

Budget-holding: The answer to Australian primary care reform?

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Abstract

In common with other Organisation for Economic Cooperation and Development (OECD) countries, Australia is experiencing growth in expenditure on health care. However, while many other nations continue to pursue some variation of managed competition to address these problems, Australia has chosen a more incremental reform path, with initiatives such as the General Practice Strategy, restrictions in doctor supply and coordinated care trials. This article reviews the likely effectiveness of such initiatives in the light of experience and evidence of budget-holding in achieving similar objectives overseas. It concludes that budget-holding offers a more effective strategy than current 'piecemeal' reforms to contain costs and increase efficiency within Australian health care.

Introduction

Australian health care is financed and provided through a complex mix of government and private sources (Australian Institute of Health and Welfare, 1998). Although achievements in cost containment, efficiency and equity have been substantial, the system is not without problems (Richardson 1995). Growth in public health care expenditure in particular, due to declining private health insurance coverage, cost-shifting and expenditure increases in the Pharmaceutical and Medical Benefits Schemes, is viewed as unsustainable (Mooney & Scotton 1998). This has provided an impetus for the reform of funding arrangements. The secondary care sector has experienced increases in technical efficiency through casemix funding, and attention has thus shifted toward primary care; both in terms of containing primary care expenditure and the level of 'flow-on' costs from the General Practitioner's (GP's) role as 'gatekeeper' (Duckett 1995; Cunningham 1997).

A similar desire to contain costs and increase efficiency has led to reform in many other OECD nations, with many incorporating some form of budget-holder to be responsible

for purchasing services for an enrolled population (Harris & Richardson 1994; OECD 1994; Van de Ven 1996). (In this article the term 'budget-holder' is used to refer to an institution which is allocated funds with which to purchase services for enrolled populations. This may be at the individual GP level, but may equally be at a higher level, such as the proposed Primary Care Groups in the recent White Paper from the United Kingdom.) In both the United Kingdom and New Zealand, organisational and financial reforms along the lines of a purchaser-provider split, and the introduction of budget-holding responsibilities for GPs, have been introduced (British Audit Commission 1995; Brown & Crampton 1997). Similarly, in the United States (of America) primary care provision through health maintenance organisations (HMOs) is also of a budget-holding nature (Navarro 1991; Robinson & Casalino 1996). While these countries have achieved different levels of success, Australia in comparison has chosen a different, more incremental, primary care reform path (Smith & Wilton 1998a, 1998b). This article seeks to assess whether the piecemeal Australian primary care reform strategy is likely to produce a more effective outcome than wider budget-holding initiatives.

Following this introduction, the article provides a brief overview of Australian primary care provision, places Australia's primary care reform initiatives within a broader international budget-holding primary care reform perspective, and critically reviews Australian reform initiatives in comparison to the potential for some form of budget-holding to address them. It concludes with a brief outline of how Australian primary care may be reformed, considering the potential benefits of some form of budget-holding while bearing in mind some of the distinct institutional features of the Australian health care system.

Issues facing primary care in Australia

Increasing costs

General practice is a significant determinant of overall Australian health care expenditure and efficiency. It is generally the first point of contact with the health care system, with approximately 80% of the population visiting a GP at least once each year (Health Insurance Commission 1998). Most GPs are private practitioners, whose services are offered on a fee-for-service basis, with this fee set and reimbursed by the Commonwealth Government through the Medicare Benefit Schedule with, in the majority of cases, the consumer not being required to pay any out-of-pocket fee at point of use. There is also no system of patient enrolment with a specific GP.

Importantly, there is no limit, or budget cap, on Medicare Benefit Schedule expenditure. This means that the cost of Medicare to the Commonwealth Government is determined significantly by the volume of patients seen by GPs; on average 5.5 consultations per head of population per year (98 million in total), generating a cost to the

Commonwealth Government of approximately \$2.2 billion (representing approximately 53% of services funded under Medicare fee-for-service arrangements) (Commonwealth Department of Health and Family Services 1996). Such expenditure has also increased as a proportion of total health expenditure, from 24% in 1984–85 to 28% in 1992–93, with (in comparison) public hospital expenditure decreasing over this period (from 36% to 30%) (Commonwealth Department of Health and Family Services 1996). In addition to significant budgetary outlay themselves, GPs, as gatekeepers, also have a central role in determining other health care services used by patients, such as pharmaceuticals and hospital services.

