# *Paying for performance in primary healthcare*

Professor Des Gorman MD PhD

# *Health care in New Zealand in 2013*

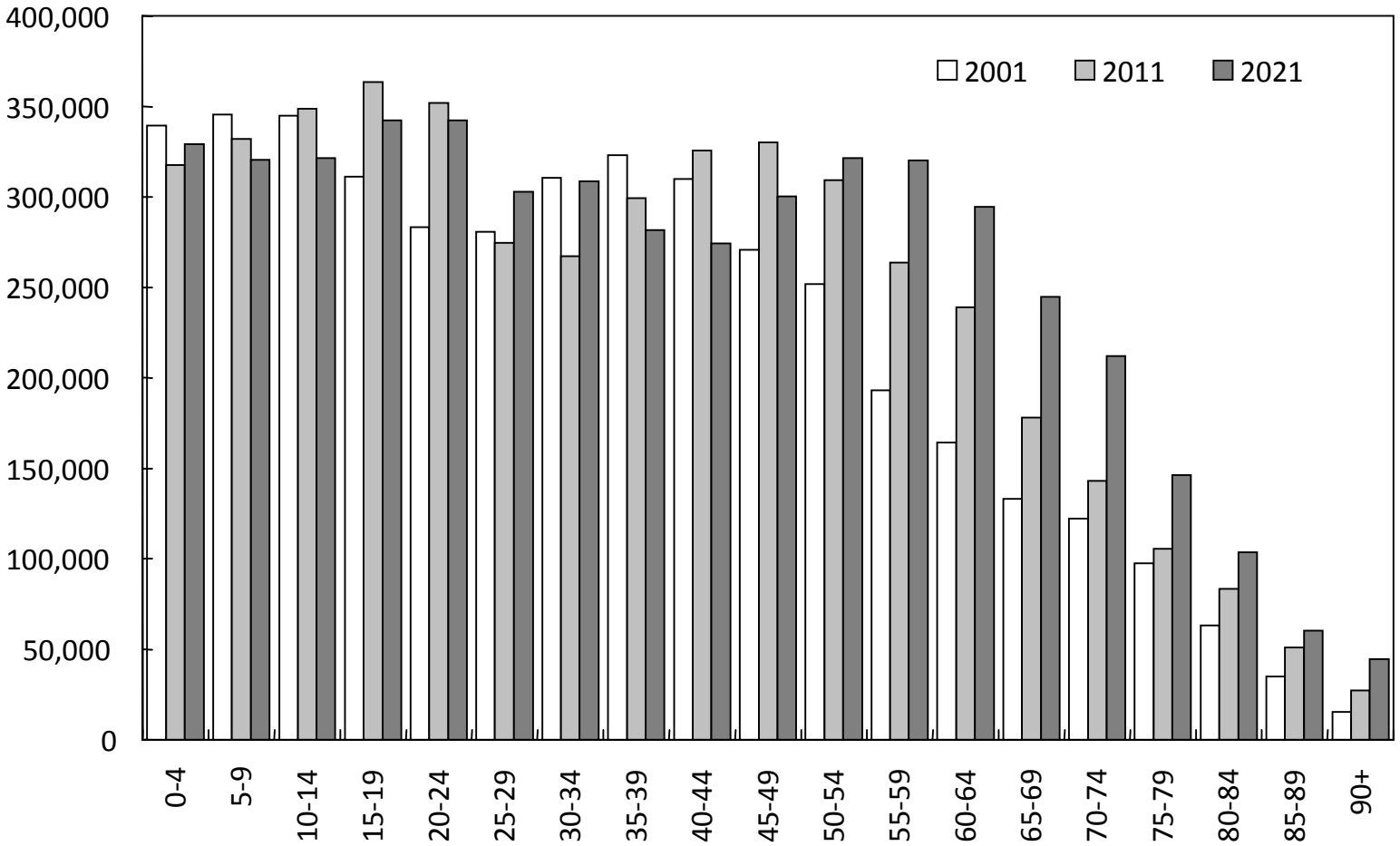
- Most New Zealanders with a health problem receive appropriate and timely care, and most outcomes meet **societal expectations**.
- But, …..

