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AUSTRALIAN CENTRE  
FOR  
ECONOMIC RESEARCH  
ON HEALTH

# Should government provide additional subsidies for GP Super Clinics and the long-term effects on financial sustainability

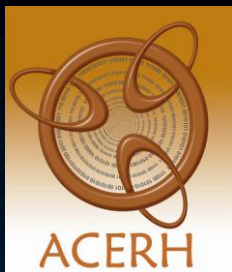
Jim Butler  
ACERH, ANU

A presentation to the inaugural GP Super Clinics Conference,  
Sydney, 26-27 August 2009

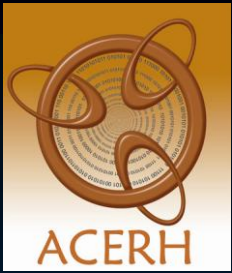


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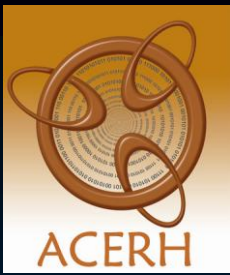


# Background to, and outline of, the GP Super Clinics initiative



# Background

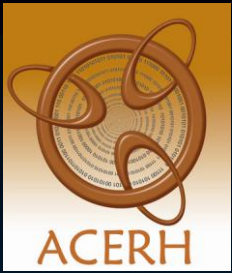
- GP Super Clinics are part of the Government's National Health and Hospitals Reform Plan
- Concept of GP Super Clinics first articulated in an ALP policy paper released in August 2007 (Rudd and Roxon 2007)
- 2008-09 Budget: funding for 31 GP Super Clinics to provide "better coordination between privately provided GP and allied health services, as well as state and territory funded health services"  
(Commonwealth of Australia 2008, p.16)



# Budgeted expenditures

Year	Amount (\$ million)
2008-09	76.6
2009-10	66.3
2010-11	49.3
2011-12	49.8
<b>Total</b>	<b>242.1</b>

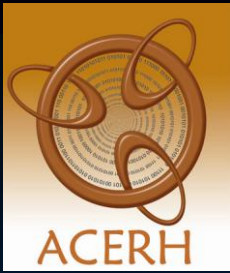
Commonwealth of Australia (2008, p.26)



# Purpose

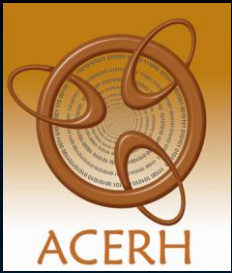
Labor's GP Super Clinics will:

- Help take the pressure off hospitals;
- Provide a greater focus for tackling the challenge of chronic disease in local communities;
- Attract medical graduates and health professionals to areas of need; and
- Mean much greater convenience for patients.



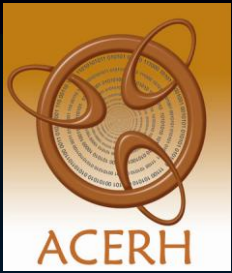
# Some key features

- Provide infrastructure (capital) funding
- Subsidise construction of facilities designed for multidisciplinary care incl. allied health services
- Provide space and training facilities
- Tailored to needs of local communities (no 'one size fits all' with respect to scope of services, staffing, etc)
- Funding mostly via a tender process
- Not Commonwealth owned or operated



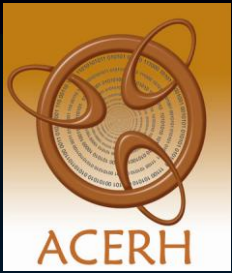
# Motivation

- Overall GP workforce shortage
- Urban/rural/remote imbalance in service use
- Growing chronic disease burden
- Get GP-type services out of hospital emergency departments
- Improve integration with state-funded community health services
- “shift preventative health care from the margins to the centre of our country’s health policy” (p.6)



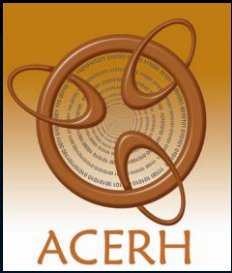
# Range of services

- 5+ privately practising GPs
- after-hours care
- dental services
- allied health services (podiatrists, dieticians, etc)
- a psychologist and mental health support program
- consulting rooms for visiting medical specialists
- practice nurses
- chronic disease management programs
- clinical training facilities
- possibly diagnostic services and a pharmacy



# Financing and choice

- Not about salaried medicine
- Choice of doctor and clinic is retained
- No patient enrolment required
- Super Clinics will not be fundholders for MBS/PBS services
- Services to be provided under usual fee-for-service arrangements
- Tenders that propose to bulk-bill for services will be preferred