There are, therefore, two primary causes behind this increase in primary care-related expenditure: growth in GP attendances, and growth in flow-on costs.

Growth in GP attendances

Although some growth in per capita health care expenditure during the 1990s can be explained by GP transition to vocational registration, and the associated entitlement to higher Medicare benefits (fees), most is attributable to an increased quantity of services consumed per capita, rather than increases in the prices of those services (Commonwealth Department of Health and Family Services 1996). For example, the average number of unreferral consultations per capita increased from 4.1% in 1984–85 to 5.5% in 1996–97, representing an average annual rate of growth of 2.5% (General Practice Strategy Review Group 1998).

A variety of reasons are hypothesised to explain this growth, including changes in technology, an ageing population and cost-shifting (Doessel 1987; National Commission of Audit 1996). In addition, fee-for-service medicine has been criticised as leading to the provision of medically unnecessary services and supplier-induced demand (Rosenman & MacKinnon 1992).

Growth in flow-on costs

GPs also create flow-on costs, through prescription and referral to specialists, allied health professionals, hospitals and other health care services (for example, pathology and imaging). Such flow-on costs have become increasingly significant. For example, between 1994 and 1996, expenditure on non-specialist ordered tests and drugs increased by 50%, while expenditure on non-specialist attendances increased by only 23% (Commonwealth Department of Health and Family Services 1996). Furthermore, between 1992 and 1998 per capita Pharmaceutical Benefits Scheme expenditure grew by 48%, while in contrast population growth increased by only 4.7% (Health Insurance Commission 1998). As the Commonwealth Department of Health and Family Services reports: 'It is this trend that is at least partly responsible for the growing interest in budget-holding arrangements in the funding of medical services in Australia' (Commonwealth Department of Health and Family Services 1996, p 163).

Cost-shifting

One of the most important issues in the Australian health care system is the significant degree of overlap and lack of articulation between both Commonwealth and State governments, and public and private sectors. For example, there are over 60 separately funded government programs for health and community services, each with its own organisational, management and funding boundary (Paterson 1996). In many instances there are insufficient links between services delivering care in institutions and in the community, and between health care services and community care services (Council of Australian Governments 1995).

Many health care services are close substitutes, and are not only provided on different terms to patients, but are also financed through different sources. In particular, there is obvious overlap between Commonwealth-funded GP care and State-provided (hospital) services in two major areas:

- fee-for-service GP care funded under Medicare (Commonwealth responsibility) and outpatient services provided in public acute hospitals (State responsibility), and
- GP pharmaceutical referrals (with Commonwealth benefits for private dispensing) and public hospital dispensing (with costs incurred by the States).

Given the nature of Australia's heterogeneous health care system, the question of service substitution (and cost-shifting) cannot easily be viewed in a global fashion (Sax 1984). However, some insight into the level of substitution between Commonwealth-funded GP care and State hospital outpatient use has been provided for Queensland (Doessel 1994). This analysis suggests that the decline in use of public outpatient departments since the introduction of Medicare in 1984 is due to the potential for State public hospitals to shift their costs to the Commonwealth Government. Furthermore, some State public hospital outpatient services have closed completely, thereby forcing patients to use Commonwealth-funded GP services (Deeble 1991).

Although cost-shifting has an immediate and obvious effect on the budget of the party incurring additional costs, opportunity costs are a further consequence of cost-shifting (Duckett 1995). For instance, developing ways to shift costs between different jurisdictions means less time will be dedicated to devising more efficient ways of providing care.

Budget-holding: An international perspective

The notion of managed competition strengthening primary care has been an important health care reform initiative in many countries (particularly in the United Kingdom, the United States and New Zealand), with a key element of reform being the introduction of explicit budget-holding responsibilities (Van de Ven 1996). In this article, 'managed competition' is used generically to refer to the specific separation of purchaser and provider of health care services, whereby purchasers are budget-holding

entities, receiving risk-adjusted capitated funds (for their enrolled populations), and entering into contractual arrangements with providers of services based on specific price/quantity relationships. Although the United Kingdom, United States and New Zealand have adopted variations of the concept of managed competition (as defined), a common element has been the transformation of the health care sector into one with bodies explicitly responsible for purchasing services. In this article the bodies of interest are those which have the responsibility for the purchase of primary care services. Although arrangements across countries may take different forms (for example in terms of size, specific funding arrangements and enrolment of population groups), there are a common set of incentives encouraging efficiency and cost-effectiveness (Smith & Wilton, 1998b). It is useful to set the Australian primary care reform agenda in the context of these international reforms, considering both the problems leading to budget-holding and resultant incentives from such primary care reforms.