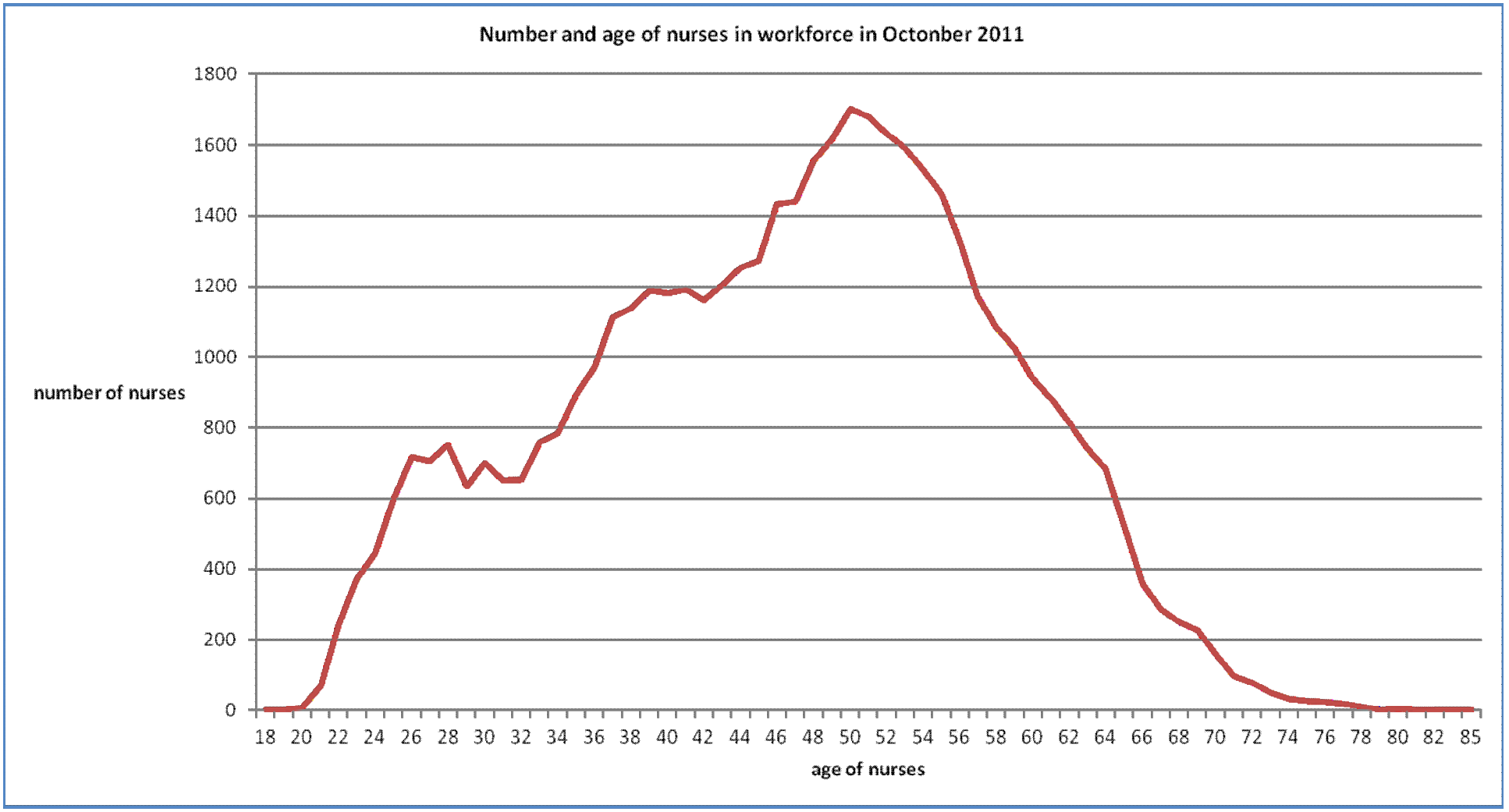
# *A demand, supply, and affordability mismatch for future health care*

There is a significant mismatch with respect to future healthcare demand, supply and affordability. In large part, this is a consequence of an ageing community and a healthcare system that has evolved to address acute communicable disease. However, part of the mismatch arises because of a failure of clinician leadership and poor community health literacy.

# NZIER (2005)

## NZ Population Projections by Age Cohort
## (Assuming medium population growth)




Number and age of nurses in workforce in Octonber 2011
number of nurses
1800
1600
1400
1200
1000
800
600
400
200
0
18 20 22 24 26 28 30 32 34 36 38 40 42 44 46 48 50 52 54 56 58 60 62 64 66 68 70 72 74 76 78 80 82 85
age of nurses

