initial triage will result in practices receiving less PIP under the current scheme. Whether any reduction in payments will lead to practices stopping provision of after-hours care is a real consideration, particularly given there is no longer a requirement for practices to ensure care at all times to obtain general practice accreditation [46]. As noted in the after-hours review there is "a need to ensure that rural GPs did not walk away from providing after hours – as once a GP ceases after hours service provision, it is difficult to reengage them" [6].

practice rather than a local arrangement by the Commonwealth [43]. This categorisation limits Tasmanian general practices' ability to utilise GP Assist and/or obtain after-hours PIP funding (Textbox 3). Thus "encouragement of regional specificity" as recommended in the national review [6] appears to have been given insufficient consideration in the development process. Further, the classification of this local telephone triage service appears inconsistent with consideration of the reinstated national afterhours GP helpline, because general practices in rural areas where it operates are still eligible for Level 5 status.

The impact on general practice morale and service provision of the new after-hours PIP should be monitored. Assessment of how well "[t]he PIP after-hours incentive will give General Practices positive support for ensuring that their patients have access to quality after-hours care" is also required [44]. Evaluation of how well the mechanism "encourage[s] and support[s] general practices to provide after hours coverage for their patients" [45] and what, if any, impact there is on continuity of care; and how this varies by region should be pursued.

4. Conclusion

The PIP mechanism is a long-standing tool employed by the Australian Government to support and/or influence general practice, including after-hours care provision, and has the wide-spread acceptance of general practice both in rural and urban locations. Incentive payments may thus be a useful tool to 'encourage' general practice behaviour in other countries. However, the objectives of any mechanism should be determined *a priori*, and potential differential impacts on urban and rural providers considered during design, implementation and evaluation. In the context of Australia's new general practice after-hours incentive funding mechanism, rapid implementation has led to inconsistencies compounded by uncertainties,

and inherent biases towards large urban practices have been exacerbated. Robustness and fairness have been undermined. Impact of the mechanism on morale and after-hours service provision in non-urban areas should be monitored. There remains room for improvement in Australian general practice after-hours incentive funding, particularly regarding funding distribution.

Conflict of interest

In January 2014, the Menzies Institute for Medical Research, University of Tasmania was funded under contract to the then Tasmania Medicare Local to develop a new after-hours incentive funding model for Tasmania under the Australian government funded after-hours program. The Tasmanian General Practice Incentive Funding Model 2014–15 was implemented on 1 January 2015 and ceased with the implementation of the new after-hours PIP mechanism on 1 July 2015. We are currently evaluating the acceptability of, and satisfaction with the Tasmanian incentive funding mechanism; and the value of the Tasmanian after-hours triage service GP Assist to Tasmanian general practice and general practitioners for Primary Health Tasmania.

Acknowledgements

None.

References

- [1] Berchet C. Emergency Care Services. OECD Publishing.
- [2] Sjonell G. Effect of establishing a primary health care centre on the utilization of primary health care and other out-patient care in a Swedish urban area. *Family practice* 1986;3:148–54.
- [3] Lambert J. Economics undermine after-hours lure. *Medical Observer: Cirrus Media Pty Limited*; 2015. Available at <<http://www.medicalobserver.com.au/news/economics-undermine-afterhours-lure>>, (accessed: 7 June 2015).
- [4] Dunt D, Day SE, Kelaher M, Montalto M. Impact of standalone and embedded telephone triage systems on after hours primary medical care service utilisation and mix in Australia. *Australia and New Zealand Health Policy* 2005;2:30.
- [5] Dunt D, Day SE, Kelaher M, Montalto M. The impact of standalone call centres and GP cooperatives on access to after hours GP care: a before and after study adjusted for secular trend. *Family Practice* 2006;23:453–60.
- [6] Jackson C. Review of after hours primary health care. Report to the Minister for Health and Minister for Sport. 31 October 2014, Canberra; 2014. Available at <<http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-ahphc-review>>, (accessed: 25 May 2015).
- [7] Medicare Australia. Practice Incentives Program. After Hours Incentive Guidelines - August 2011. Canberra: Australian Government; 2011. Available at <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/2709-1-after-hours-guidelines.pdf>>, (accessed: 2 June 2014).
- [8] Horvath J. Review of Medicare Locals. Report to the Minister for Health and Minister for Sport; 2014. Available at <<http://www.health.gov.au/internet/main/publishing.nsf/Content/review-medicare-locals-final-report>>, (accessed: 11 June 2015).
- [9] Powell Davies G. Everything you need to know about your Medicare Local (but didn't know who to ask). *The Conversation*. Australian Edition; 2011.
- [10] Kecmanovic M, Hall JP. The use of financial incentives in Australian general practice. *Medical Journal of Australia* 2015;202:488–91.
- [11] Commonwealth of Australia. Budget Paper No. 2: Budget Measures 2015–16. Part 2 Expense Measures - Health. Canberra: Commonwealth of Australia, 2015. Available at <<http://www.budget.gov.au/>>

