Exploration of funding models to support hybridisation of Australian primary health care organisations

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ABSTRACT

PRIMARY Health Care (PHC) funding in Australia is complex and fragmented. The focus of PHC funding in Australia has been on volume rather than comprehensive primary care and continuous quality improvement. As PHC in Australia gets to be increasingly delivered by hybrid style organisations, an appropriate funding model that matches this set-up while addressing current issues with PHC funding is required. This article discusses and proposes an appropriate funding model for hybrid PHC organisations.

Hybrid organisations adopt structures and practices of both the private and public sector.[1,2] The interest, access and agency aspects in hybrid structures span across the values and artefacts of both sectors. Hybrid organisational forms have been challenging conventional conceptions of economic organisation but offer flexibility to reorganise functions and emphasise focus areas.[1,3] A vast number of primary health care (PHC) groups in Australia function as hybrids, but vary in their emphasis on public or private sector features.[4–6] The hybridisation of the Australia PHC sector is a result of multiple factors, including funding mechanisms, health sector reform and market forces.

Primary health care in Australia, which has been described as complex and fragmented, is delivered through several organisations including general practices, community health centres, allied health practices and through innovative technology such as telehealth.[5,6] Those involved in the delivery of PHC services comprise general practitioners, nurse practitioners, nurses, allied health professionals, Aboriginal and Torres Strait Island health workers, midwives, pharmacists and dentists. The activities covered in these settings and by these professionals includes preventive health activities such as health promotion, management of chronic diseases and treatment of acute conditions.[5,6]

Funding for PHC in Australia is derived from various levels of government and other sources.[4] The Federal funding for PHC is mainly through Medicare, Australia's national public health insurance scheme. The Medicare components relevant to PHC are the Medical Benefits Scheme, which covers visits to general practitioners and the Pharmaceutical Benefits Scheme, which covers some prescription pharmaceuticals.[4,5] The Federal Government funding also supports Aboriginal and Torres Strait Islander-specific health services and preventive health and quality improvement programs. In addition to the Federal Government funding, the state and territory governments and local governments provide funding for PHC services such as community health and preventive health services. Further to state funding, PHC service providers access funding from private health and worker's compensation insurers, fees charged to patients and non-governmental sources of financing such as charities.[4]

Overall, PHC funding in Australia can be categorised into two funding models: population-based funding and patient-focused funding.[4]

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Population-based funding involves block funding of service providers based on the population served and the health needs of the community. The payments are paid in a lump sum on a periodic basis. This funding model is less applied in Australia, but many Aboriginal Community Controlled Health Services are funded through this approach. The patient-focused funding involves pay for performance, a fee for service, activity-based funding and any method of funding that uses incentives and support mechanisms to improve the quality and efficiency of PHC service delivery. Most PHC providers in Australia use the fee-for-service model, which involves billing the funder and patient for each item of service they provide. Pay for performance involves payment for delivery of services of a particular type. In Australia, the payments through this mechanism include service-incentive payments, chronic disease management items, and practice incentive payments.[4,5]

Until the late 90s, general practice in Australia was primarily delivered through a 'cottage industry framework'; that is, independent practitioners or partnerships of them.[7] While the independent practitioners or partnerships model continues into the present, the context in which general practice operates has remarkably changed. Concerned with the fragmented landscape of PHC delivery and lack of coordination among providers, the Australian Government set up a series of PHC reforms over the past 8 years.[6] This has now led to the establishment of 31 Primary Health Networks (PHN) tasked to work with PHC providers in delivering coordinated and efficient primary care.[5] The PHNs are also meant to work with Local Hospital Networks or their equivalents to enable contiguous care across acute and primary care services.

Coupled with this development, the past two decades has seen the emergence of significantly important corporate groups delivering PHC in both metropolitan and regional Australia.[7] These corporate groups operate on a profitable enterprise model, which involves keeping down costs and bringing in revenue. The emergence of these corporate groups and the introduction of national health-care reforms has brought forth a distinctive business model for the delivery of PHC in Australia.[7,8] The rollout of corporatised PHC models in Australia has had mixed results for practices and patients. Amalgamation of small practices into large practices has led to of one-stop services being offered in central easily accessible areas; the closure of smaller practices has meant less accessibility for some patients. While there has been less administrative burden on doctors working in corporatised practices, it has also led to some of them feeling as agents of the corporation whose main concern is profits.[7] Though they have seen growth over the past many years, corporate organisations occupy only a small part of the PHC market.[7]