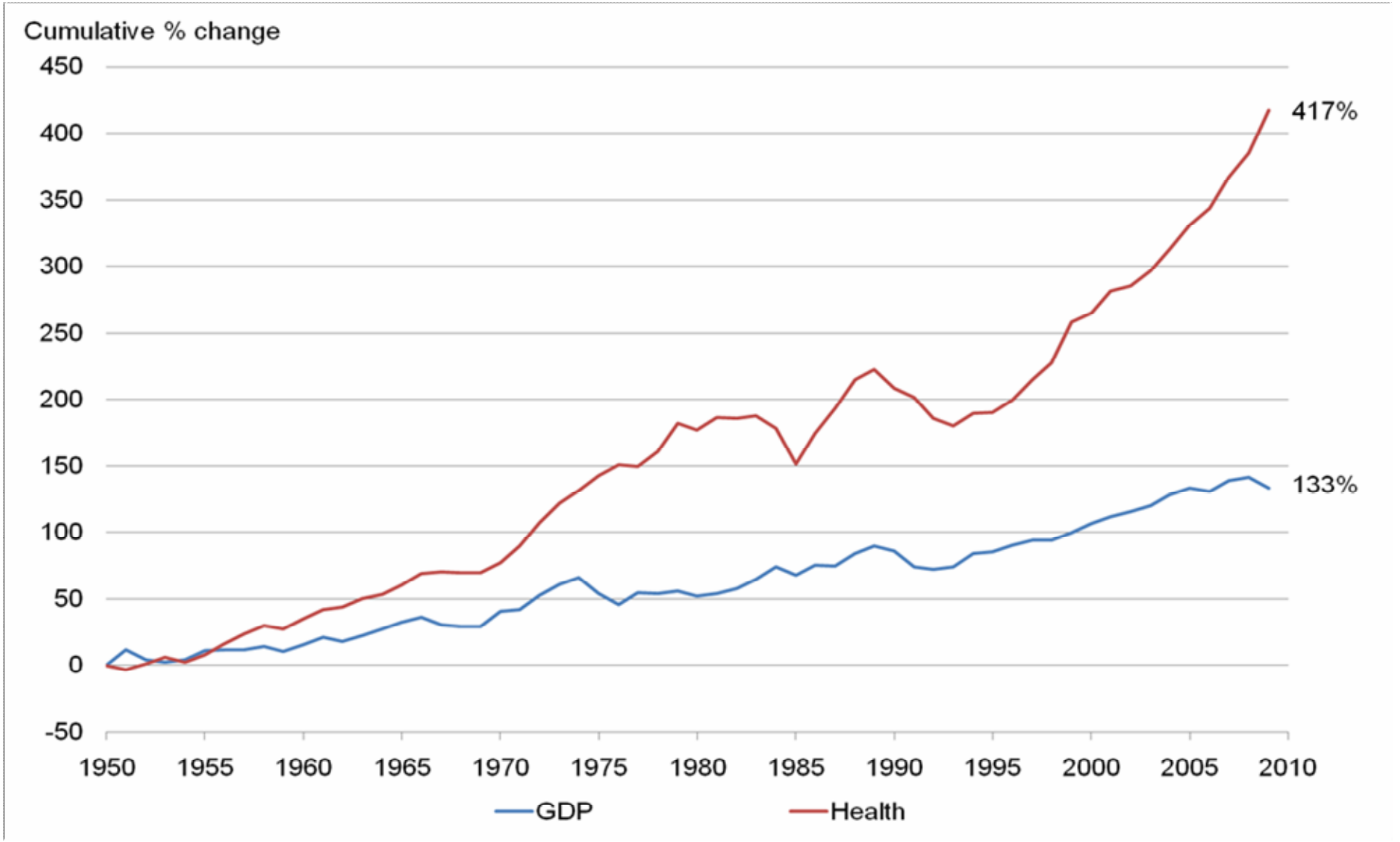
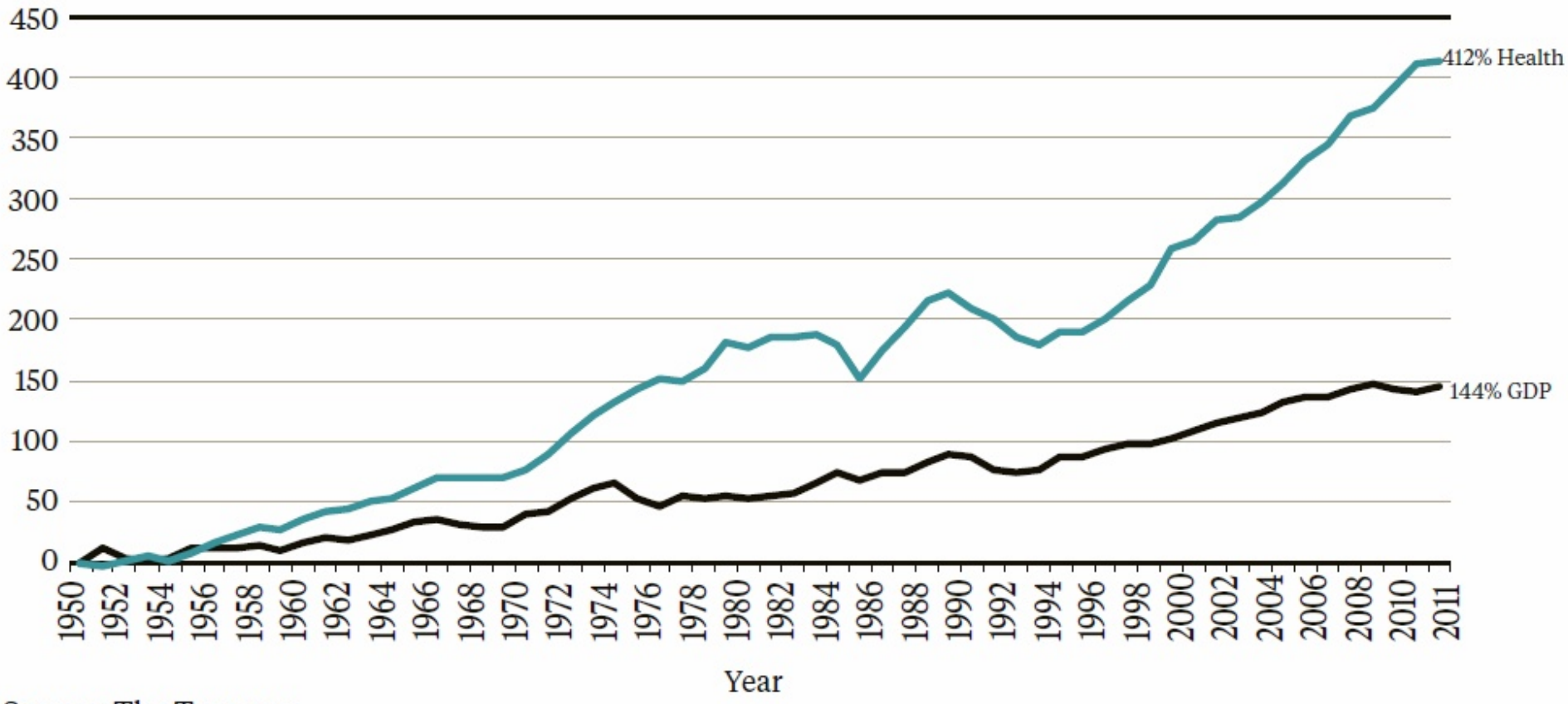
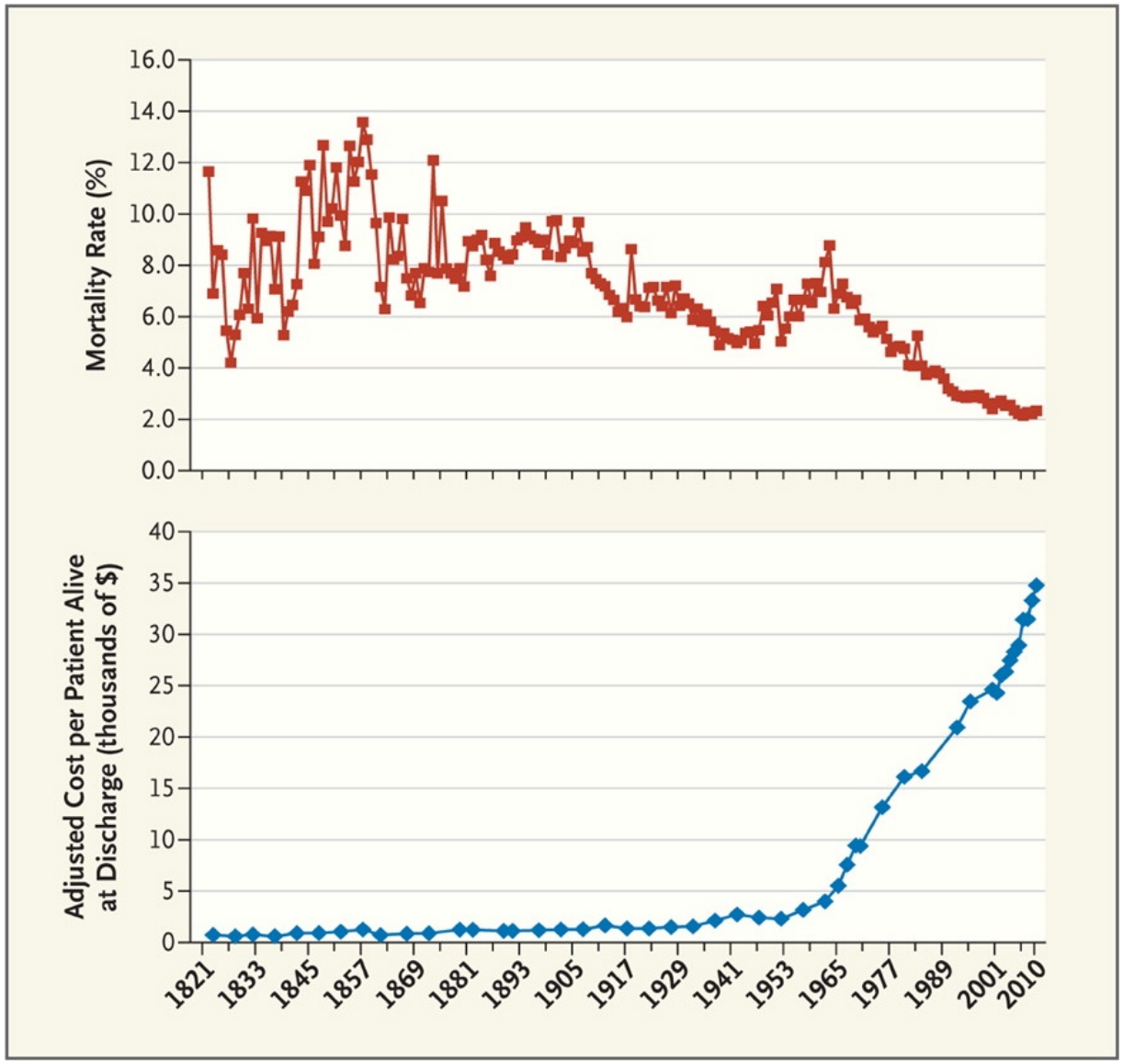