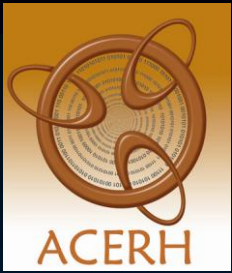


# Funding available

## Capital

- Facilities may be new or upgraded
- Mostly, capital grants are between \$1 million and \$10 million with a few in excess of this range
- Based on the maximum grants to be made available to the 31 Clinics, as specified in the National Program Guide, the mean grant per clinic is \$4.85 million

(Department of Health and Ageing (undated), Attachment A)



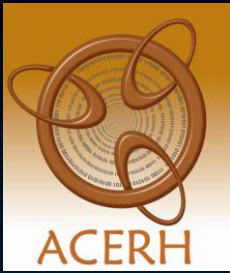
# Other funding

## Recurrent

- “Small funding streams” will be provided to assist with cost of admin support
- Maximum over 4 years = 12.5% of total Commonwealth funding for the clinic

## Relocation incentives (all amounts are maximums)

- GPs – \$15,000
- Allied health professionals – \$7,500
- Nurses, mental health workers, ATSI health workers – \$6,000
- Pharmacy/pharmacist – \$7,500

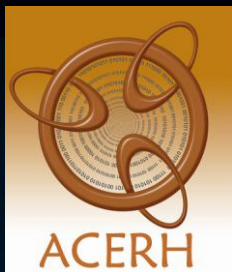


# Funding process

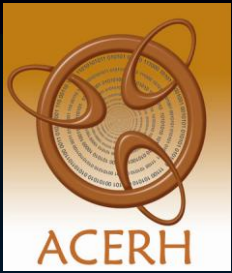
Funding is awarded in three different ways:

1. Invitation to apply process (tender) (21 clinics)
2. Joint government process (Comm/State)  
(7 clinics)
3. Direct engagement (recipient already identified)  
(4 clinics)

(Notes: (1) Hobart Eastern Shores clinic has two sites, which accounts for the number of clinics here summing to 32; (2) These data exclude three new GP Super Clinics, added to the program on 14 August 2009, to be built in Victoria – see Rudd and Roxon (2009)).



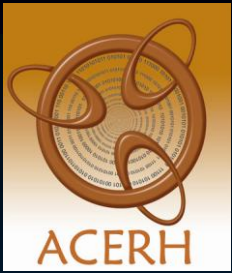
# Evaluative comments



# Market failure?

The Australian Government is committed to ensuring that Australians have access to high quality, cost-effective and appropriate primary health care services, which are predominantly funded through the payment of Medicare benefits ... However, other funding models and infrastructure development are required to support the provision of certain types of care, *particularly in cases of market failure*. Examples of such initiatives include GP Super Clinics ...

(Commonwealth of Australia 2008, p.110, emphasis added)

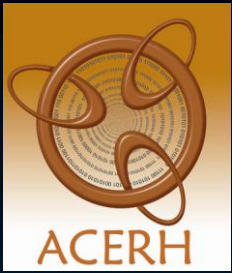


Q: Where is the market failure?

A: Market has failed to deliver this type of business organisation in primary care

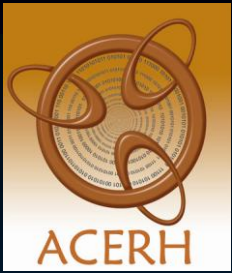
But

Other clinics that have pursued horizontal and vertical integration have emerged outside the GP Super Clinics program



## *Example:*

Run by Allied Medical Group, a company with links to Dr Geoffrey Edelsten, the Casey Superclinic was opened in 2005 and currently has consulting rooms and two “emergency room styled treatment rooms,” with an on-site pharmacy, Gribbles Pathology collection rooms, and rooms for physiotherapy, optometry and dental services, according to its web site. Open 24/7 and bulk-billing all patients with a Medicare card, the clinic is situated across the road from a local hospital.

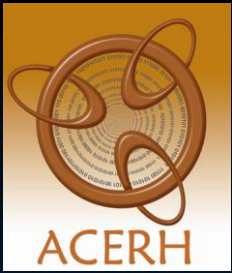


The GP Super Clinics could therefore be argued to be receiving an unfair competitive advantage.

*Possible response:*

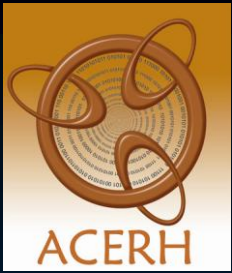
GP Super Clinics are not located in areas where they might otherwise emerge so no unfair competitive advantage is bestowed upon them.

But note that Berwick is a counter-example – this is the site of both the Casey Superclinic and a GP Super Clinic.



