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Title

"It's what we should be doing anyway": Financial incentives for relational continuity in Australian General Practice.

Priority 1 (Research Category)

Healthcare Services, Delivery, and Financing

Presenters

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Abstract

Context: Relational continuity is a core value of primary care. Little is known as to how it can be promoted. EQuIP-GP was a 12-month cluster RCT in 36 practices exploring whether financial incentives can improve relational continuity in general practice (GP). Objective: We examined a) how financial incentives are perceived and experienced by patients and GP teams and b) how routines related to relational continuity are influenced by financial incentives. Study Design: Mixed methods case study. Setting: Maximum variation sample of 6 (2 per state) of the 18 EQuIP-GP intervention practices from the Australian states of New South Wales, Victoria and Tasmania. Population: Each practice provided quantitative data on 30 patients aged ≥55 and qualitative data from patients, GPs, practice nurses (PN) and practice managers (PM). Intervention: Intervention practices received quality-linked financial incentives for offering longer consultations and early post-hospital review for enrolled patients. Outreach facilitators worked with practices to modify continuity routines. Instruments: Baseline practice attributes survey; Patient Primary Care Assessment Tool (PCAT); semi-structured interviews (13 patients, 10 GPs, 1 PN and 5 PMs). The 3 facilitators collected reflective notes of practice visits and participated in post-study interviews. Outcome Measures: Change in pre-post PCAT relational continuity using paired t-tests and one-way ANOVA. Qualitative "practice intervention narratives" helped investigate the response to the intervention and concepts about financial incentives. Results. As with the EQuIP-GP trial, there was no change in relational continuity - PCAT and interview data both suggesting continuity was high at baseline. Participants saw relational continuity as a core component of primary care that should not need incentivising, seeing incentives as a "blunt instrument". Both patients and GPs favoured rewarding, rather than incentivising, quality care. Many felt that Equip-GP's incentive model increased attention to pre-existing routines rather than facilitating new ways of working.

Conclusions: While financial incentives can help practices identify how existing routines can influence continuity, incentives for this core component of primary care seem better framed as a reward for good practice rather than an incentive for improvement. Further research could explore these issues in practices with lower baseline continuity of care.