Cumulative % change
450
400
350
300
250
200
150
100
50
0
-50
1950
1955
1960
1965
1970
1975
1980
1985
1990
1995
2000
2005
2010
417%
133%
GDP
Health

**Figure 2: Health spending and GDP per person, inflation-adjusted**




Source: The Treasury

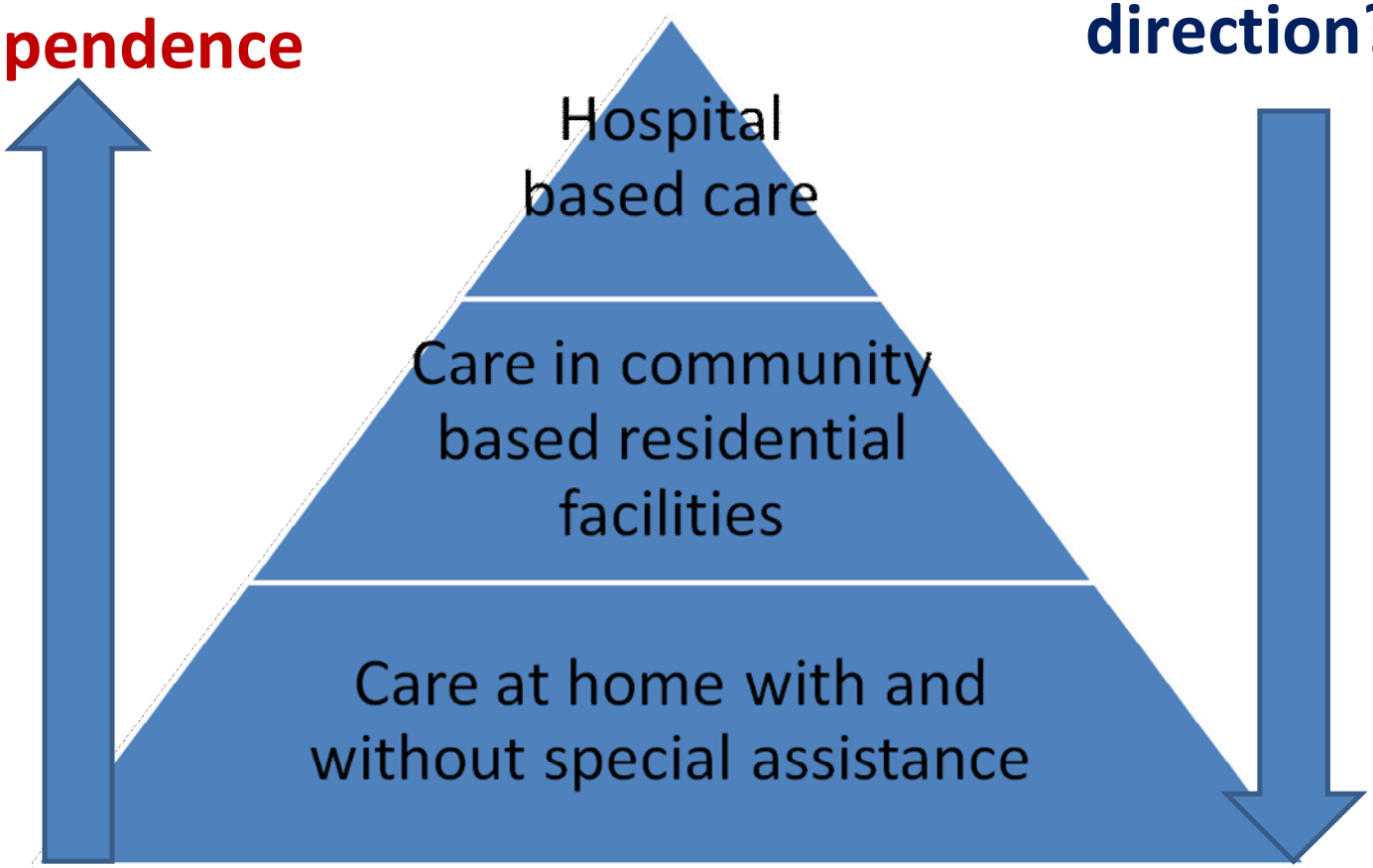

Mortality Rate (%)
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Adjusted Cost per Patient Alive at Discharge (thousands of $)
40
35
30
25
20
15
10
5
0
1821
1833
1845
1857
1869
1881
1893
1905
1917
1929
1941
1953
1965
1977
1989
2001
2010

# *A demand, supply, and affordability mismatch for future health care*

- The comparative benefit of lifting health worker productivity versus that of lifting community productivity by way of better health maintenance and more appropriate help-seeking behaviours.
- Engaging clinicians in appropriate leadership roles.
- Shifting from provider-centric to genuinely patient-centric care.

**Increased cost and reduced independence**

**What is necessary to shift care in this direction?**



# *Towards a sustainable and fit-for-purpose health system*

- A shared care record to underpin integrated care.
- A new way of funding services and of rewarding providers and consumers.
- A diversified and fit for purpose community based health workforce that works as much as is possible at the “top end of their licence.”
- Genuine patient-directed and centred care.

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**Figure 6: Average hours worked per week by work role at main work site**