- 2015-16/content/bp2/html/bp2.expense-14.htm>, (accessed: 22 May 2015).
- [12] Department of Human Services. After hours incentive. Canberra: Commonwealth of Australia; 2015. Available at <http://www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/pip-after-hours-incentive>, (accessed: 7 June 2015).
 - [13] Dutton P. (Minister for Health, Minister for Sport). Medicare Locals Review. Media Release 16 December. Canberra: Commonwealth of Australia; 2013. Available at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/A2B4614AB99CB4D3CA257C43000CF88A/\$File/PD025.pdf>, (accessed: 17 August 2015).
 - [14] Commonwealth of Australia. Budget Paper No. 2: Budget Measures 2014-15. Part 2 Expense Measures - Health. Canberra: Commonwealth of Australia, 2014. Available at <http://budget.gov.au/2014-15/content/bp2/html/bp2.expense-14.htm>, (accessed: 23 June 2016).
 - [15] RACGP. \$7 co-payment widens the gap to accessible health-care. Royal Australian College of General Practitioners; 2014. Available at <http://www.racgp.org.au/yourracgp/news/media-releases/federal-budget-announcement/>, (accessed: 14 December 2015).
 - [16] AMA. AMA ramps up campaign against crippling co-payment. Canberra: Australian Medical Association; 2014. Available at <https://ama.com.au/ausmed/ama-ramps-campaign-against-crippling-co-payment>, (accessed: 14 December 2015).
 - [17] Ley S. (Minister for Health, Minister for Sport). Government continues Medicare consultation. Media Release 3 March. Canberra: Commonwealth of Australia; 2015. Available at <https://www.health.gov.au/internet/ministers/publishing.nsf/Content/223AE2CC4BB4C324CA257DFD0014DDD3/\$File/SL013.pdf>, (accessed: 13 December 2015).
 - [18] Grattan M. Medicare co-payment: a case study in policy implosion. Australia: The Conversation; 2015. Available at <https://theconversation.com/medicare-co-payment-a-case-study-in-policy-implosion-38311>, (accessed: 13 December 2015).
 - [19] Dutton P. (Minister for Health, Minister for Sport). Review of After-Hours Service Delivery. Media Release 19 August. Canberra: Commonwealth of Australia; 2014. Available at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarelyr2014-dutton065.htm>, (accessed: 17 August 2015).
 - [20] Department of Health. Review of after hours primary health care. Australian Government; 2015. Available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-ahphc-review>, (accessed: 10 July 2015).
 - [21] Merhab B. Govt backflips on After Hours GP helpline. The Australian. Australia: New Limited; 2015. Available at <http://www.theaustralian.com.au/news/latest-news/govt-backflips-on-after-hours-gp-helpline/news-story/5de6d76e61e4266ca06efa922c9f77d8>, (accessed: 13 December 2015).
 - [22] RACGP. Budget delivers mixed bag for general practice. Royal Australian College of General Practitioners; 2015. Available at <http://www.racgp.org.au/yourracgp/news/media-releases/federal-budget-2015/>, (accessed: 11 June 2015).
 - [23] AMA. Incentives hold out promise of better after hours care. Canberra: Australian Medical Association; 2015. Available at <https://ama.com.au/ausmed/incentives-hold-out-promise-better-after-hours-care>, (accessed: 14 December 2015).
 - [24] Department of Health. After hours primary health care. Last update 22 May 2015. Canberra: Commonwealth of Australia; 2015. Available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-ahphc>, (accessed: 11 June 2015).
 - [25] Medicare Australia. Practice Incentives Program (PIP) payments and calculations. Canberra: Australian Government; 2014. Available at <http://www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/>, (accessed: 10 June 2014).
 - [26] Department of Human Services. Calculating the SWPE value. Canberra: Commonwealth of Australia; 2016. Available at <https://www.humanservices.gov.au/health-professionals/enablers/calculating-swpe-value-0/>, (accessed: 11 April 2016).
 - [27] Department of Human Services. Calculation of payments. Canberra: Commonwealth of Australia; 2016. Available at <https://www.humanservices.gov.au/health-professionals/enablers/calculation-payments/>, (accessed: 11 April 2016).
 - [28] Department of Primary Industries and Energy & Department of Human Services and Health. Rural, Remote and Metropolitan Areas Classification, 1991 Census Edition. Canberra: Australian Government; 1994.
 - [29] Australian Institute of Health and Welfare. Rural, regional and remote health. A guide to remoteness classifications. Rural Health Services Number 4. PHE 53. Canberra: AIHW; 2004. Available at <http://www.aihw.gov.au/publication-detail/?id=6442467589>, (accessed: 17 March 2014).
 - [30] AMA. Submission to the Review of the Rural, Remote and Metropolitan Areas (RRMA) Classification. Canberra: Australian Medical Association; 2005. Available at <https://ama.com.au/system/files/node/AMA.RRMA.submission.pdf>, (accessed: 11 March 2014).