# Market Failure → Business Failure?

- Market failure argument can be interpreted as follows:  
In the absence of further subsidies, clinics of the type envisaged as GP Super Clinics will not be established, at least in certain geographic areas
- Similarities to the “infant industry” argument – industry needs subsidies in early years of operation to become established, but once established will be competitive without the need for further subsidies

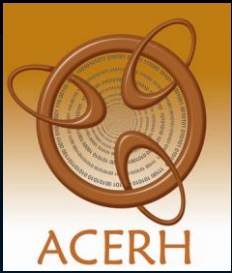


Subsidies are time-limited (so far)

- Capital – once-off
- Recurrent – payable in first 4 years only
- Relocation incentives – once-off

What happens after first 4 years?

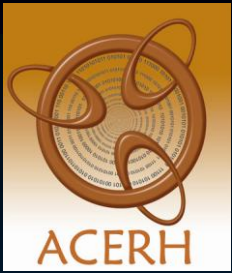
- If clinic revenues  $<$  avoidable costs, these losses provide an incentive to shut down (even not-for-profit organisations commonly operate under a zero-profit constraint)



But GPSC National Program Guide states:

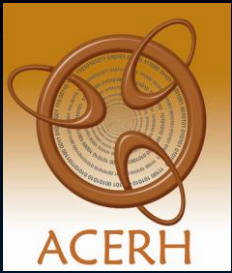
“Commonwealth funding agreements are *likely* to require the funding recipient to use the GP Super Clinic consistently with the Program Objectives *for a 20-year period.*”

Department of Health and Ageing (undated), p.14 (emphasis added)



Qs:

- Will the Australian Government enforce this as a contractual obligation?
- If so, how will operating losses be covered if they arise?
- Will the government end up correcting market failure or underwriting business failure?

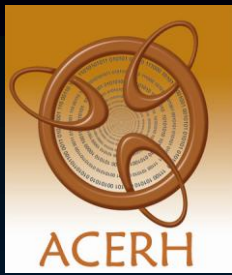


# Preventative care

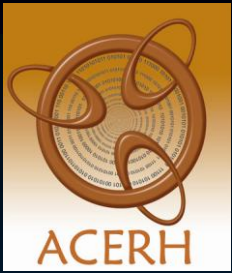
- Will GP Super Clinics provide more preventative care?
- GP Super Clinics have access to:
  - \* the same range of MBS items, and
  - \* the same rebates as other clinics

## Question:

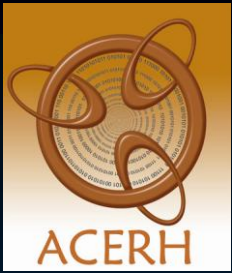
- Where is the economic incentive for more preventative care?



- Preventative care includes both screening/secondary prevention and health promotion
- Sammut (2008a) provides an extended discussion of the implications of this distinction for GP Super Clinics
- Argues that “behavioural change” medicine lacks evidence of efficacy (hence The False Promise of GP Super Clinics)

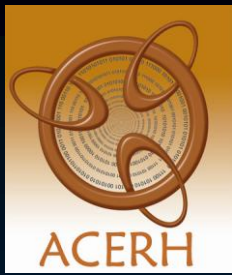


- While investments in some preventative care programs may be cost-effective, they are not often cost-saving (i.e. the cost of the intervention usually exceeds any treatment cost savings attributable to the intervention)  
(Russell 2009; Cohen *et al* 2008).
- Expanding preventative care is therefore unlikely to reduce the growth in health expenditures



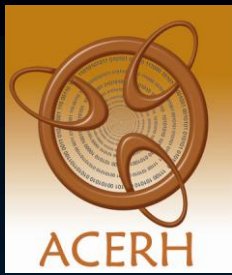
# Coordinated care

- Premise: Multidisciplinary care available at a single site will improve care coordination
- Sammut (2008b) - the evidence suggests that more care coordination results in more hospitalisations, not less

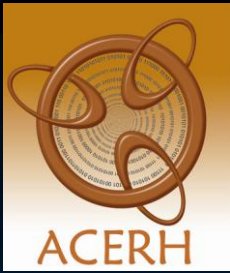


# Concluding comments

- GP Super Clinics receive no favourable treatment through the MBS
- Subsidies are one-off and/or time limited to 4 years
- If GP Super Clinics cannot pass a “market test” in the absence of further subsidies, will they survive after the first 4 years?
- What happens after the first 4 years, particularly with Clinics that turn out not to be economically viable?



- Bringing horizontally and vertically integrated clinics to under-serviced areas may be a laudable policy objective
- Is the GP Super Clinic model the best way of achieving this objective?



# References

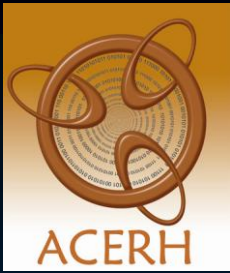
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