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title Options for Finance in Primary Care in Australia

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Key messages

- Innovative and outcome-focused health care financing models are required to address health funding challenges.
- Discussion of primary health care financing typically revolves around exploring different payment systems (fee-for-service, pay for performance, activity based funding etc.) but should examine broader concepts such as risk, outcomes, performance and responsibility.
- Social impact bonds provide a mechanism for private investors to fund programs such as health care initiatives with a return paid on their investment by government once the program goals have been met. This provides an outcome-focused approach that simultaneously mitigates financial risk to governments and promotes innovation and broader social benefits.
- Primary Health Networks could adopt practices such as a shared services finance model to better support primary health providers. There should be a focus on reducing financial risk, relieving duplication and centralising core services and operating liabilities.
- Rather than using meso-level governance only to commission services and advise and support the primary health sector, an opportunity exists to provide valuable services and shape a framework for the implementation of impact investment. This would provide greater flexibility for general practitioners and other service providers and allow them to focus on delivering patient outcomes.

Executive summary

A number of policy initiatives aimed at reform of primary health care financing are currently either being debated nationally, or trialled in different jurisdictions. Commonwealth Government austerity and an interest from a wide range of stakeholders to mobilise capital from different parts of the economy have provided an incentive to explore new finance policy options for primary health care. However, recent reviews of primary health care finance have focused on contrasting the different payment systems, rather than the financing of primary health care in a more systemic sense. Finance is more than just an approach to payment, reflecting the flows of capital that structure service. Debates centred on payment systems (such as fee-for-service, salaries, capitation, pay for performance and activity-based funding) tend to eclipse the conceptual underpinnings of primary health care finance.

This issues brief explores policy options that move beyond payment systems. It approaches primary health care from a deeper perspective with a focus on how to link objectives to outcomes through different financing approaches. For example, the separation of primary health care payment systems (mostly fee for service) from hospital payment systems (activity-based funding) creates numerous boundaries between parts of the sector. Although different payment systems separate health care into discrete segments, the lived reality for many people managing their health care is that they need to move across these fragmented elements of the system, with little overall sense of outcome.

This issues brief will identify ways to consider primary health care finance policy options, by focusing on the objectives of different financing systems, how they connect to financial tools (such as impact investing), with a focus on health outcomes. It aims to broaden and deepen debate about primary health care finance.

It is anticipated that the issues brief will also be a starting point for a structured debate through policy engagement events between policy makers, academics and practitioners about new models of finance for primary health.

Primary health care policy context

Many of the current initiatives to reform primary health care financing in Australia are related to the 2009 National Health and Hospital Reform Commission report *A Healthier Future for All Australians* (NHHRC 2009). A number of policy initiatives currently being debated and trialled in different jurisdictions have their origins in concerns about access to services, equity, quality, innovation and governance in primary health care. Most states and territories when responding to the 2009 NHHRC report intended to streamline funding and financing arrangements (Victorian Department of Health 2009). Recent Commonwealth Government austerity and an interest from a wide range of stakeholders to mobilise capital from different parts of the economy (Social Impact Investment Taskforce 2014) have provided additional incentives to explore new financial policy options for primary health care.

There are a number of other significant policy issues that inform this discussion paper:

Introduction of new meso-level primary care organisations in 2015

Introducing a middle tier of primary health care governance has always been difficult in the Australian health care system. There have been a number of attempts to improve efficiency and coordination of primary care at a local and regional level, first with Divisions of General Practice, then Medicare Locals. The 2013 Horvath review proposed the replacement of Medicare Locals with a smaller number of Primary Health Networks (PHNs) which commence operations on 1 July 2015. Some States and Territories have previously recognised that regional level primary health organisations have an important role to play in future health system reform beyond planning and stakeholder engagement (see Figure 1 on the following page).

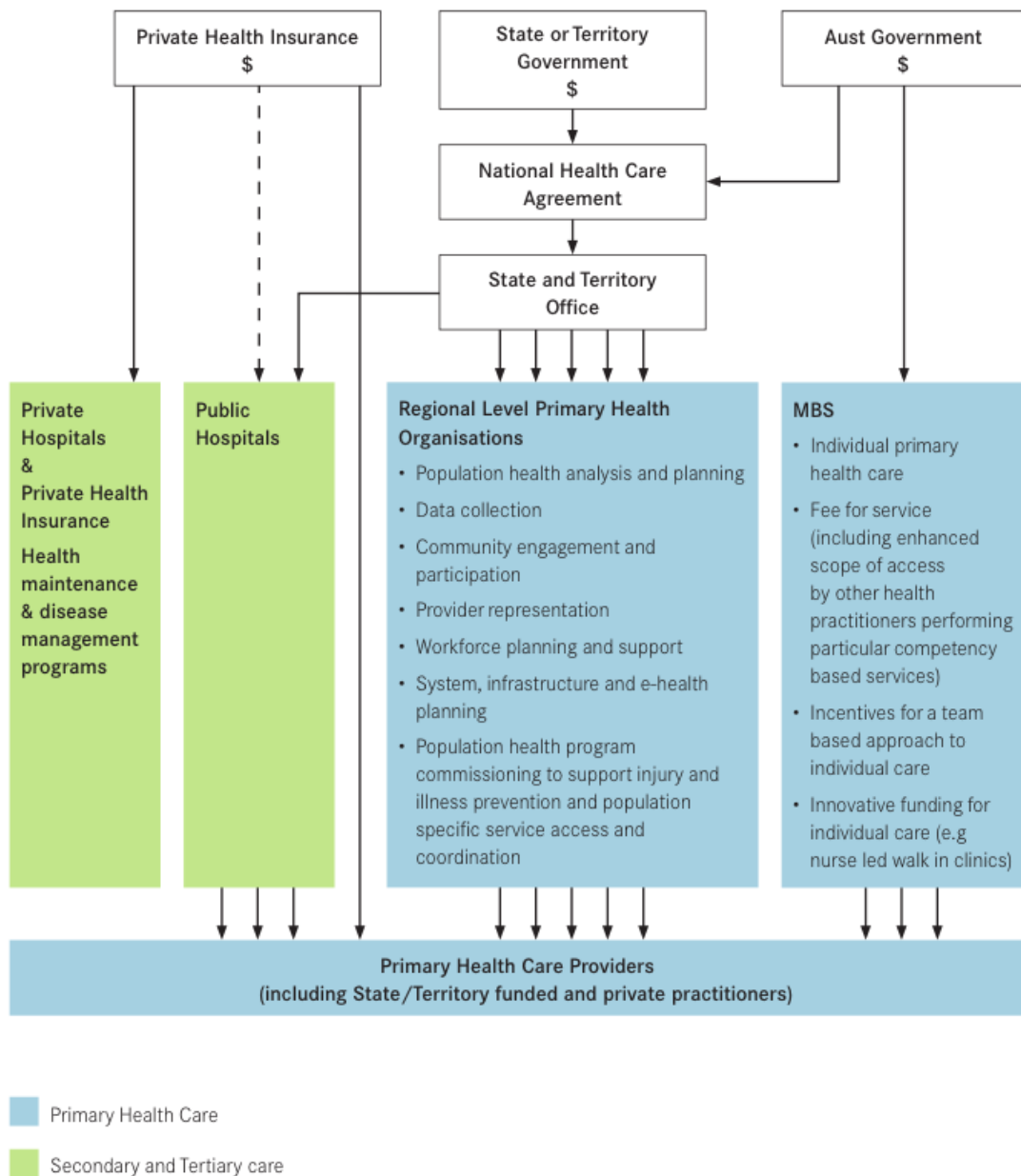
GP payment reductions and patient co-payments

In 2014-15 the Commonwealth Government proposed a series of options including reduced Medicare rebates to GPs and the introduction of patient co-payments, all of which have been met with significant public concern relating to equity, affordability, impact on emergency departments and negative population health outcomes.

Models of integrated care

With a growing prevalence of complex chronic illness in the population, there is increased interest in developing models of integrated care that can deal with complex and chronic conditions. There has been growth of models of integrated care building on shared electronic health records and vertical integration of services.

Figure 1: Victorian Government Blueprint (2009) for the primary care sector



(Victorian Department of Human Services 2009)

Increasing costs of doing business

The continued corporatisation of primary health care providers through a small number of primary care corporates suggests that the financial costs of small single primary care providers may be prohibitive. These pressures are felt in both the private and public segments of the primary health care sector. Recent mergers of community health care centres in some jurisdictions have opened up questions about the sustainability of community-based primary health care based on older financing models.