Cost containment and increasing the efficiency of service provision were the leading factors behind the introduction of budget-holding reforms in the United Kingdom, United States and New Zealand (OECD 1994). In the United Kingdom, for instance, the principal aim in giving GPs direct responsibility for budgets concerning patient care (that is, GP fundholders) was to improve cost containment (United Kingdom Department of Health 1989; British Audit Commission 1995; Smith & Wilton 1998b). The need to reduce pharmaceutical expenditure in particular was a key objective (United Kingdom Department of Health 1989; Chew 1991).

In contrast, in New Zealand increasing primary care expenditure (Jacobs & Barnett 1996) was largely due to open-ended fee-for-service payments to GPs, which were increasing at approximately 6% per annum (adjusted for inflation) during the 1980s (Malcolm 1993). A further impetus to reform was poor integration of primary and secondary care through separate funding arrangements (Ashton 1993) which lead to Area Health Boards partly shifting the cost of care to primary care and other parts of the health sector (Scott 1994). Reform in New Zealand led to the emergence of Independent Practice Associations (a hybrid American HMO/British GP fundholding arrangement (Brown & Crampton 1997)), with these 'umbrella' organisations typically acting as budget-holders rather than individual practices (Malcolm & Powell 1996).

Similarly, in the United States much of the increase in expenditure has been attributed to open-ended fee-for-service (indemnity plans) and rising premiums (Rosenman 1996). This led to the expansion of HMOs, and managed care more generally (with their implicit budget-holding incentives). Indeed, the highest penetration of HMOs is in areas such as California, Massachusetts and Florida, where per capita health spending has historically been significantly above the national average (Reinhardt 1996; Robinson & Casalino 1996).

Reform of primary health care in Australia

In 1991, the Australian Medical Association, the Royal Australian College of General Practitioners and the Commonwealth Government entered into discussions on general practice to examine proposals to enhance the status and quality of general practice. These discussions formed the foundation of the General Practice Strategy (1991), which was concerned with developing a framework for helping general practice reassert its role in Australia's health system and ensure the highest quality of care (Bollen 1996; Commonwealth Department of Health and Family Services 1996). The strategy introduced a number of separate programs, two of which are important here.

The first of these is the Divisions and Projects Grants Program, which provides infrastructure and project funding to Divisions of General Practice. Divisions are self-managed entities formed on a geographic basis, and cover over 90% of GPs. There are around 116 divisions which function as local associations of GPs, and all GPs who work in the area covered by a division are invited to become members, with a membership rate generally around 70% (Pegram, Sprogas & Buckpitt 1995, Saltman 1995). Divisions are responsible for encouraging GP involvement in cooperative activities and projects, improving GP integration with other elements of the health care system and meeting identified local health needs.

Divisions were introduced to provide GPs with a strong voice in their interaction with other local and regional bodies and provide support at the local level for other GP strategy initiatives, such as education (for vocational registration), better practice guidelines and accreditation. They are, however, not accorded any funding responsibilities (in terms of allocating GP budgets for primary care expenditure, or purchasing any GP services themselves). Funding for divisions takes the form of block grants, with fee-for-service remuneration for individual GP activity funded separately through Medicare arrangements.

The second important element was the Better Practice Program, providing payment supplements to fee-for-service for GPs who meet certain eligibility criteria in providing a more comprehensive range of services (for example, better continuity of care). This policy initiative represented an attempt to 'move away' from fee-for-service as the predominant form of payment to GPs.

Further policy announcements have been made recently concerning restriction of Medicare Provider numbers, restriction of overseas doctors working in Australia and moves towards better incorporation of evidence-based medicine in general practice. These reforms represent an attempt to achieve cost-containment and improved cost-effectiveness within the primary care sector without the more radical reform of, for example, invoking patient registration (to reduce the rate of 'doctor shopping' (Health Insurance Commission 1998)) or making a wholesale change from fee-for-service funding.

A separate, although important, reform involves the recent introduction of coordinated care trials. These trials attempt to coordinate services for specific patient groups better than under 'traditional' fee-for-service medicine, and in doing so improve quality of care and reduce cost-shifting (Council of Australian Governments 1995; Duckett 1995). At present these are being trialed at various sites around Australia, and comprise several key features:

- Medicare entitlements are preserved
- client (patient) participation is voluntary with exit allowed at any stage
- enrolment is offered only to defined populations in target groups expected to have high service use/needs
- clients have access to a skilled coordinator (often a GP)
- funding is provided from an envelope of funds, initially based on average client costs, and
- services covered by the trial include medical (both GP and specialist care), pharmaceutical, community support, allied health and hospital inpatient and outpatient services.