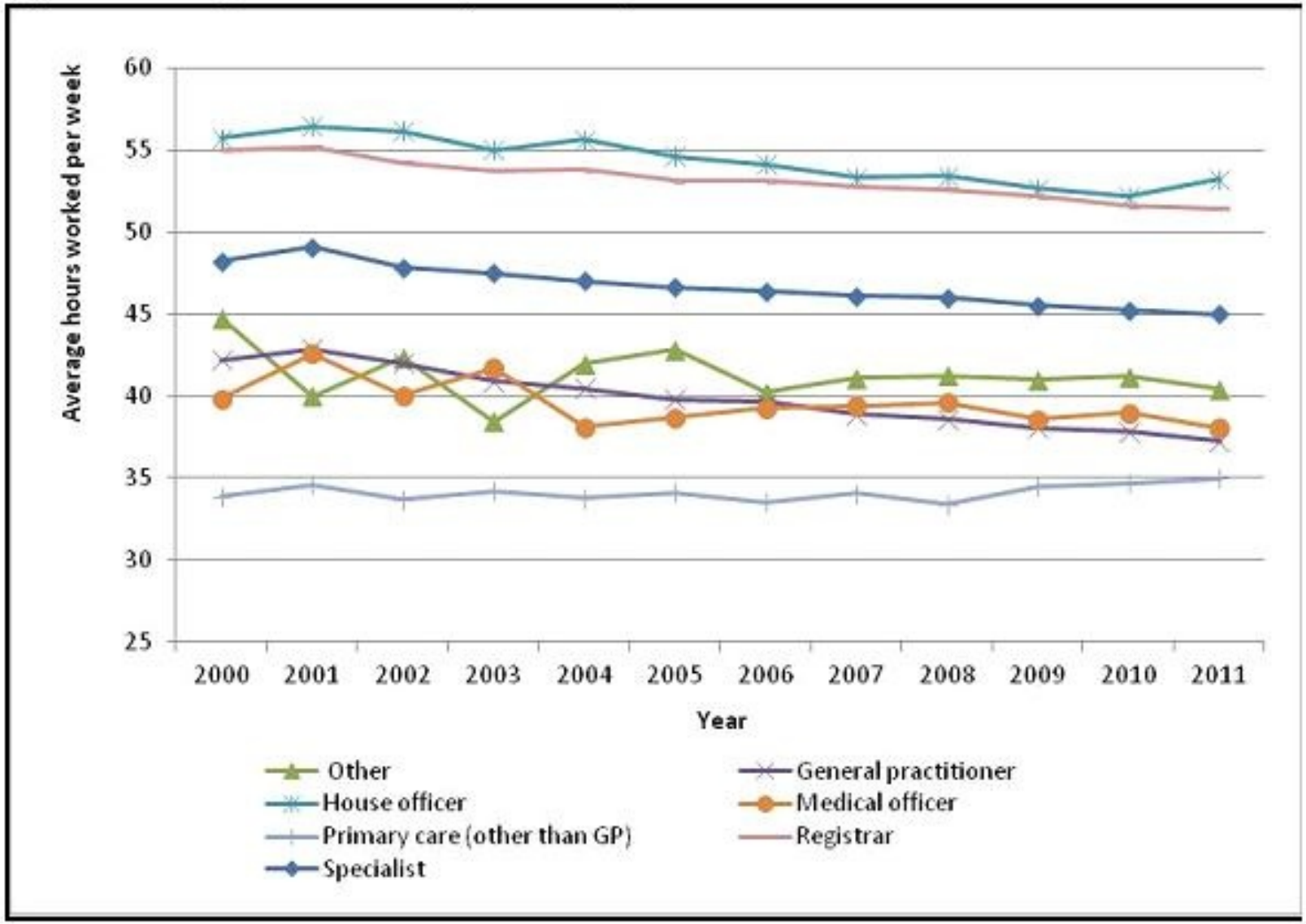
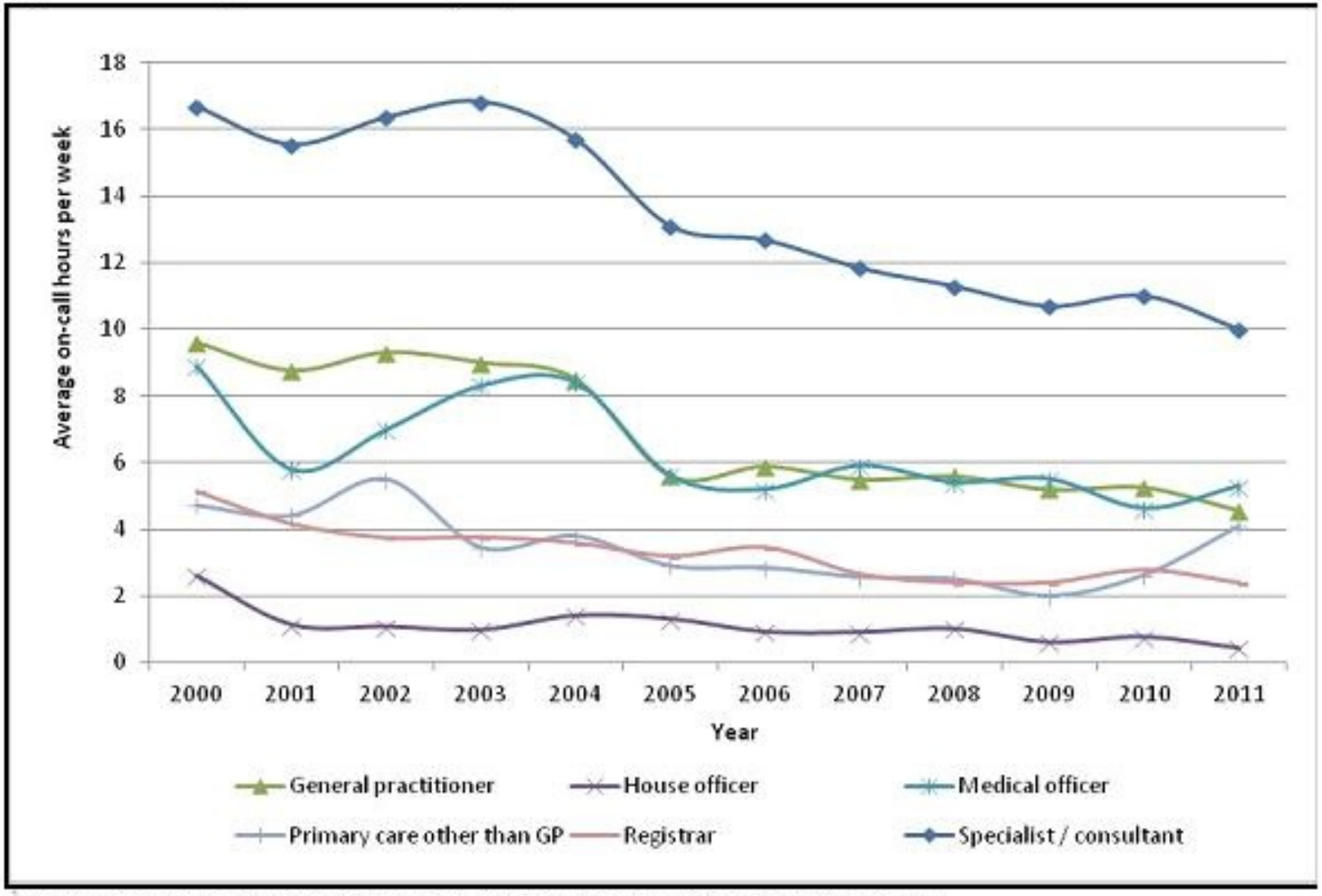