Exploration of outcome-based rather than activity-based funding

Different governments between 1998 and 2010 introduced multiple reforms to the funding of general practice in Australia. These funding reforms were focused on blending outcome-based funding into the Medicare Benefits Schedule (MBS) funding system in an effort to mitigate the negative impact of activity-based funding on the quality of service provision (Duckett and Willcox 2011:167).

Incentives and Innovations in GP funding

As part of its intention to “rebuild primary care”, the 2014-15 Commonwealth budget signalled the interest of the Federal Government in exploring incentives and innovations in models of primary health care funding and delivery, including partnerships with private insurers (Department of Health 2015).

Impact investing in primary health care

Impact investing offers substantive innovation in the financing of primary health care in the UK. In March 2015 the UK National Health Service announced that one of its regional primary health Clinical Commissioning Groups (CCGs) was introducing a Social Impact Bond (SIB) project focused on “social prescribing” to support 8,000 people with long-term health conditions such as lung disease, diabetes and asthma.

Mindful of the current policy context, and recent attempts to reform primary care funding, this document aims to provide a series of discussion points for the reform of the financing of primary health care in Australia.

The scope of primary health care

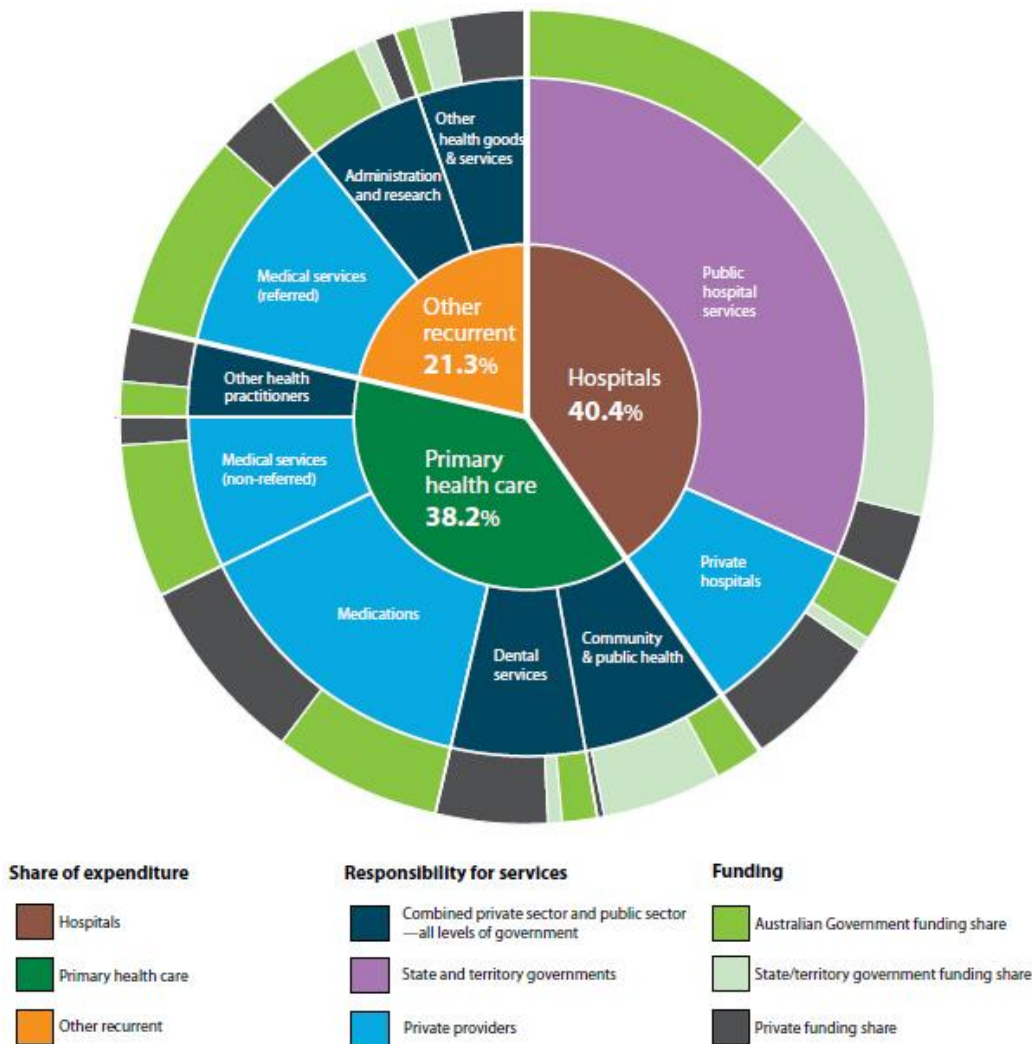
Primary health care is often the first point of contact for a wide range of health issues from immunisation and maternal and child health problems, to preventable illnesses related to lifestyle risk behaviours. Primary health care includes a range of front-line health services delivered in the community such as those delivered in general practice (GP), physiotherapy and optometry services, dental services and all community and public health initiatives. It also includes the cost of medications not provided through hospital funding and diagnostic services such as pathology and radiology. Preventive health is also considered integral to primary health, as primary care settings often deliver preventive services (Harris & Lloyd 2012).

As an indication of the scope of primary care in Australia the 2013 National Primary Health Care Strategic Framework identified four priority actions (Department of Health 2013):

- Build a consumer-focused integrated primary health care system;
- Improve access and reduce inequity;
- Increase the focus on health promotion and prevention, screening and early intervention; and
- Improve quality, safety, performance and accountability.

Primary health care service delivery is a mosaic of services. Similarly, the governance and financing of primary care is complex. The temptation in the past has been to focus on how people get paid within this complex system. As Figure 2 illustrates, funding is sourced from both private and public sources and there are both government and non-government providers.

Figure 2: Funding and responsibility in the health system 2011-12



(Source: Australian Institute of Health and Welfare 2014: s 2.1)

In economic terms, primary health care could be considered a merit good. By definition it is bound to be undervalued by the consumer, its benefits extend beyond the individual, and demand-supply imbalance must be considered. There will always be a broader public good arising from the provision of health services, and it is the choice of government to provide this good. The complexity in conceptualising the role of government in primary care and preventive health funding is that: (1) many health problems presenting to primary care providers are not necessarily only medical in origin; (2) many of the health problems arise from poor consumption choices (such as alcohol and drug consumption, poor diet and low exercise); and (3) there can always be more primary health care as there are few limits to

the demand for care. As a consequence, placing boundaries around what level of primary health care funding is enough, how much should be paid for by government and how much by the individual, is a complicated policy discussion.

A premise of this discussion paper is that there will always be a mix of public and private funders and providers, as the good that is provided needs to be stewarded by government either through price, subsidy, incentive or access and quality regulation, or through creating an environment where a market for merit goods can form.

Capital in the health system¹

Primary health care accounts for almost as much health spending as hospital services, accounting for 36.1% of total health expenditure in 2011-12 compared with 38.2% on hospital services (AIHW 2014).

The Australian health system is supported by funding from different levels of government, by private health insurers and by individuals. Primary health care has a higher proportion of individual expenditure than any other area of health expenditure (Figure 2). Individual expenditure is usually incurred through co-payments in general practice payment visits or diagnostic services. Medicare data reports that there are around 134 million non-referral visits to GPs and related primary health care providers annually (Vos et al. 2010). On average, individuals visit a GP 5.6 times per year (NHPA 2015) and 82.2% of those attendees are bulk-billed (MBS statistics 2014; table 1.4).

In the 2014-15 Commonwealth budget papers, Government primary health care program expenditure (including ATSI, rural health, mental health and primary care practice incentives) was estimated to be approximately \$2.3 billion (Department of Health 2015: p 106).

In 2001-2002 around 77% of the income of GPs was derived from Medicare activity-based funding. About 23% of general practice funding was attached to a variety of other government programs (Australian Medical Workforce Advisory Committee 2005).

The focus on government expenditure however does not provide the full picture about primary care financing in Australia. Management of the finances of a service is not wholly about managing activity-based income, it is also about planning and managing risk, assets and other forms of capital, much of which is held in private hands.