Assessment of reform

The major difficulty in assessing the effectiveness of these reforms is that no systematic evaluation has been undertaken. The General Practice Strategy Review Group itself reported in 1998 that the effectiveness of primary care reform is difficult to evaluate because the General Practice Strategy extends well beyond specifically funded programs and has changed over time (General Practice Strategy Review Group 1998). Therefore, the analysis presented here focuses on a comparative assessment of the potential for these reforms, compared with budget-holding, to tackle rising costs and cost-shifting.

Rising costs

Growth in GP attendances

The Commonwealth Government has introduced a number of strategies to stem the increase in GP attendances (for medically unnecessary care). One of the most significant has been limiting the supply of GPs (restricting Medicare Provider numbers and the number of overseas doctors), which should help reduce the increase in GP attendance patterns by:

- restricting the number of practitioners who are able to claim benefits from the Medicare Benefit Schedule, and
- encouraging improved quality of care (through reductions in unnecessary visits).

However, the link between supply restrictions and reductions in expenditure has been questioned (Butler 1994), and it is not clear that these arrangements are likely to produce greater impetus for the provision of more cost-effective care, as restricting the supply of new GPs is unlikely to encourage current GPs to be more efficient. This is because there are few incentives in the system which reward sparing use of health resources (without compromising standards of care).

In contrast, primary care budget-holding provides a set of financial incentives through which more cost-effective care by all GPs is encouraged. This has been a prime reason for the establishment of budget-holding, and the latest primary care purchasing schemes for general practice in the United Kingdom and New Zealand (Borrem & Maynard 1994; Maynard 1994; United Kingdom Department of Health 1997), while also accounting for the substantial spread of managed care (and HMOs more generally) in the United States (Reinhardt 1996; Rosenman 1996). Importantly, cost-effective care is encouraged through two central characteristics of budget-holding: financial risk and enrolment/registration. Through financial risk-sharing, there is an incentive to ensure that services are funded within budget constraints (Smith & Wilton 1998b), which eliminates over-servicing. Enrolment not only enhances the bargaining capacity of GPs through 'force of numbers' (Reinhardt 1996), but also ensures that budget-holders are better able to provide 'continuity of care' while counteracting the potential of patients to 'doctor-shop' (Macklin 1992).

However, while budget-holding may eliminate incentives for over-servicing, there is the potential for cost-cutting objectives to predominate. In the United States, for instance, some commentators believe that the pace of cost-cutting is occurring too quickly and that quality of care may be compromised (Luft 1995). In addition, there is evidence to suggest that HMOs are operating as risk brokers rather than providers of more efficient care (Reinhardt 1996).

Flow-on costs

Pharmaceutical costs, under the Pharmaceutical Benefits Scheme, continue to represent a major expense for the Commonwealth Government, with expenditure doubling from \$1.5 billion in 1991–92 to \$3.1 billion in 1996–97 (Australian Institute of Health and Welfare 1998). Although price increases are a factor, it is mainly increased utilisation/volume that determines the total cost to the Pharmaceutical Benefits Scheme (Hill, Henry & Smith 1997). While some increase is expected (for example, due to an ageing population), it is also recognised that inappropriate prescribing accentuates the problem. For instance, prescription-drug related hospital admissions are viewed as a significant, and expensive, public health problem, with approximately half these admissions considered preventable. In 1994–95 the cost of such admissions in public hospitals was estimated at \$350 million (Roughead et al. 1998). This suggests that there are issues of quality to be addressed, both in terms of prescribing and use of pharmaceuticals.

Presently there is little restriction on GPs' prescribing behaviour. The Pharmaceutical Benefits Scheme exerts only limited control over prescribing, mainly through the decision to list or not list a drug. In the 1997 Commonwealth Budget, there were moves to de-list some drugs and introduce a premium, to be paid by patients, for some brand name products. Although it is likely that this will have some impact on drug use and/or expenditure, it is not clear to what extent. For instance, high-cost prescription drugs comprise the top 30 prescriptions (in cost and volume) and are mostly for common conditions (for example, antiulcer/antireflux treatment, cholesterol-lowering drugs, antidepressants and ACE-inhibitors), which suggests that their use or cost will not alter significantly (Hill, Henry & Smith 1997).

