AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

# Performance Assessment in Primary Health Care

Summary of Background Information, Views and Debate at an APHCRI Forum
Canberra, July 4-5, 2005

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## Preamble

In 2005 the Department of Health and Ageing introduced the first set of National Performance Indicators (NPIs) for the Divisions of General Practice program. Similar developments are underway for Primary Health Organisations (PHOs) in New Zealand. These follow the introduction in the United Kingdom of 147 indicators in the Quality and Outcomes Framework for general practice.

The introduction of performance indicators in general practice and primary health care more broadly, raises many issues relating to the underlying theory and scientific rigour, the policy setting, and a range of complex issues to do with implementation.

In July, 2005 the Australian Primary Health Care Research Institute (APHCRI) hosted a small, trans-Tasman, invitation-only forum on performance assessment in primary health care (PHC). Participants from Australia were from Divisions of General Practice, the Australian Government Department of Health and Ageing, a state health department, a consumer group, medical practitioner representative bodies and academia; and from New Zealand were from the Ministry of Health, District Health Boards and academia. Special guest was Mr John O'Brien, Director of Health Policy at the Center for Health Program Development and Management (CHPDM) at the University of Maryland.

The aims of the forum were to:

1) To compare and contrast the approaches to performance assessment in primary health care being taken in Australia and New Zealand, with a particular emphasis on chronic disease;
2) To examine the strengths and weaknesses of these approaches, drawing on experience in the United States and elsewhere; and
3) To identify future policy challenges and options in the two countries.

## What is reported here?

Highlights from the background information presented to the forum and the ensuing debate are summarised here. The views expressed reflect the range of professional and consumer orientations and perspectives around the table. They are not necessarily evidence-based. Nor do they represent the official positions of any of the participants' organisations.

Though there was broad agreement on many issues, this summary does not constitute forum findings or consensus positions. Further, it does not necessarily

reflect the views or policies of the Australian Government Department of Health and Ageing, nor those of APHCRI.

## Context for PHC performance assessment in Australia and New Zealand

The contexts for the introduction of performance assessment in primary health care in the two countries are strikingly different in some important respects.

In comparison to the Australian economy, New Zealand's economy has a great deal less money available for public services, including health care. In New Zealand, it is widely accepted that there is a need to know what outcomes are being achieved for health care expenditure. Health disparities and equity are at the forefront in policy debate. There is a national health policy and a national primary health care policy which set out priorities and direction of travel for the health care system. PHOs are a new and central element of the primary health care policy and the primary platform through which reform is being implemented. General practices and general practice organisations are members of PHOs, and in many instances general practices exert considerable influence over the policies and directions of their PHO. Community membership of PHO governing boards is prescribed by policy. Relative to provider interests, community interests have a growing voice in primary health care policy debates (albeit the debates are still dominated by the provider voice). New Zealanders are well advanced in the implementation of a unique identifier for health care, and patient enrolment with a PHO through primary care providers. Significant structural reform to the health care system, including major changes in the primary health care sector, have been enacted over the past decade.

Australia is comparatively wealthier, and has significantly more money to spend on health care. To the New Zealanders present, it seemed extraordinary that there had been increases in Medicare funding that had not been tied to outcomes. With the exception of Aboriginal and Torres Strait Islander health disadvantage, health disparities are less politically visible and equity is not at the forefront in primary health care policy. There is no national health policy, or primary health care policy. Divisions are important players in primary health care reform, but not central in the way PHOs are. Divisions are general practitioner organisations and community representation on Division boards is only now gaining momentum. Relative to community interests, provider interests have a much stronger voice in primary health care policy debates. Australians do not have a unique identifier for health care and there is no enrolment with primary care providers. Under the Howard government, health system reform has been achieved through incremental change.

## Do you need to have a PHC strategy?

There was some discussion about what difference having a primary health care strategy made. Can you embark on performance assessment if you have not set down what it is you are trying to achieve, and by what means? In the end, there was general agreement that a strategy *per se* was not essential, as long as there was a clear vision of what you wanted the system to achieve.

## What do we mean by performance assessment in PHC?

This was expressed by one participant as follows: *What we are thinking about is how a government agency or regulator assesses the performance of a health care system. The key word here is system. We are not talking about the content of care in the individual interaction between a physician and a patient. In this context, a system can be defined as a group of health care providers responsible for the delivery of health care to a specific population.*

There are three main mechanisms for ensuring health system performance - though credentialing providers, accrediting provider organisations and monitoring process and outcome data for defined populations.