Expenditure in the private health sector (including both the for-profit and not-for-profit sectors and out-of-pocket costs) plays a smaller but significant role in delivering and financing health services in Australia. (Duckett and Willcox 2011: p53; AIHW 2014: p53). Around a third of all health care in Australia is paid by non-government sources, with out-of-

¹ Capital in this paper is used in a broad sense to refer to any produced thing that can be used to enhance wealth. There are a range of other applications of the term such as “financial capital”, “cultural capital”, “social capital” and “intellectual capital”, reflecting a wider application of the term than in pure economic terms.

pocket expenditure the major component of this funding contributing to 19% of total health expenditure (Australian Bureau of Statistics 2010).

Private health insurance provides cover for hospital care, including basic, supplementary and co-payment cover; general treatment cover and cover for ambulance, optometry and physiotherapy services. Approximately 47% of the population in 2013 had some form of private hospital cover and 55% had some form of general treatment cover (AIHW 2014; p41).

There has been increasing levels of corporatisation of private service delivery in the primary health care sector with a concentration of private ownership and a reduction in the number of small GP services. According to the BEACH study of Australian GPs (Britt, et al. 2010a) between 2001 and 2010:

- the proportion of participants in solo practice more than halved
- the proportion of GPs working in practices with 5–9 individual GPs, increased from 32.7% to 41.4%
- the proportion of practices with 10 or more individual GPs increased from 9.5% to 19.5%

In the past 15 years there has been a corporatisation of health care in Australia. Up to the late 1990s, the primary health sector could be characterised as a “cottage industry”, dominated by sole traders and partnerships. By 2000, there were six publicly-listed corporate groups in operation. By 2010 there were just three publicly listed corporations, Primary Health Care, Sonic Health Care and Healthscope. Through the 2000s, Primary Health Care (PHC) expended more than \$400 million acquiring hundreds of unincorporated medical and health related practices (Primary Health Care 2011). In 2012 PHC was the second largest pathology provider in Australia, with approximately 30 percent market share. It also hosts the second largest diagnostic imaging network in Australia (PHC 2012).

In 2008 PHC acquired Symbion (formerly Mayne Nickless) and added more medical centres, around 80 pathology labs and 690 pathology collection centres. PHC has vertically integrated pathology, diagnostic and clinical services. In 2010-11, PHC revenue for medical centres was \$274.6 million with earnings before interest, taxes, depreciation, and amortization of \$150.3 million (PHC 2011).

These companies still account for a relatively small percentage of industry revenue, estimated at 12% (Fitzpatrick 2011). Primary Health Care, Sonic and Healthscope are publicly traded on the Australian Securities Exchange. Tristar Medical Group, Ochre Health and Aspen Medical have interests in primary health across Australia. For example, Tristar has nine primary health services in rural and regional areas with approximately 500 staff and 200 doctors on contract.

The Australian pathology market is highly concentrated. Sonic Healthcare (39.4%), Primary Health Care (31.3%) and Healthscope (11.4%) together account for over 80% of the market by revenue. Given the level of corporatisation of private service provision and private financing, it is worth reflecting on the financial relationships between Government and the private sector, by looking beyond provider payment strategies.

Financing and payment approaches

Many reviews of primary health care finance focus on contrasting the different payment approaches, rather than the financing of primary health care in a more systemic sense (Oliver-Baxter and Brown 2013). Although this document will move beyond the current suite of payment systems, it is important to appreciate the current range of payment approaches (see Table 1).

Finance is however more than just an approach to payment for service, and reflects the flows of capital supporting those service structures. Debates centred on payment systems (such as fee-for-service, salaries, capitation, pay for performance and activity-based funding) can inadvertently obscure the connections between risk, outcomes, performance and responsibility. It is this balance between financial risk, outcomes, assets and expenditure that is at the heart of health financing.

Table 1: Primary health care payment methods

| Payment method | Description |
|--|--|
| Fee for Service | Providers bill for each item of service they provide. |
| Capitation Funding | Allocation of funding among GPs is determined by patient registrations. |
| Fixed Payments per Unit of Time | Salaries negotiated centrally (e.g. between provider associations and government), with individual-based adjustments to allow for experience, location and other considerations. |
| Pay-for-Performance | Payments to individuals (GPs) or organisations (practices) based on type/number of services provided of a specific standard/type. Payments to practices instead of individuals as compensation for risk. |
| Activity-based Funding | Providers are funded based on expected activity, i.e. expected costs for clinically-defined episodes of care. |

(Adapted from Oliver-Baxter and Brown 2013)

For example, in 2014 a number of Victorian community health centres either had, or were in the process of merging to form a fewer number of larger primary health care providers, in order to better manage the financial risks. These risks emerge from a combination of rising operating costs and poor indexation of government service rebates. For many small providers, when operating liabilities are pitted against organisational assets, financial

viability can threaten the quality of service and the sustainability of universal access to primary health care.²

Outcomes and Performance

There are advanced metrics for the measurement of outcomes and performance in the Australian hospital sector, based usually on case-mix activity and system efficiency. There are also quality measures, however these tend to be of lower consequence in the day-to-day financial management of the system (Duckett and Willcox 2011). In primary health care however, outcomes and performance have been very difficult to assess because of a profound lack of data and the fragmented nature of the service system (AIHW 2014: p372-373).

Accreditation is one method to measure performance against standards. The Australian Commission on Safety and Quality in Healthcare (ACSQHC) does not directly report on quality in the primary care sector, however it does liaise with the primary health care sector through its subcommittees. General practices are not required to be accredited in Australia, however, 67% are accredited to Royal Australian College of General Practitioners (RACGP) Standards (ACSQHC 2014; p12).

Performance reporting, including against a range of indicators under the National Health Reform Act 2011 (Cth) and reported in the Productivity Commission's Report on Government Services provides some measures on the relationship between health sector performance and financing but there is little monitoring of primary care performance and particularly on health outcomes and their relationship with health expenditure.

Financial Risk

In the case of the private primary health care sector, directors and equity providers carry the financial risk of service provision. It is possible to index the financial risk of listed companies through stock market indicators and reporting, however the task is more difficult for unlisted companies.

Public hospitals are a limit case for the power of government to mitigate financial risk. Because of their low level of self-financing, public hospitals cannot effectively replace their assets over the long term using income generated by their own operations (Victorian Auditor General's Office 2014). Typically Victorian public hospitals are able to self-finance only 10% of their financial risk. The only reason hospitals can operate at this level of risk exposure is because they have letters of comfort from the State Government, which guarantee their operations (Victorian Auditor General's Office 2014).

The financial risk of primary care in community health centres is borne by board directors. Community sector risk management is however quite fragmented, with risk management

² A recent Federal Government response to financial unsustainability was to attempt to increase consumer co-payments in an effort to drive revenue and send price signals to health consumers. Many commentators observed that this would produce inequitable outcomes by impinging on universal access to primary health care.

models poorly matched to the sectoral needs that often reinforce risk shifting to weaker parties, and reduce incentives for collaborative and integrated service provision (Brett et al. 2010).

Accountability

Financial risk in the public health system is quite visible through public reporting by state and federal auditing agencies. The same cannot be said for however for privately-owned primary health care providers.

This accountability gap is also apparent in the governance of primary health care in Australia. The performance and accountability framework for the national health reform agenda explicitly allocates roles for the Commonwealth (through Medicare Locals, which may be assumed as extending to successor Primary Health Networks), States and Territories (as managers of the public hospital system) and private hospital owners (for their private hospital interests) (National Health Performance Authority 2012). It is notable that there are currently 31 indicators for primary health although these may be modified as the Primary Health Networks are established. Relative changes in these measures may be used to assess primary health sector performance (National Health Performance Authority 2012: s 6.3). The indicator for “efficiency” is however simply financial performance against budget. Specific indicators for sustainability and quality are yet to be developed.

There are improvements in national reporting on primary health care service utilisation through the National Health Performance Authority (NHPA). For example, the NHPA reported that the 2.9 million Australians who attended 12 or more GP visits in 2012-13 were more likely to be older and live in areas with the most socioeconomic disadvantage, and had the lowest rates of private health insurance coverage (NHPA 2015). These measures were derived from Australian Bureau of Statistics (ABS) surveys and analysis of MBS data. To date, utilisation data has not however been linked to outcome, quality and performance or information about service management. Utilisation data does not necessarily denote quality of service provision.