In contrast, both the United Kingdom and New Zealand implemented budget-holding initiatives which were designed to stem the increase in pharmaceutical costs (Bradlow & Coulter 1993; Crump et al. 1995; Jacobs & Barnett 1996). Budget-holding introduces incentives to encourage cost-effective care through making GPs, as purchasers, responsible for the wider flow-on costs of any care prescribed and providing an effective cap on the level of overall public expenditure (Malcolm & Powell 1996). For pharmaceuticals, this means that GPs will more carefully consider which drug is most appropriate and in which circumstance and, thus, prescribing of the most expensive 'flavour of the month' drug is unlikely to be sustained (Wilson, Buchanan & Walley 1995).

Although there is little evidence from New Zealand that prescribing costs have been contained (as evaluation is premature), in the United Kingdom there have been considerable savings in prescription costs through a switch to generic drugs (Bradlow & Coulter 1993, Crump et al. 1995). It is, however, difficult to argue conclusively that overall efficiencies in prescribing have resulted, as many practices strategically delayed entry into the fundholding scheme to maximise their prescribing budgets (Wilson, Buchanan & Walley 1995).

Additional costs imposed by budget-holding

It should also be recognised that a move to budget-holding will itself not be a costless activity: there will be initial start up costs associated with the system, as well as recurrent management, transaction and administrative costs which may offset the gains. In the United Kingdom, for example, contracting takes most of the financial year, entailing significant transactions costs, to both purchasers and providers, in finding and collating information, negotiating and monitoring contracts (Rosen & McKee 1995). For instance, in 1989, management costs of the fundholding scheme were estimated to be £15.6 million per annum (£14 million on administration and £1.6 million on computer expenses) but these had more than doubled by 1993–94 (Petchey 1995). While the addition of more GPs to the scheme makes it difficult to assess the precise increase in cost (combined with no formal evaluation of the system), there is considerable anecdotal evidence suggesting that transaction costs have increased significantly (for example, a

marked increase in fundholder workloads (Corney 1994) and costs to District Health Authorities in reconciling budgets, auditing expenditure and monitoring operations). In New Zealand similar experiences have been reported (Coulter 1995), although here the administrative workload for GPs has been increased by the lack of enrolled populations (Jacobs & Barnett 1996).

Although budget-holding entails such transaction costs, the critical question is whether these may be outweighed by cost savings elsewhere, or whether improved health outcomes have resulted. There is currently no reliable information about these issues due to the nature of wholesale change brought about by such reforms, and the lack of prospective evaluative trials. However, evidence suggests that GP fundholding in the United Kingdom, for example, does reduce prescribing costs (Dixon & Glennerster 1995) and increase the diversity of services offered by practices which are funded through savings made elsewhere, thus suggesting improved efficiency, if not necessarily reduced cost.

Cost-shifting

Coordinated care represents an important step towards a more unified approach to health care provision, thus providing less incentive and scope for cost-shifting. However, problems with this approach exist (Montalto 1997). For example, the trials focus on high users and, while this may be justified, as there are significant health care improvements to be made in this area (Jackson 1996), the definition of high users has been questioned (Duckett 1996). Chronically ill patients, for instance, may be high users of medical services in one year and not another (the population is not static). Additionally, a focus on high users emphasises the cost-saving objectives of health reform rather than targeting service enhancement (Henderson 1988; Duckett 1996).

Although coordination may improve through these trials, it is not clear that coordinators will necessarily be encouraged to search for services which are most cost-effective. This is because there is no financial incentive to encourage this within the trialing arrangements, as coordinators ultimately do not stand to benefit if savings can be made. While budgets are fixed in absolute terms (that is, with no over- or under-spend in each year), and although this budget neutrality provides some incentive to discover less costly services, it does not match the incentives provided by explicit budget-holding. Here both profit and loss can be sustained (with those holding the budget either gaining or losing), while also encouraging quality of care (that is, improved continuity of care) through enrolment. In particular, it is not apparent that the same continuity of care incentives will be encouraged through the coordinated care trials as patients will be able to drop out, or receive additional services outside of the trial, if they so choose.