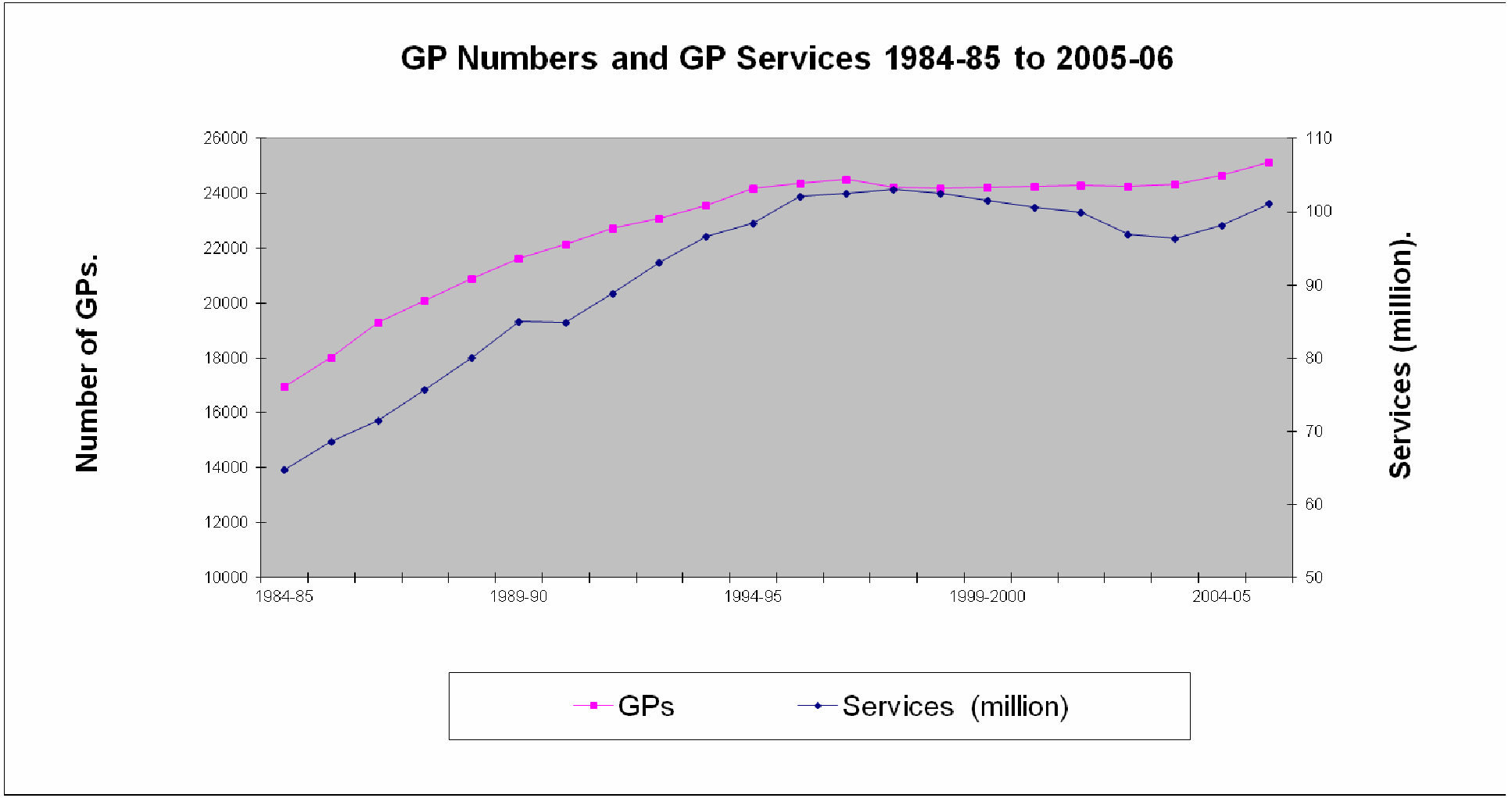