It is not apparent just how far we have come since the NHHRC 2009 report in terms of financial accountability of the primary care system. Activity-based funding only covers a proportion of the cost of financing primary health care in Australia, and the financing of primary health care goes well beyond activity payments. The more substantial financing of primary care lies in the management of the risk in the full cost of primary care.

Government pays for the activity in the system through the MBS and individuals pay out-of-pocket expenses. The additional costs of financing primary health care risk are borne by the private sector. Although the Commonwealth Government pays for the activity of the system, primary health care is predominantly a private sector activity where the financial risks are mostly borne by private interests.

So what does this mean when exploring options for financing primary health care in Australia?

Financing policy options

Historically there have been two basic approaches to primary health care funding in Australia, “population-based funding” and “patient-focused funding” (Oliver-Baxter and Brown, 2013). Population-based approaches allocate funding according to population characteristics. This funding is sometimes called “input funding” where funding is indexed to the population attributes and health care needs of the population. Patient-focused funding is defined as any method of funding where providers are funded according to a unit price per patient or episode of care. This approach can include wide variations such as fee for service (FFS), and activity-based funding (ABF).

Oliver-Baxter and Brown (2013) provide a comprehensive account of primary care funding models internationally and in Australia. Part of the discussion of primary care financing however is a higher-level consideration of whether the universal health care system in Australia requires a universal financing system. On the one hand the current mosaic of unaligned funding models is confusing and inefficient. As Oliver-Baxter and Brown (2013) assert:

“Each system brings its own set of desired and perverse incentives. The situation is often worsened when multiple funding models are implemented simultaneously and when financial incentives between sectors are not aligned (eg. GPs paid through FFS [fee for service] whilst hospitals receive ABF [activity-based funding]: ABF gives hospitals an incentive to limit the volume of cases, whilst FFS gives GPs incentive to increase volumes). On the other hand with such a diverse system, perhaps it is not appropriate to have a single funding model at the level of individual service provider. Perhaps a higher consideration is whether there can be a level of subsidiarity applied to funding models, depending on the scale of the funding.”

It has been noted previously that MBS activity-based funding is insensitive to local primary health demands and that there is a need for financing models that allow for local flexibility to meet a specific community’s requirements and the need for inter-sectoral collaboration (NHHRC 2009).

An example of a solution to this constraint of the MBS was the use of outcome-based funding (using both facilitation and reward payments) in the National Partnership Agreement on Preventive Health (NPAPH). In this COAG agreement, states were required to meet state-wide population-health targets (e.g. a reduction in daily smoking rates) in order to be eligible later for “reward” payments. At the level of service provision however, services were funded through different payment systems depending on the service. In fact the implicit commitment to subsidiarity in this approach allowed the states to be flexible in how they deployed COAG NPAPH funding, resulting in different approaches being used across jurisdictions. In Victoria subsidiarity was taken a step further, allowing local governments to shape the mix of services to be provided in the Healthy Together program. It is not clear whether the NPAPH agreement produced any improvement in population health outcomes because of a paucity of evaluation and the long-term nature of such interventions. It is also not clear whether the different state-level funding strategies or the subsidiarity principle implicit in the funding approach was an efficient use of public money.

Although the Commonwealth Government announced the termination of the NPAPH in the 2014-15 Commonwealth budget, the principles underpinning this funding strategy remain salient: (1) a focus on outcomes and (2) allow those most proximal to the delivery of services to be financed in a manner that assists in the effective delivery of services.

In light of the elevation of Primary Health Networks as a new middle-level governance structure for primary health care, and the development of a new performance indicator framework matched to this governance mechanism, it seems appropriate to focus in on primary health care finance policy options that are centred around Primary Health Networks. Importantly there is also the opportunity to specifically explore population-level funding approaches, rather than provider-focused funding, and to link governance with financing in a more transparent manner.

The following policy options are not comprehensive. They do not intend to capture all the possible policy options available to finance primary health care. This selection of options highlights the following principles:

1. Primary health care is a merit good. Government should steward that good by providing services, purchasing private services to be delivered on its behalf, or by creating environments that establish the conditions for markets to sustain that merit good with equity for all.
2. Financing should reflect a focus on achieving quality outcomes.
3. Government financing of services should be transparent and accountable to the public regardless of the sector in which service delivery occurs.
4. Those most proximal to the delivery of services should be financed in a manner that assists in the effective delivery of services.

Variations in service models

A number of variations in financing and payment approaches have emerged in recent years that have attempted to balance the benefits and perversities of the different payment approaches and financing arrangements in primary care.

Capitation and Quality Outcomes Framework (UK)

Primary health care in the United Kingdom is structured around two payment approaches: capitation, (where practitioners are funded according to the number of patients) and the Quality Outcomes Framework (QOF), where practitioners are paid according to meeting any of 121 indicators across a number of practice domains.

Under the QOF each practice domain has a set of measures against which practices score points (up to 900) according to their level of achievement. The domains are weighted and achievements are measured in the areas of: clinical (up to 610 points); public health (up to 113 points); public health additional services (eg child health surveillance and maternity services (up to 44 points); quality and productivity; (up to 100 points) and patient

experience (up to 33 points). Not all practices have to perform across all domains, but clearly some domains are weighted more heavily than others.

This payment approach tries to integrate an outcomes focus with service activity payment. In this way the financing strategy manages the tensions between the benefits and perverse outcomes of both payment approaches. This is however at its heart a strategy focused on payment, rather than a deeper strategy to manage financing of primary health care. The situation in the UK is of course different to Australia's as the regional purchasing of primary health care is coordinated through Clinical Commissioning Groups (CCGs) financed by their National Health Service (National Health Service 2015).

Medibank trials

Over the past two years, Medibank has announced a number of trials, the Queensland "GP Access Pilot program" and Victoria's "Carepoint" Trial, that ostensibly are variations on existing funding arrangements, utilising the health insurer's capital base to underwrite and align a range of coordinated services (Medibank Private 2014).

Between 2014-2017 the Victorian Department of Health and Human Services in partnership with Medibank Private, public and private health services, Medicare Locals and successor Primary Health Networks, the Australian Medical Association (AMA), and the Royal Australasian College of General Practitioners (RACGP) is trialling "CarePoint", an integrated model of care for people with chronic conditions and complex needs (Medibank Private 2014).

Built on person-centred care principles, services will feature home monitoring, care navigation and an electronic care plan and patient record. Patients are recruited through Peninsula Health and GP clinics in the eastern region of Melbourne and Mornington Peninsula. The aims of the trial are to (1) improve patient, carer and provider experience; and (2) improve health outcomes and health system utilisation by reducing patient hospital admissions by 25% (including reducing readmissions).

The trial involves 2,200 patients with high service usage including Medibank members and non-insured adults with multiple chronic and complex conditions. The CarePoint trial is not exclusive to Medibank members (Health Victoria 2014). The trial is of a model of coordinated care rather than a trial of alternative financing. In this case primary care providers are still reimbursed in the same way as they would be for non-trial patients. There are no changes to the underlying financing of the providers involved.

It is interesting to note an aspirational outcome measure (a 25% reduction on patient admissions) for the trial.

A second variation on existing arrangements is the vision forwarded by Medibank for what it calls "The Medibank Effect". This is a coordinated care model that vertically integrates its investments in telehealth, workplace health and online health support services (Medibank 2013).

The “Medibank Effect” model integrates:

- healthcare platforms
- networks of providers
- new gateways (Gateway 24x7)
- new models of care
 - integrated care coordination
 - continuity of care across primary and secondary care
 - continuity of patient information / support
 - care teams

This is more aligned to a managed care arrangement where Medibank purchases and manages care plans across a spectrum of primary health care providers, most of whom Medibank owns.