The eventual success of the trials (in terms of improving coordination and mitigating incentives for cost-shifting) places great faith in government bureaucracies being able to overcome their respective State/Commonwealth vested interests. An alternative to this method of reducing cost-shifting is the establishment of some form of total budget-

holding. The advantage of total budget-holding is that it places financial responsibility for all patient care within a single entity, the primary care budget-holder (British Audit Commission 1995). This limits the opportunity to shift the costs of care to other organizations.

Budget-holding arrangements lead to important efficiency savings. They also encourage (particularly in the United Kingdom and New Zealand) the better facilitation and coordination of care (United Kingdom Department of Health 1989; Scott 1994). In the United States HMOs are also popular with their enrolled populations for the continuity of care which is encouraged (Davis et al. 1995). This demonstrates that budget-holding can not only offer similar (if not better) coordination of care than the current coordinated care trials but also have the additional advantage of offering strengthened cost-effectiveness incentives. However, these gains have to be weighed against equity considerations, as there is some evidence to suggest that GP fundholders in the United Kingdom, and HMOs in the United States, engage in 'cream-skimming' (that is, selection according to health risk) (Newhouse et al. 1989; Glennerster, Matsaganis & Owens 1992). However, the extent of such cream skimming and the impact of policies to resolve it is unclear. For example, in the United Kingdom the £5 000 ceiling for any one GP expenditure per patient per year has the drawback of reduced incentives for efficiency (Matsaganis & Glennerster 1994). However, such cream-skimming incentives may be mitigated through appropriate stop-loss incentives or regulatory controls.

Discussion

Australia experiences health care problems, such as upward pressure on health care expenditure, common to other OECD countries. Many nations, such as the United Kingdom, New Zealand and the United States have attempted to tackle these problems by strengthening primary care through introducing (implicit or explicit) budget-holding responsibilities. In contrast, Australia has been relatively unusual in not moving down a budget-holding route, but instead focusing on incremental reform, such as through the General Practice Strategy, restrictions in doctor supply and coordinated care trials.

This article has presented an argument that reform strategies in Australia will not effectively address the core problems underlying primary care finance and provision. Reforms, such as the General Practice Strategy, while commendable for encouraging GPs to become more involved in decision-making, planning and local government, are, at best, short-term Band-aid solutions. This is because they do not address the underlying problems of primary care and provide few incentives for encouraging greater efficiency in health care provision stemming from primary care decisions. In particular, they offer few long-term systemic improvements with respect to cost constraint (particularly through relying significantly less on fee-for-service medicine) and cost-shifting.

As an alternative, this article has argued that the incentives created through budget-holding, or purchasing, of GP services, such as those evidenced in the United Kingdom, the United States and New Zealand, be considered as offering a potential solution to the current problems facing Australian primary care. Although recent proposed changes to the United Kingdom system of primary care include the removal of GP fundholders, budget-holding still remains under the guise of purchasing by Primary Care Groups (United Kingdom Department of Health 1997). An analogous situation in Australia could be the use of Divisions of General Practice, which are geographical institutions covering a number of GPs, as budget-holders. The population covered may then be required to enrol with that division and would purchase services from GPs within its area, who would continue to be sole providers of care. The patient would therefore maintain their freedom of choice of GP. This would be expected to encourage competition for patient services, but the capped budget of such divisions would maintain a degree of cost-control.

However, the issues of practical implementation of such a scheme in the Australian context deserve further research. For example, a prerequisite to budget-holding would be the enrolment, or registration, of populations with specific divisions (or GPs). This was already established in the United Kingdom and eased the transition to budget-holding. In contrast, Australia has no such registration system and so a move to budget-holding would involve this extra process of registration. Conversely, information systems in Australia have progressed far more than when GP fundholding was introduced in the United Kingdom; this would facilitate the introduction of such a scheme in Australia.

In conclusion, the authors suggest that piecemeal reforms to date have not, and will not, effectively address the core problems facing primary care in Australia. Instead, some form of holistic reform, such as budget-holding for general practice, should be considered further as a viable and more efficient alternative.

Acknowledgements

The authors would like to express their appreciation to Professor Richard Scotton and Ms Leonie Segal of the Health Economics Unit at Monash University, and an anonymous reviewer, for providing comments on earlier drafts of this article. The Health Economics Unit receives core funding from the National Health and Medical Research Council and Monash University. The research described in this article is made possible through the support of these bodies.

Note

The views expressed in this article are those of the authors and do not necessarily reflect the views of the National Health and Medical Research Council, Monash University or the Victorian Department of Human Services. All errors are the authors' responsibility.

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