**Figure 8: Average on-call[1] hours, by work role at main work site**




[1] On-call hours are defined as hours when the doctor was on call, but not actually working.

# Relationship between GP numbers and services in the Australian fee-for-service health system



**Campbell SM. Effects of pay for performance on the quality of primary care in England. NEJM 2009; 361: 368-78**

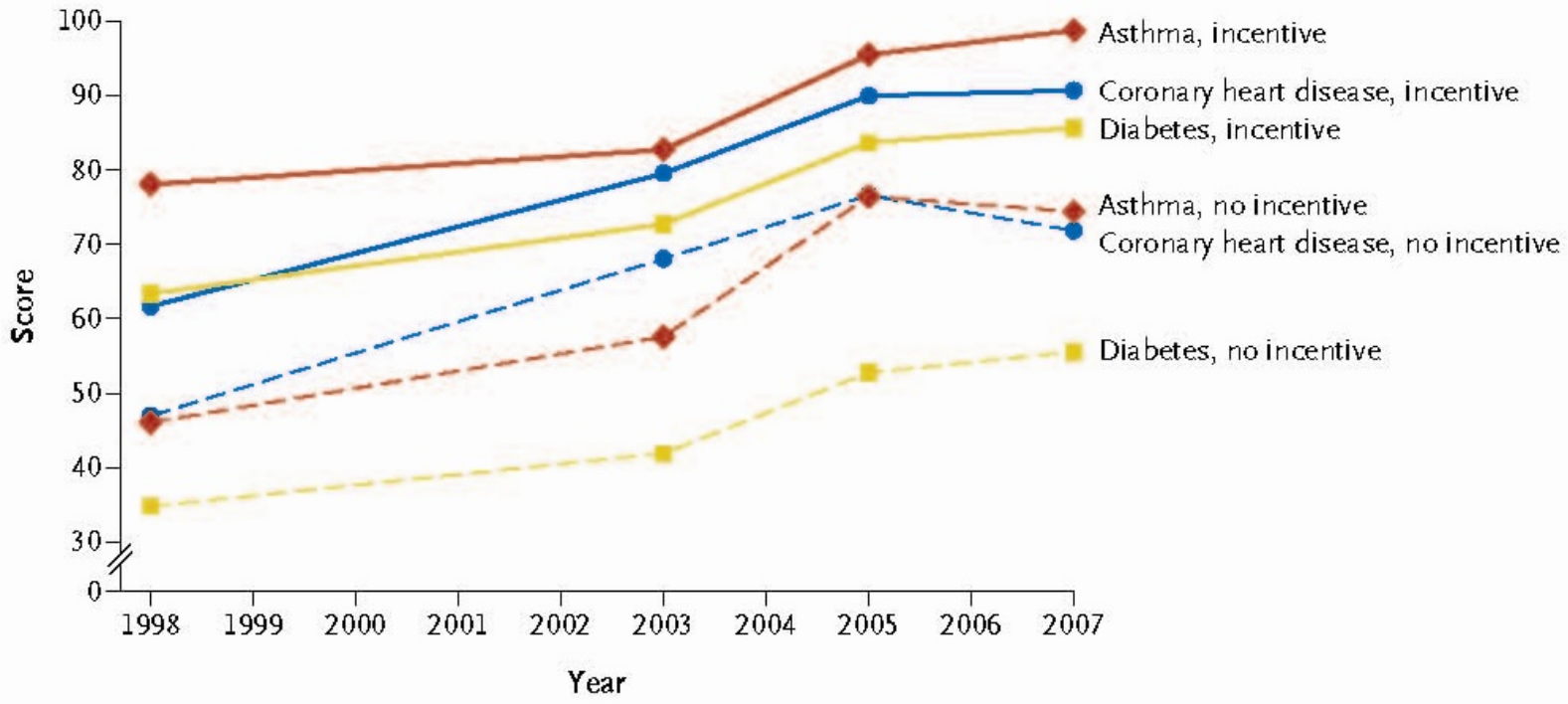
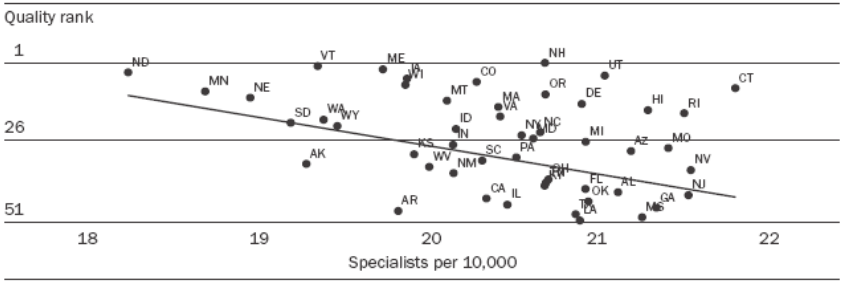



**Figure 2. Mean Scores for Clinical Quality at the Practice Level for Aspects of Care for Coronary Heart Disease, Asthma, and Type 2 Diabetes That Were Linked with Incentives and Aspects of Care That Were Not Linked with Incentives, 1998–2007.**

Quality scores range from 0% (no quality indicator was met for any patient) to 100% (all quality indicators were met for all patients).