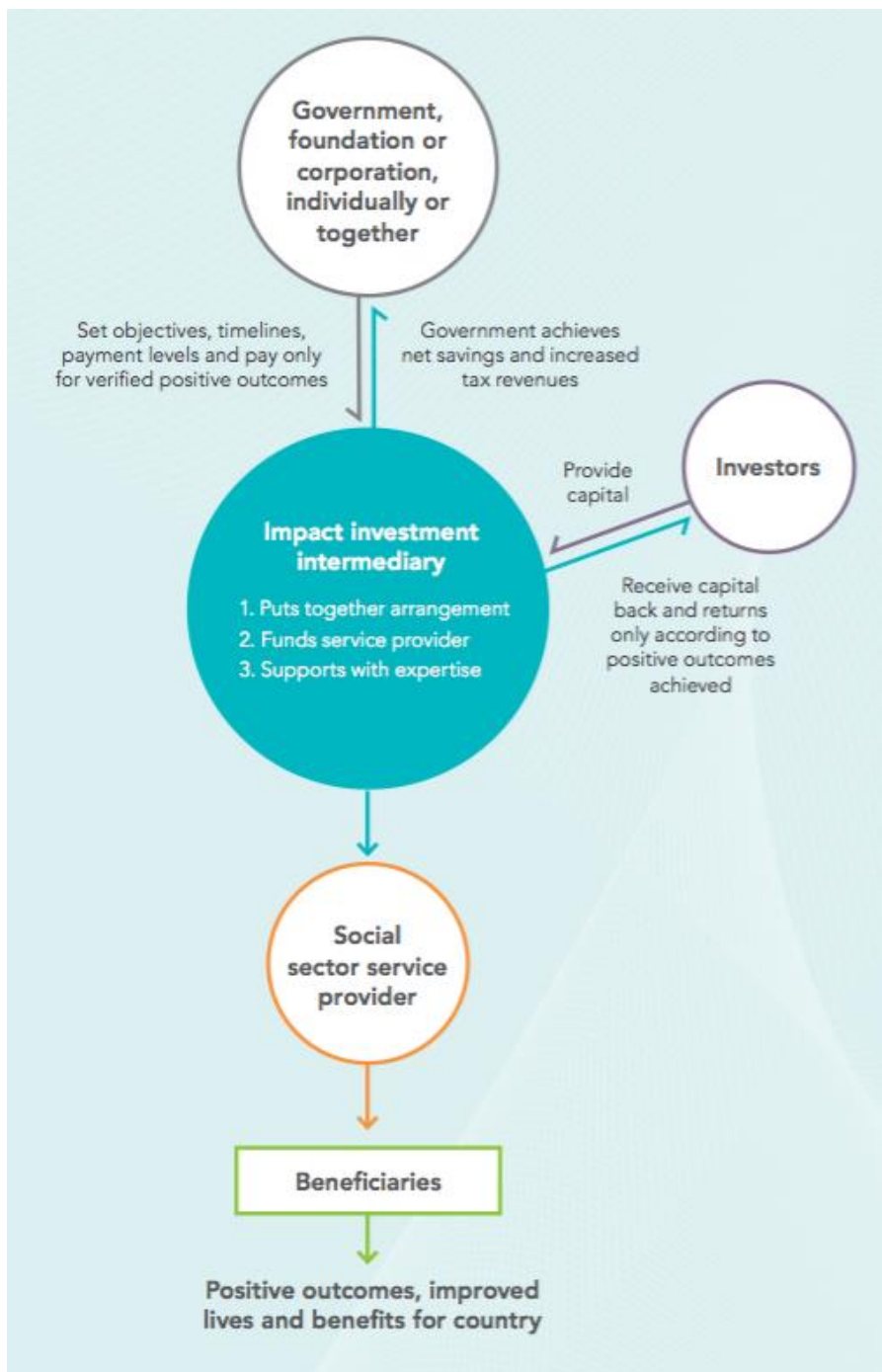
What is apparent from the increasing corporatisation of primary care providers, and the recent moves by Medibank Private to acquire and vertically integrate primary care services and to integrate those services into scaled up coordinated care initiatives is that the primary care sector is now seen to be amenable to investment and private capitalisation. This opens up an opportunity to examine some new models of financing that may have salience for the sector.

Impact investing

Impact investing refers to a type of investing where the focus is on an outcome from the investment that goes beyond economic return. This can include simple loan arrangements in social enterprises which mobilise both economic and social capital, to more complex financing tools such as environmental bonds and social impact bonds (SIBs). The type of bonds used in impact financing generally involve the measurement and achievement of specific kinds of outcomes. For example, environmental bonds tend to focus on the achievement of environmental outcomes, whereas SIBs (also called social benefit bonds, or pay for success bonds) tend to focus on investments that produce social impacts.

SIBs are a particular type of impact investing that involve the issuing of a bond by a bond issuer and a commitment by government to private investors to provide a return on investment related to the issuing of the bond (see Figure 3 on the following page).

Figure 3: Organisation of Social Impact Bonds



(Source: Social Impact Investment Taskforce 2014)

In SIBs, private investors fund interventions through a contractor and the government pays the investors (through a combination of principal repayment and return on investment) only if the program meets its goals (Figure 3). Investors provide financing for programs with the potential to achieve savings for government and to produce a broader social benefit. The attractiveness of SIBs lies in risk mitigation to government, cash flow management for

government departments and the potential of SIBs to encourage private investment in evidence-based preventive services, promote innovation and increase accountability (Addis 2014).

SIBs are being trialled in a range of sectors using a wide range of interventions. In the United States, SIBs are predominantly being used in justice, out of home care, social welfare, education, homelessness and job training (see Table 2).

To date, SIBs have been used for specific programs to complement broader funding of the healthcare system (Table 2). Four states in the USA have SIBs in progress and a further nineteen have SIBs in development (Centre for American Progress 2014; and Social Finance US 2015).

In 2011 the NSW Government launched two SIBs (called social benefit bonds in NSW). UnitingCare Burnside received \$7 million for out of home care, and the Benevolent Society received \$10 million to prevent family breakdown (McLeod 2014).

The premise of the utility of SIBs in prevention and health promotion among volitional populations is that when the tastes of its citizenry, e.g. their health choices, are harmful, there is a role for government in changing those tastes (Fitzgerald 2013).

This is a different rationale to the traditional economic logic of market failure. Under the premise of a merit good, there is no requirement to assert that a market has failed in order to justify government intervention. Rather, the tastes of a citizenry simply need to be adjusted, because those tastes are harmful. Alcohol and tobacco taxation are obvious examples where government assumes the role of correcting the tastes of its citizenry. There are however, other less obvious examples where governments take on the role of “adjusting tastes” through a wide range of micro and macroeconomic policies. Compulsory superannuation policies, mutual obligation welfare strategies, and sin taxes are examples where government does not just intervene when there is market failure, but when consumption produces harm to the individual and to the broader health of the population.

Impact investing is less concerned with the origin of harm, and more concerned with the production of outcomes. In these more complex financing models where both private and public finance is used, the focus is not on the attribution of the source of failure, but rather, on the mitigation of harm regardless of its origin.

In a subtle way, impact investing requires a change in mindset away from discussions of which interests (private or public) are responsible for harm. The focus shifts to the mitigation of harm by adjusting the tastes and behaviours of the citizenry. This is a more utilitarian approach to financing, and stands as an alternative to public financing based on market failure. Ultimately, the citizen ends up paying, either through taxation or through private payment.

The working models for SIBs are mostly drawn from settings where those subject to interventions are in either highly dependent populations (such as those in foster care) or captured populations such as those in the prison system (see Table 2). This does not mean

that SIBs are only feasible for these populations, it just signals that at the centre of the logic of an SIB is behavioural change and the lowest hanging fruit have previously been found in populations that are dependent on the state.

There are a few reported SIB interventions that have a primary health focus such as an SIB focused on asthma prevention in Fresno, California and a “social prescribing” SIB in Newcastle, United Kingdom. The rest of the interventions in the US tend to focus on social health. The examples can be separated into those programs which are oriented around specific programs and those that are focused on a geographic precinct or catchment with a focus on broader health and wellbeing.

Catchment-level outcomes funding

From 1 July 2015, 31 Primary Health Networks will begin operations across Australia. The need for this mid-level organisational role has previously been recognised through the establishment of Divisions of General Practice and Medicare Locals. Crucially, this middle level of governance has largely been federally funded, although a number of funded initiatives are also in place in the States and Territories.

This long-standing commitment to some middle layer of governance between federal funding and local delivery reveals an implicit belief in subsidiarity. Primary health care needs to be organized at a regional level for it to be integrated and coordinated properly.

While the new Primary Health Networks cover much larger geographic areas than previous Medicare Locals, Mazumdar et al. (2014) identified 392 Primary Care Service Areas (PCSAs) or natural service catchments of health service users in NSW. This method of identifying “natural” geographic catchments of health service users may provide an even finer tool for understanding health service utilisation patterns and for allocation of health system resources.