 - [31] McGrail MR, Humphreys JS. Geographical classifications to guide rural health policy in Australia. Australia and New Zealand Health Policy 2009;6:28.
 - [32] Neil A, Palmer AJ, Richardson T, Sanderson K, Mann M, Nelson M. Tasmanian General Practice's Satisfaction with the Tasmanian General Practice After-Hours Incentive Funding Mechanism 2014-15. In: 9th Health Services and Policy Research Conference. 2015.
 - [33] Queensland Government Statistician's Office. Estimated resident population (a) by urban centre and locality (b), Queensland, 2004 to 2014p. Brisbane: Queensland Government; 2015. Available at <http://www.qgso.qld.gov.au/products/tables/erp-ucld-qld/index.php>, (accessed: 14 December 2015).
 - [34] Queensland Health. Cairns and Hinterland Hospital and Health Service. Brisbane: Queensland Government; 2015. Available at <https://www.health.qld.gov.au/services/cairns-hinterland/default.asp>, (accessed: 14 December 2015).
 - [35] Department of Health and Human Services. Rural Medical Practitioners (Public Sector) Agreement 2009. Hobart: Tasmanian Government; 2009. Available at <https://ama.com.au/sites/default/files/Rural_Medical_Practitioners_Award_2009.pdf>, (accessed: 14 December 2015).
 - [36] Neil A, Nelson M, Richardson T, Mann-Leonard M, Palmer A. General practice after-hours incentive funding: a rationale for change. Medical Journal of Australia 2015;203:82–5.
 - [37] The Auditor-General. Audit Report No.5 2010-11 Performance Audit. Practice Incentives Program Department of Health and Ageing Medicare Australia. Barton, ACT: Australian National Audit Office Commonwealth of Australia; 2010. Available at <https://www.anao.gov.au/sites/g/files/net616/ff/ANAO_Report_2010-2011.5.pdf>, (accessed: 10 June 2014).
 - [38] Australian Bureau of Statistics. National Regional Profile: Australia. Environment/Energy. Canberra: ABS; 2013. Available at <http://www.abs.gov.au/AUSSTATS/abs@nrr.nsf/Latestproducts/0Environment/Energy12007-2011?opendocument&tabname=Summary&prodno=0&issue=2007-2011>, (accessed: 5 June 2014).
 - [39] Australian Bureau of Statistics. National Regional Profile: Tasmania. Environment/Energy. Canberra: ABS; 2013. Available at <http://www.abs.gov.au/AUSSTATS/abs@nrr.nsf/Latestproducts/6Environment/Energy12007-2011?opendocument&tabname=Summary&prodno=6&issue=2007-2011>, (accessed: 5 June 2014).
 - [40] Medicare Australia Statistics. Statistics. Divisions of General Practice Statistics Reports. Approved Practices in the Quarterly Calculations by RRMA Category. All Medicare Locals (999). Canberra: Department of Human Services. Australian Government; 2015. Available at <http://medicarestatistics.humanservices.gov.au/statistics/pip_med_locals.jsp>, (accessed: 16 December 2015).
 - [41] Medicare Australia Statistics. Statistics. Divisions of General Practice Statistics Reports. Approved Practices in the Quarterly Calculations by RRMA Category. Tasmania (601). Canberra: Department of Human Services. Australian Government; 2015. Available at <http://medicarestatistics.humanservices.gov.au/statistics/pip_med_locals.jsp>, (accessed: 16 December 2015).
 - [42] Commonwealth of Australia. Senate. Community Affairs Legislation Committee. Estimates (Official Hansard). Monday 1 June 2015. Canberra: Commonwealth of Australia; 2015. Available at <http://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/e03d5771-637b-4266-8fd1-d726e5f311ff/toc.pdf/Community%20Affairs%20Legislation%20Committee_2015.06.01_3481.pdf;fileType=application/pdf#search=%22Community%20Affairs%20Legislation%20Committee%20Estimates%20Health%20Portfolio%22>, (accessed: 11 June 2015).
 - [43] Primary Health Tasmania. After Hours Program. Frequently asked questions for general practice. In: Tasmania PH, editor. Hobart: Primary Health Tasmania, 2011. Available at <http://www.primaryhealthtas.com.au/sites/default/files/After%20Hours%20Program%20General%20Practice%20FAQs.pdf>, (accessed: 15 December 2015).

- [44] Ley S. (Minister for Health, Minister for Sport). New funding arrangements to boost after hours GP Services. Media Release 22 May. Canberra: Commonwealth of Australia; 2015. Available at <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley058.htm>>, (accessed: 19 June 2015).
- [45] AMA. Review Report recommends better after hours primary care arrangements. Canberra: Australian Medical Association; 2015. Available at <<https://ama.com.au/media/review-report-recommends-better-after-hours-primary-care-arrangements>>, (accessed: 11 June 2015).
- [46] RACGP. Changes to PIP After Hours Incentive and the Standards. In Practice. East Melbourne: Royal Australian College of General Practitioners; 2015. Available at <<http://www.racgp.org.au/yourracgp/news/inpractice/04-08-2015/>>, (accessed: 17 December 2015).