Corporate strategies involve reducing costs by using economies of scale in the management and implementation of efficiency models.[7] These strategies have become an integral component of PHN and Aboriginal Community Controlled PHC services because of conditions associated with Federal Government funding.[4–6,9] Annual plans of these organisations are to clearly demonstrate annual goals with key performance indicators such that progress can be monitored.[4,5,9,10] Also, the goals are to be based on a needs assessment of the community served. These features align with features of hybrid organisations, where mission orientation and the creation of social value is coupled with the creation of economic value.[1] There is some evidence that the adoption of best practice models and key performance indicators in Aboriginal Community Controlled health services has resulted in the improvement of health outcomes.[9] Adoption of a community driven patient-centred medical home model, but funded by the Australian Government, in these health services has led to improvement in access to PHC services and in sexual health, maternal and child health and cardiovascular health outcomes among the Aboriginal population.[9] While it is too early to determine the effectiveness or the impact on health outcomes by the PHNs in Australia, evidence from New Zealand Primary Health Organisations, which are funded on a capitation basis associated with key performance indicators, has shown improvement in access and health outcomes for enrolled patients.[8,11]

While there has been criticism of hybrid organisations having confused principles, and having

set themselves up to face contradictory pressures and be unpredictable in their behaviour,[12] noting the acute challenges PHC in Australia faces like increasing patient expectations for high-quality health care, disparity in access, and an uncertain economic climate; hybridisation, which mixes features of agency and enterprise, seems to hold great promise in addressing these challenges. Hybrid organisations are said to bring together the forces of the state, market and society, and create synergy and innovation.[12] This is thought to lead to effective and efficient public service provision and financial savings. Considering the extent and progression of hybridisation of PHC organisations in Australia, it is not if hybridisation needs to be introduced, but rather which funding mechanism would best support a hybrid set-up and deliver optimal outcomes for patients? While hybridisation of PHC is becoming ubiquitous in Australia, planning for appropriate funding models has been inadequate. The current roll out of PHC reform in Australia presents an appropriate platform to review PHC funding mechanisms. However, pragmatism dictates that funding of hybrid practices has to be derived from existing PHC funding models.

The main PHC funding model in Australia (fee-for-service model) is inherently focused on volume rather than a comprehensive approach to patient care,[4,8] thus rendering it a poor model to support optimal patient outcomes or efficient service delivery. In Australia, the popular funding mechanism to bring about required change in PHC practice is through pay for performance or financial incentives like Chronic Disease Management Items care plans and Service Incentive Payments.[4] However, there is insufficient evidence that financial incentives improve the quality of PHC.[13] This leaves us with the capitation model.

Aside from the progress demonstrated by NZ Primary Health Organisations and Australian Aboriginal Community Controlled health services through a capitated funding model, systematic reviews have indicated of all the funding models capitation encouraged general practitioners to provide preventive services.[14] The emphasis on preventive services is said to reduce future costs by having the general practitioners provide ongoing care for their fixed patient lists. However, capitation may lead to under servicing, patient selectivity and less incentive to improve performance.[4] Therefore, a hybrid-funding model to support a hybrid organisational model is called for. In the US and Germany, incentives are offered to PHC providers, in addition to the base funding model, to allow for delivery of holistic or comprehensive health care.[4] The advent of PHNs in Australia presents an opportunity to expand the current narrow capitation funding model base to replace the traditional fee-for-service model. Though, capitation has to be coupled with incentives or pay for performance initiatives to ensure there is appropriate focus on improvement.

Hybridisation of PHC has occurred in great strides in Australia over the past many years. While corporatised PHC practices relatively account for a small percentage of PHC services, the hybrid model does represent a significant portion of PHC service delivery in Australia. However, there seems to be a mismatch of funding mechanisms in supporting the hybridisation process. Inappropriate funding models are bound to have an adverse impact on PHC service delivery and, consequently, on patient outcomes. The Federal and State and Territory Governments have a stake in ensuring there is a viable and efficient PHC system, as rising costs and administrative pressures continue to afflict PHC delivery in Australia. [4,6–8] Therefore, a review of the current funding policy is called for in the context of current reform and hybridisation of PHC services.

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