Similarly, outcomes from primary health care can also be measured at a regional level. The United States may not be an obvious place to look for a solution to this issue of autonomous meso-level primary care governance. However, the coordination of the Camden Coalition of Health Care Providers provides an interesting case example of how a regional approach to primary health care can be organized around outcomes.

Camden Coalition of Healthcare Providers

In response to an observation in Camden, New Jersey, that a high proportion of hospital care was being used by a segment of emergency room “superutilisers”, a coalition of primary care providers and hospital staff developed a coordinated care program that linked the hospital emergency room to primary care providers. Emergency room “superutilisers” were identified spatially (Highmark Foundation 2013) and a platform was developed to exchange daily data on patient movement between primary care providers, outreach teams and the local hospital. The coordinated care model leveraged additional funding for providers, created incentives for practitioners and established conditions for a more

financially sustainable catchment-level coordinated care model focused on health teams, coaches, nurse practitioners and social workers.

Importantly the spokesperson for the model (Dr Jeffrey Brenner) popularised the issue of financing for the coordinated care model, and legislation (the New Jersey Social Innovation Act) was drafted to support a social impact bond-like investment model for the coordinated care coalition. The New Jersey Social Innovation Act was designed to provide a governmental loan guarantee for a SIB pilot program aimed at early intervention hospital superutilisers (Princeton University 2013). The legislation was drafted, debated, passed and then vetoed by the Governor. Its current status is unclear. However the intent of the legislation was to create a specific fund that would support leveraged investment in the coordinated care model.

A similar coordinated care coalition in South Central Pennsylvania (Camden Coalition of Healthcare Providers 2014) is funded by the Highmark Foundation, the charity arm of Highmark Inc., one of the largest health insurers in the United States. However it is unclear why regional level coordinated care coalitions are increasingly becoming the target of investment in the United States.

Newcastle West Clinical Commissioning Group (CCG) and Ways to Wellness: (United Kingdom)

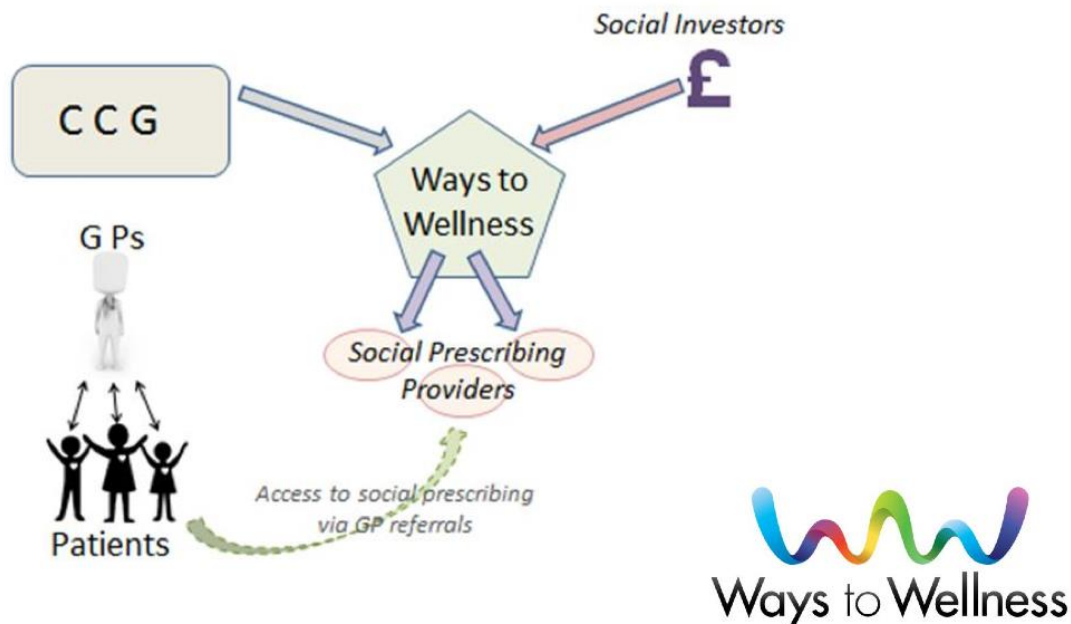
In March 2015 the UK Government announced four SIBs connected to the Youth Engagement Fund. The four SIBs are mostly program level interventions focused on young people at risk of social harm. Three SIBs linked to the Social Outcomes fund were also announced. One SIB involves a NHS Clinical Commissioning Group (CCG).

Clinical Commissioning Groups (CCGs) replaced Primary Care Trusts as the commissioners of most services funded by the NHS in England. They now control around two-thirds of the NHS budget. CCGs commission most of the hospital and community NHS services in the local areas for which they are responsible. There are 211 CCGs across England.

One of the recently announced SIBs (Newcastle West Clinical Commissioning Group in collaboration with Ways to Wellness Ltd) will be focused on “social prescribing” to support 8,000 people with long-term health conditions such as lung disease, diabetes and asthma (see Figure 4 on the following page). Social prescribing activities, delivered by charities and community groups, include physical activity, healthy eating/cooking, social interaction, welfare rights advice and support with positive relationships.

General Practices will be the point of referral of individuals to the Ways to Wellness program (Fuse Centre for Translational Research in Public Health 2014). Individuals will be encouraged to take up healthy activities and the program aims to reduce health care costs by £8.7m and generate wider cashable benefits of £10.7m. This SIB is supported by a £1.5m social investment repayable after three years and will make up to £2m outcome payments if the wellbeing of 8,571 people improves to the levels expected.

Figure 4: Organisation of the Newcastle West Clinical Commissioning Group (CCG) and Ways to Wellness SIB (UK)



(Source: [Fuse Centre for Translational Research in Public Health 2014](#))

The SIB relationship explicitly involves GPs in the CCG (Figure 4), however they are just a point of referral in the SIB. In this case the outcomes are focused on aggregate clinical outcomes for the target high-risk group. There is however no detail as to how the SIB relates to financing and payment of GPs. As the commissioner and purchaser of services, the CCG will still control the financing of primary care. The SIB in this situation will function as an additional line of cash flow linked to improved outcomes for a patient group. There is however no deeper structural change to the financing of the primary health care sector brought about through using this SIB. In some senses the SIB is acting like program-level funding to attempt to improve outcomes using an intervention purchased from Way to Wellness. This was made possible through the deeper structural reform (linking hospitals to primary care providers in a single purchasing/commissioning structure) that had already occurred outside of the SIB through the CCG's enhanced commissioning and purchasing role.

The application of impact investing

Impact financing has a focus on outcomes. Measuring outcomes however is not a simple activity in primary health care. Some outcomes have long temporal lags and some outcomes are logically distal to the intervention or initiating activity.

SIBs to date have been focused predominantly on interventions that are cognitive-behavioural or with coerced populations. Two issues emerge in discussions about the deployment of SIBs in Australian non-justice environments. The first is how do SIBs work in populations of people who are not coerced to participate in the intervention? Secondly, how do these interventions attribute causality in multi-agency and multi-level interventions? In simple terms how do you reward an intervention when you don't know which intervention has worked to impact health behavioural change?

The needs of SIBs for coercive behavioural interventions may not be well matched to best practice in primary care. One of the most well publicized SIBs is the New York City Rikers Island Prison SIB. In this SIB, teenage offenders (16-18 years of age) who are sent to Rikers Island Prison are exposed to an intervention that is designed to reduce reoffending. If the intervention service reduces reoffending to an agreed level, then a return on investment is paid to the investors.

Of interest is the nature of the intervention. As noted earlier, most SIBs have been piloted with captive populations in highly controlled environments in order to ensure the outcome is attributable to the intervention. A downside of this highly controlled approach is that it may not be amenable to interventions that are either voluntary or in uncontrolled social environments.

The Rikers Island intervention uses a cognitive behavioural therapy called Moral Reconciliation Therapy (MRT) (Moral Reconciliation Therapy 2012) designed to "Change the way they think". Whilst cognitive behavioural therapy is useful for some behaviours, there are significant limitations to this kind of intervention for volitional health behaviours such as diet and obesity prevention, physical exercise and drug and alcohol use. There is limited evidence of efficacy of this kind of intervention in conditions most likely to present in primary care.