# *The dual case for general scopes of practice*

**EXHIBIT 6**
**Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

**EXHIBIT 8**
**Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000**

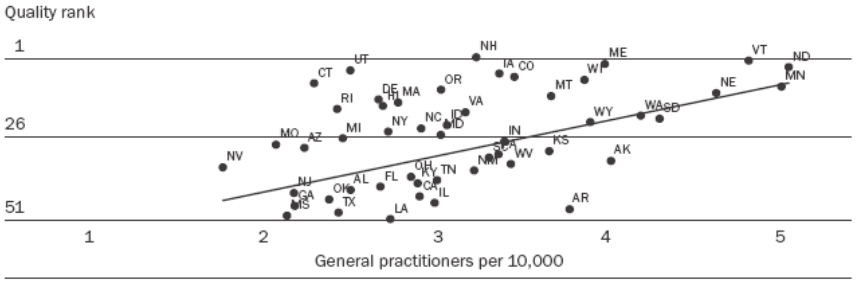



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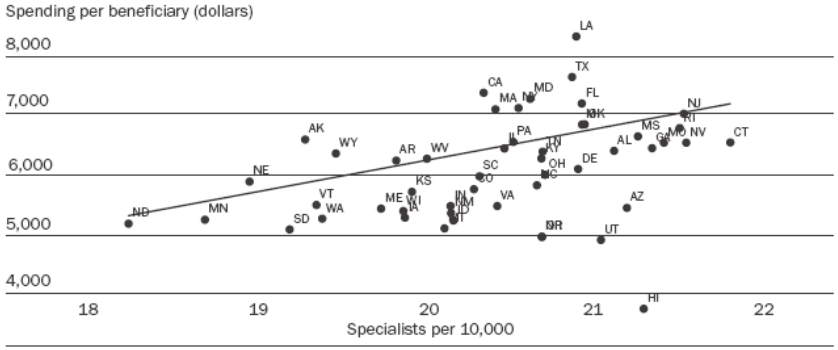
**EXHIBIT 7**
**Relationship Between Provider Workforce And Medicare Spending: Specialists Per 10,000 And Spending Per Beneficiary In 2000**

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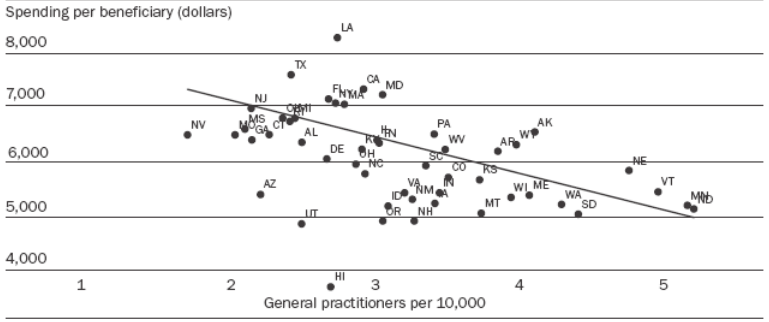


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**NOTE:** Total physicians held constant.

# *Paying for performance in primary healthcare*

- A review of both European and North American experience in paying healthcare providers for performance, in any form of healthcare, shows little evidence of better health outcomes or reduced costs to the health systems.
- But, there are lessons, which can be derived from this experience and that are applicable in New Zealand primary healthcare.

# *Eleven lessons from the UK QOF experience*

- Do not reward people for what they are doing anyway.
- Involve clinicians in system design and in road testing.
- Be clear about objectives and desirable changes.
- Create a scheme that can evolve.
- Avoid large bureaucracies and over-engineering.

# *Eleven lessons from the UK QOF experience*

- Publish (accurate and clinically-owned) comparative (benchmarking) data.
- Do not rely on remuneration alone to improve performance.
- Be careful in linking quality improvement activity and rewards, to avoid gaming and unexpected perverse outcomes.
- Invest in leadership.

# *An investment in leadership*

- What are needed are middle managers and clinician leaders who can set and measure performance goals, and can use available improvement tools.

# *Eleven lessons from the UK QOF experience*

- Employ a national reward network, but ensure system flexibility for local applications.
- Incentivise role and task substitution.

# *Ten (behavioural economics) lessons from the US experience*

- Use a series of incentives rather than a single ‘mega’-incentive.
- Use a series of tiered thresholds rather than one absolute threshold.
- Minimise the time between the care episode being incentivised and the receipt of the reward.
- Use withholding measures as these are more effective than bonuses.

# *Ten (behavioural economics) lessons from the US experience*

- Keep incentive schemes simple - many health care providers are risk adverse.
- Use shared-savings or shared-risk programs.
- Separate rewards for performance from usual reimbursement.
- Used in-kind rewards rather than cash.
- Pay enough or don’t pay at all.
- Use a broad dashboard of measures.

# *Paying for performance in primary health care – conclusions*

Paying for performance in primary healthcare in New Zealand must involve a hybrid, organic and blended reward system.

# *Paying for performance in primary health care – conclusions*

Where possible, the reward systems employed in primary healthcare in New Zealand should be ‘tight’ about the quality of outcome expected and equally ‘tight’ about how these outcomes are measured, and reasonably ‘loose’ about the processes employed to achieve these outcomes (e.g. incentivised capitations for maternity services and diabetes).