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## Measuring and rewarding performance in primary health care

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Australia is grappling with the next steps in measuring and rewarding performance in primary health care. In New Zealand and the UK this is a 'hot topic'.

At the New Zealand Independent Practitioner Association Council (IPAC) conference held in Auckland this month, delegates from New Zealand, the United Kingdom and Australia gathered to discuss developments in performance assessment in the three countries. Performance was approached from two perspectives – the performance of individual providers as they interact with their patients, and the performance of the system as it interacts with populations.

Performance at a patient-provider level is about ensuring patients can trust their health care providers to provide safe and effective care. Performance at the population level is about ensuring the system is accessible and fair and achieving population outcomes that are value for taxpayers' money. These can be seen as the 'book-ends' of a good health care system and are of legitimate interest to consumers, providers and funders alike. While there is clearly some overlap between them, they are in some important respects quite different and even have the potential to be counter-effective. For example, target-based systems for populations may detract from the quality of individual patient care.

A key question for any system is how to reward performance.

### Performance at Patient-Provider Level

High profile cases of patient endangerment and death caused by doctors in hospital and community settings in the three countries have highlighted patient safety issues. While recognising these failures were ultimately system failures, doctor competence is still an issue. The primary mechanisms for achieving this were seen as training, credentialing and perhaps more controversially, lifelong re-credentialing[1], and clinical governance. Incident reporting and complaints mechanisms are also important quality assurance mechanisms. It is acknowledged that professional self-regulation is no longer acceptable.

There has been some recent research on errors in general practice[2] but there is no system-wide adverse incident monitoring in Australian primary health care. On the other hand, each state and territory does have formal health care complaints mechanisms.

### System Performance

In the past few years Australia, New Zealand and the United Kingdom have introduced mechanisms for monitoring primary health care system performance. Key elements of the three systems are summarised in the table on the following page. The number of performance indicators varies hugely, but all include a mix of process and outcome indicators. All three countries have targets for the quantitative indicators, though in Australia these have yet to be set.

Though the evidence for the effectiveness of pay-for-performance is weak and seems to have as many risks as benefits [3], both England and New Zealand have taken this approach. With the payments in New Zealand going to Primary Health Organisations and in England to general practices. While the financial incentives in New Zealand are modest, in the UK a significant proportion of practice income is now derived from Quality and Outcomes Framework payments. These have far exceeded government expectations, highlighting the dangers of setting targets without good baseline information. The rationale for paying for performance in the two countries also varies. In England it is to quickly accelerate quality improvement in population health care, while in New Zealand it is intended to bring about gradual, incremental change within a philosophy of Continuous Quality Improvement[3].

Publication of comparative data is a performance incentive widely used. However, it is not always clear who the audience is and the data may have limited impact on quality over the longer term. Shaming and punitive systems tend not to achieve the desired ends and have negative, unintended consequences including gaming and misrepresentation[4].

Key elements of the primary health care performance monitoring systems in Australia, New Zealand and the UK

| | *System* | *Contracted entities* | *Data sources* | *Number of Indicators#* | *Targets* | *Recognition of Performance* |
|---|---|---|---|---|---|---|
| Australia | National Quality and Peformance System (NQPS) | Divisions of General Practice | Divisions and general practices | 52 | Planned | Still being developed |
| New Zealand | PHO Performance Management Programme | Primary Health Organisations (PHOs) | National collections (general practices in next wave of indicators) | 13 | Yes | $$ |
| United Kingdom | Quality and Outcomes Framework (QOF) | General practices | General practices | 146 | Yes | $$ |

*#Australia (accessed 15 October, 2006)*
*http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pcd-programs-divisions-rictoolkit.htm*
*New Zealand (accessed 15 October, 2006)*
*http://www.moh.govt.nz/moh.nsf/0/99A0368DE5E5D948CC256F50000FFC49/$File/PHOperfmagmtsummaryinfo.pdf*
*United Kingdom (accessed 15 October, 2006)*
*http://www.dh.gov.uk/assetRoot/04/07/86/59/04078659.pdf*

In Australia, the mechanisms for rewarding Division performance are still being developed. However, it is unlikely the Australian Government will adopt a pay-for-performance approach. Other ways of recognising performance have been considered, including 'earned autonomy' and competitive access to additional funds.

What difference will performance monitoring make? Carefully planned and implemented system monitoring unquestionably results in improved information systems and a richer information base for primary health care policy and planning. It can reduce variation in practice and reveal inequalities within and between populations. Aspects of quality that are essentially population focused, such as wating times, can be dramtically improved - in the UK, access targets have transformed waiting times (a government objective). It is too early to say though, what impact it will have on chronic disease prevalence and outcomes. Experience in the UK suggests that in terms of the content of encounters between patients and providers system performance monitoring might have little observable effect[5]. This is where the mechanisms identified above — training, credentialing, clinical governance, incident monitoring and complaints systems - come into their own.

## References


*1. Donald Irvine. Performance: Challenges for the Health Sector; Challenges for the Medical Professions. Paper presented to the IPAC Conference, Auckland, October 6-8, 2006.*
*2. Meredith A B Makeham, Michael R Kidd, Deborah C Saltman, Michael Mira, Charles Bridges-Webb, Chris Cooper and Simone Stromer. The Threats to Australian Patient Safety (TAPS) study: incidence of reported errors in general practice. MJA 2006; 185 (2): 95-98.*
*3. Stephen Beutow S. Pay for Performance. Paper presented to the IPAC Conference, Auckland, October 6-8, 2006.*
*4 Tim Freeman. Using performance indicators to improve health care quality in the public sector: a review of the literature. Health Services Management Research 2002; 15: 126-137.*
*5. Judith Smith. Performance: A Policy Perspective. Paper presented to the IPAC Conference, Auckland, October 6-8, 2006.*


## An Eye on the Media - APHCRI comment

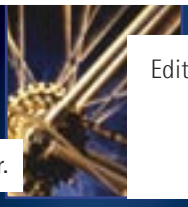
Patient safety – or the lack of it – is portrayed in the media as a series of often avoidable tragedies – Queensland's Jayant Patel, given the moniker 'Dr Death', the avoidable death of a young NSW girl from meningitis and the shortage of medical staff and the affects on patient care.

Almost all of it is focussed on hospitals - the errors are more visible, the statistics are easy to collect and patients and avoidable deaths often prompt relatives to speak to the media about hospital errors as they are more obvious.

In primary care there is virtually no data and unless General Practitioners are procedural their errors and near misses are much more easily hidden, less obvious to patients and their families, and attract little media attention. Of about 30 news stories in the past three months under a 'patient safety' search only two can be directly related to primary health care. One reports the call of an overseas patient safety expert to: "Drug Test Our Docs" (Herald Sun, 23 August 2006), another followed up research suggesting rural doctors need to take at least a day off work "Doctors' day off is good medicine" (Northern Daily Leader 24 October 2006).

It is difficult for media to access data on errors in primary care because there is little data available or sought. It was this failure to engage successfully with primary care that was a criticism of the Australian Council of Safety and Quality, which has now been remodelled.

Until there is open reporting of primary care errors, patients will remain in the dark about the standard of primary care they receive.

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