Similarly, Hull and Ritter (2014) find very little evidence that pay for performance (P4P) interventions are particularly efficacious in the alcohol and drug treatment sector. Overall, they find that the size of the effects attributed to P4P is around 5%, and the change is usually observed in improved treatment processes, rather than for client health and wellbeing outcomes.

As noted earlier, there are two dominant applications of SIB interventions. The first application is usually a highly specific client-based intervention for an isolated behaviour usually in a controlled setting with a captive population. It is unclear how this kind of application will be applied in the primary care setting.

The second, less common application is a scaled-up intervention in a multi-causal environment where the outcome is measured at a population level. The Newcastle West Clinical Commissioning Group's "social prescribing" and The Camden Coalition of Healthcare Providers coordinated care initiatives are perhaps the clearest examples of complex SIBs operating across a local area.

Regulatory considerations

Consistent with the role of government to use a range of mechanisms to create conditions that adjust the tastes of its consumers, a number of developed countries have adopted beneficent taxation regimes to redirect capital into impact investing. The following material drawn from the Social Impact Investing Taskforce (2014) provides some indications of the kind of regulatory environments that can support the introduction of SIB financing at a larger scale.

In the US, Federal New Markets Tax Credits and the Community Reinvestment Act were designed to increase the flow of capital to poorer parts of the US. Since 2000 over \$31.1 billion in new market tax credit transactions have been reported. In 2013 \$55 billion was channelled from banks to poorer communities through social investment under the Community Reinvestment Act.

In 2014, the UK Government announced Social Investment tax relief. Individuals can deduct 30% of the cost of their eligible social investment from their income tax liability and may defer capital gains tax charges. These tax concessions can apply to SIBs, shares or debt investments in eligible social sector organisations. In March 2015, the UK Government announced seven new SIB investment schemes that aim to support social entrepreneurs and help to reform public services (Smith 2015).

In France, every employee is given the choice of including impact investments in their pension savings through 'fonds d'investissement solidaires dits 90/10'. Assets under management in social investment have grown from €478 million to €3.7 billion in 2014.

It may be worthwhile considering what Australian regulatory and taxation arrangements may be needed to support the movement of capital into the primary care sector to support SIB investment.

Outer limits of impact financing

Performance monitoring is a core concern to central government agencies and treasuries internationally, not just in the health arena. Increasingly governance of public expenditure is performed through specialised monitoring agencies. In Australia the COAG Reform Council had an explicit role to evaluate State-Federal funding agreements until its closure in 2014. A number of Commonwealth government agencies continue to monitor and report on various aspects of health system performance.

The new terrain for public financing lies in the degree to which outcomes monitoring can be linked explicitly and transparently to financing. SIBs are one tool through which this can be achieved. The limitations of outcome monitoring in preventive and primary care are similar to the constraints on outcome monitoring in other service domains. For example, outcomes in education are not solely related to the performance of teachers, schools or even school regions. Outcomes in defence are not solely related to the capacity of weapons systems. We live in complex worlds with multi-causal relationships. Increasingly, treasuries are

coming to terms with the risk associated with multi-level interventions in complex multi-causal social environments.

One issue with the application of SIBs in preventive and primary health care is the issue of causality and the temporal lag between activity and outcomes. Two options emerge. The first is to selectively target SIB financing only to those programs where causal relations can be asserted (for example, among captive and dependent populations) and SIBs are used only in specific circumstances. The second option is to explicitly apply SIBs at a meso-level of health governance, such as at a catchment/regional level where the idiosyncrasies of health and wellbeing needs can be serviced locally and yet the catchment is large enough such that outcomes can be measured at a population level. Recent experiences of regional health coalitions in the US (such as Camden and South Central Philadelphia) suggest that regional level organisations are amenable to SIB investment. The most important criterion for this kind of investment is that outcome measures are robust. It seems that this criterion has been satisfied for these most recent SIB offerings in multi-causal settings.

With such an explicit focus on outcome monitoring, other financial products and tools can be rolled out and deployed into other market settings. Investment in performance is a familiar terrain in financial markets. If the measurement of performance is routine, reliable and low risk, investments can be amenable to a range of products.

One example of how bond issuance can open up new market opportunities in health is through the International Finance Facility for Immunisation (IFFIm) (IFFIm 2015). Many countries pledged money to raise money in capital markets through bond issuance. This innovative financial mechanism has provided US\$4 billion in disbursements between 2006 and 2015 to stabilise funding for immunisation programs that service more than 500 million children worldwide.

If performance can be indexed in a robust, auditable manner, Burand (2014) suggests that a direct return on investment may be only one way in which investors could be rewarded. He proposes secondary products of performance-based debt buy-downs that integrate private sector investors into performance-based debt and social impact performance guarantees ("SIP Guarantees").

The Social Impact Investment Taskforce (2014) asserts that SIBs and other related products can be used to enhance a diversified mainstream asset portfolio. Impact investments can exist across a range of asset classes: impact equities, impact fixed income and impact alternative investments.

Likewise Private Ancillary Funds (PAFs) have emerged as possible tools through which funds managers can engage in impact investing. There are over 1200 PAFs valued at around \$4 billion in Australia (McLeod 2015). PAFs are managed through mainstream personal wealth management bodies, and were included in recent social benefit bond issues in NSW (McLeod 2015).

Discussion

There is a need to move policy discussion beyond approaches to payment of providers to the broader financing of primary care in Australia. If primary health is a merit good, then government has a role to steward the environment for the provision of the merit good. So long as equity and access to primary health care are guaranteed, there may be no need for a one-size-fits-all financing system.

The management of financial risk by smaller providers (whether they be community or privately owned) continues to be a challenge and there is an increasing move to corporatise the sector into a smaller number of larger providers. There is a strong argument to support primary care financing, to enhance administrative efficiencies, to reduce transaction costs, to reduce confusion and eliminate duplication of effort.

The current system is dominated by private providers, with the majority of activity-based funding coming from the Commonwealth Government, which is well placed to deliver a financing system that goes beyond payment strategies. Consistent with the role of government to adjust the tastes of its citizenry, the Commonwealth Government may choose to design a system of financing that is not a one-size fits all system, but a system founded on principles of equity, a focus on quality outcomes, transparency and financial subsidiarity.

These principles will enable a new system of health financing for primary care and prevention to emerge. It is a far cry from a universal pay-for-service system, and demand-reduction strategies using centrally-managed price signals. Instead the focus will be on empowering service providers at regional and catchment levels to share services and facilitate outcome-based funding strategies.

There is interest to develop payment approaches from the current activity-based funding models to ones that prioritise quality and outcomes that assist in the management of risk. The combination of capitation, quality outcomes frameworks and asset/risk management may be attractive to a wide range of providers.

Subsidiarity is an important principle. Sometimes decisions about health service planning are best done at a local or regional level. An outcomes focus for financing primary health care may well work best when outcomes are aggregated at a precinct or regional level rather than at the level of the provider. The development of SIB funding models in CCGs in the United Kingdom is an indication of the capacity for local level governance to mobilise capital for local needs.

SIBs have to date been used to simply leverage cash to improve patient outcomes at a program level. The model discussed here suggests that SIBs could be used at a scale to improve population health outcomes, however a deeper structural change would also need to occur in primary health care governance. In the UK, the formation of CCGs has facilitated the rolling out of SIBs.

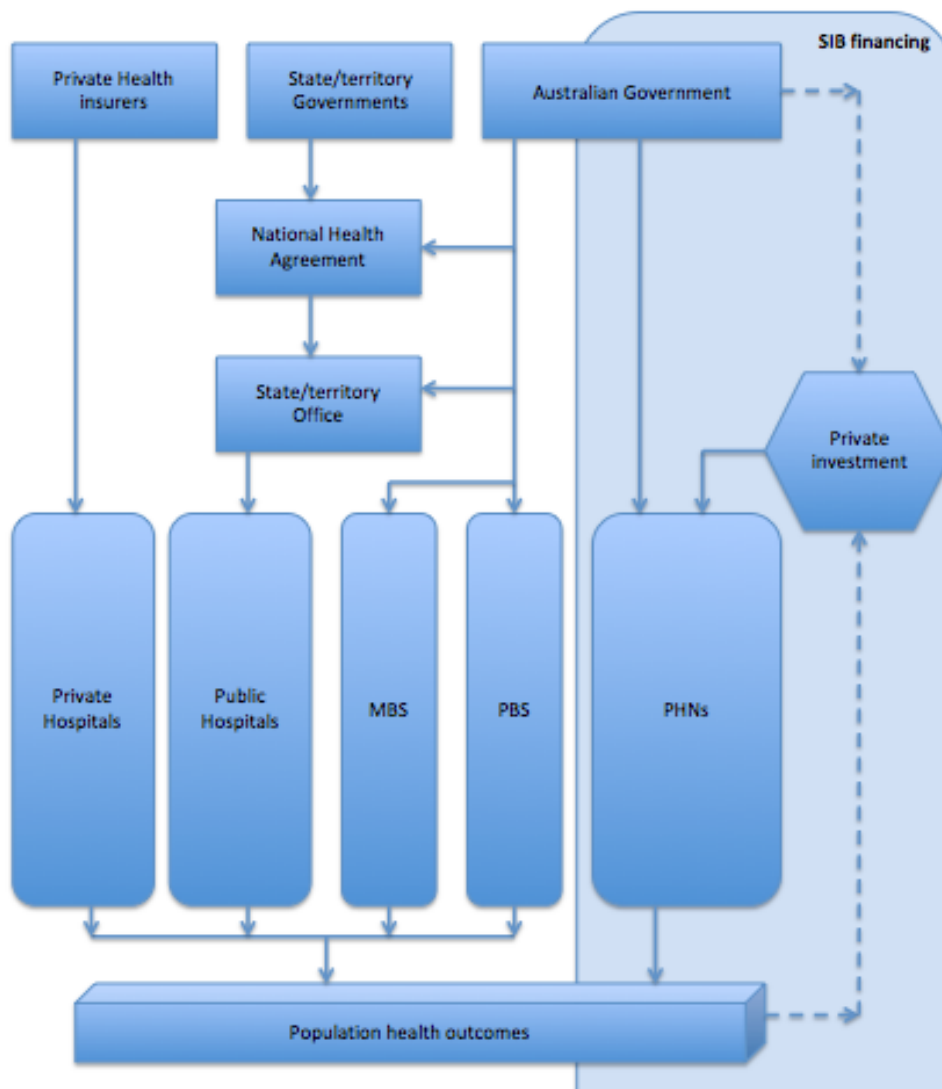
A financing model for impact investing in primary care

The meso-level of primary health care governance in Australia needs to go beyond the “light touch” advisory roles it has had in the past (see Figure 5 on the following page). It is suggested here that in order to be amenable to SIB funding opportunities, meso-level governance of primary health care needs to be more heavily involved in the business of primary care providers. One way to do this is to substantially reduce the financial risk for primary health care providers by offering robust and substantial reductions in their financial liabilities through shared services models. This will relieve service duplication at the level of the provider, reduce financial risk and allow GPs to engage with their patients in flexible ways that are focused on outcomes.

It is also possible that by reducing the financial risks to GPs, the tide of corporatisation of primary health care that has been creeping through the sector may be stemmed. Locating planning, purchasing and shared services (such as record management, pooled staff management, e-record management) in primary care service areas or catchment organisations will facilitate and support local providers. Expanding and enhancing the role and accountability of meso-level primary care services area organisations that directly resource providers with a core set of corporate services may well provide a robust framework amenable to impact investments. Rather than previous attempts to use meso-level governance to advise and support, there is an opportunity to design these organisations to provide local services to providers and be a vehicle for SIB or other forms of impact investment. These changes are already happening in the UK. Whilst Australia will need to come up with its own solutions, we also need to learn from changes that are occurring in other parts of the world.

Perhaps a better approach to financing primary care is to focus on financial risk management rather than on payment methods. Consultation with a range of stakeholders and primary care providers should open up this line of discussion. Of particular interest will be the extent to which providers are interested in alternative financing focused on asset and risk management, shared services, pooled staff management, regionalised purchasing, provider training and service planning. The centralisation of these core services and operating liabilities into a regionalised entity will radically alter the work and risk profile of primary care services. This may well provide a new ground upon which to debate the mix of payment approaches that are used to best meet population health needs at a local level.

Figure 5: A Financing option for primary health in Australia.



Impact investing in primary and preventive health care will only develop if there is confidence in the robustness of outcomes measurement and stability in the primary care service sector. Moving the focus of impact investing to precinct-level service provision rather than program or disease-specific interventions should enhance the robustness of measures, improve transparency and make health more amenable to impact investing.

Table 2: SIB interventions in the United States

| State | Year | Status | Program | Arena |
|---------------|------|----------------------|---|-------------------|
| Arizona: | 2014 | In development | Pima County: social programs | Social |
| California: | 2013 | Current | Fresno: asthma management program for children | Preventive health |
| | 2013 | In development | Santa Barbara: recidivism | Crime |
| | 2014 | In development | Santa Barbara: homelessness, mental illness | Social health |
| | 2014 | In development (RFI) | Non-profit Finance Fund and The James Irvine Foundation: Social Innovation Financing Program (AB 1837) | Legislation |
| Colorado | 2013 | In development (RFI) | Denver: Harvard Kennedy School SIB Technical Assistance Lab : housing and case management to chronically homeless | Social health |
| | 2014 | | Denver: mental health and substance abuse issues | Mental health |
| Connecticut: | 2013 | In development (RFP) | Harvard SIB Lab: children with substance abusing parents | Social health |
| | 2014 | Current | An Act Concerning Social Innovation Investment (SB105) | Legislation |
| Hawaii | 2013 | Feasibility | Early learning programs and services | Education |
| Illinois | 2014 | In development | Harvard SIB Lab: at-risk youth involved in both the child welfare and juvenile justice systems | Social health |
| Maryland | 2013 | RFP Terminated | House Bill 517 in house of delegates (pre-K to 12 public education) | Legislation |
| Massachusetts | 2014 | Current | MA Juvenile Justice Pay for Success Initiative: justice-involved youth | Crime |
| | 2014 | In development (RFP) | Adult basic education (ABE) | Education |
| Michigan | 2013 | In development | | |

| State | Year | Status | Program | Arena |
|----------------|------|---------------------------|---|----------------|
| Nebraska | 2013 | | Legislation (LR 279) calling for an interim study on SIB for juveniles and adults re-entering the community | Crime |
| Nevada | 2014 | RFI to gather information | SIBs for early childhood education | Education |
| New Jersey | 2014 | In development | New Jersey Social Innovation Act: prevention and early intervention health care for low-income and uninsured people, | Primary care |
| New York State | 2012 | Current | first US jurisdiction to launch a SIB to reduce recidivism among young men | Crime |
| | 2014 | Current | Nurse-Family Partnership | Primary care |
| | 2014 | Current | Montefiore Medical Centre/Children's Aid Society | Social health |
| | 2014 | Current | Hillside Children's Cent | Social health |
| | 2014 | Current | Primary Care Development Corporation | Primary care |
| Ohio | 2014 | In development (RFP) | Cuyahoga County: homeless mothers with children in foster care | Social health |
| Oklahoma | 2014 | In development | Legislation Senate Bill 1278: criminal justice outcomes | Crime |
| Oregon | 2013 | Current | Early Learning Division: Pilot Prevention Health and Wellness Demonstration Project | Primary health |
| Pennsylvania | 2014 | In development (RFP) | Philadelphia: feasibility study to explore PFS to reduce recidivism and support at-risk youth. | Crime |
| Rhode Island | 2014 | In development | Senate Bill 2196: to establish a five-year SIB pilot program | Crime |
| South Carolina | 2013 | In development | Nurse-Family Partnership National Service Office, 4,000 mothers to improve birth, health, and self-sufficiency outcomes | Social health |
| Texas | 2013 | legislation | Senate Bill 1788: child abuse prevention programs | Crime |

| State | Year | Status | Program | Arena |
|----------------|------|----------------------|---|-----------|
| Utah | 2014 | Current | Utah School Readiness Initiative early childhood education outcomes | Education |
| Vermont | 2012 | Pilot in development | General SIB application H 625:proposed to establish a committee to study SIBs | General |
| Washington | 2014 | Pilot in development | Substitute House Bill 2337: Washington Social Investment Steering Committee | General |
| Washington, DC | 2014 | In development (RFP) | Pilot: Reducing teen pregnancy and increasing educational attainment for high school-aged youth | Education |

(Source: [Social Finance US 2015](#))

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