## What are the drivers for performance assessment in PHC?

There was recognition of the general increase in demands for accountability in public policy, and significantly increased interest in the processes and outcomes achieved for public expenditure. The expanding evidence base in health care provides an expanding basis for the measurement of processes and outcomes. Associated with this is research evidence of variability in practice that cannot be attributed to case-mix or other factors – that is, providers are not always doing what they should be doing, based on the evidence. All these have international momentum.

Also having strong international momentum, is a shift in emphasis from hospital to community settings for health care, as nations grapple with changes in patterns of demography and morbidity, particular in relation to chronic disease. It is increasingly believed that much of 'health technology' can be delivered in community settings more effectively and for less cost. Aligned with this is a more population based approach to the purchasing, management and provision of health care and thus interest in the measurement of processes of care and outcomes for populations, rather than individuals.

Locally in New Zealand the primary health care strategy and the establishment of these new regional purchasers – the PHOs – as well as Treaty of Waitangi and equity issues were seen as important drivers. In Australia a key driver has been the need to know what the Divisions of General Practice program is delivering for the community.

## Underlying philosophies and principles of performance assessment in PHC

The philosophies underlying performance assessment include pay for performance and Continuous Quality Improvement (CQI). It was argued that pay for performance is highly transactional and CQI transformational.[1] There was considerable sympathy for the view that performance assessment with system transformation as its goal is better for providers and better for communities. A transformational approach is probably less at risk of perverse consequences, gaming and deception. However, any system of performance assessment carries some risk of these occurring.

It is important to be clear whose performance you are trying to influence through performance assessment. There has been considerable debate in Australia about the extent to which the NPIs are monitoring Division performance or the performance of general practice. There is no simple answer to this, since the purpose of Divisions is to influence general practice so to some extent their effectiveness could/should be measured there. The counter argument is 'influence yes, but no control'. Can you assess the performance of primary care organisations based on measures of performance of providers over whom those organisations have no direct control? There continue to be divergent views within Australian general practice as to whether or not this is reasonable or appropriate. In New Zealand there is very much less questioning of the government's right to monitor general practice care and outcomes. Indeed, the New Zealanders expressed surprise at the level of continuing debate about this in Australia. However, in New Zealand, PHOs have contractual

[1] Arguably there could be considerable overlap, with pay for performance being quite strongly transformational.

relationships with providers and some financial levers with which to exert influence, whereas Divisions of General Practice do not. There was a sense in which time would tell whether system transformation could be brought about where no contractual relationship (and transfer of funds) bound the primary care organisation and its constituent providers.

Performance assessment can be achieved in a way that is more or less empowering for consumers. Access and equity must be key underlying principles. A view was put that PHOs and Divisions have to ask themselves "What are we here for - to serve GPs and other providers or to serve communities?". Serving communities means PHOs and Divisions have to accept what communities are saying, even if they do not like what they hear, and work with communities to address their needs. It was argued that performance assessment can be 'captured' by particular professional groups, and community interests can get lost in the process.

On the other hand, providers need to believe in the value and feel some ownership of the process. It has to work for them or it will not work for communities. And it is not just today's providers that need to be brought along – the future workforce has to see that it has some value or it will not survive.

Governments have a responsibility as well. They have to ask themselves what system capability is needed to best deliver on the outcomes being sought. Unless there is commitment to properly support system capability, performance assessment becomes a pointless exercise that produces frustration, hopelessness, cynicism and hostility among providers and, to a lesser extent, communities.

### What are the levers and incentives for performance assessment in PHC?

The provision of funding, and contractual obligations are powerful levers for governments, but a successful system for monitoring performance needs a balance between 'sticks and carrots'. There are different kinds of incentives that can be brought to bear. However, there is a level of professional distrust of incentives – they can undermine professionalism.

Provider altruism is a real and important incentive that may be stronger than financial rewards. Measurement of performance can trigger altruism – it gives providers a basis for knowing where they want to improve or flourish and how well they are doing. Dollars may be directed not at reward/profit for performance but at off-setting the costs of compliance or achievement. In this way, payments can foster altruism.

Are payments an effective incentive? The UK experience will provide important answers to this question. If the system is too complex or the payments too small providers will not bother.[2] Who should receive payments? Only the top achievers or those doing poorly, so that they have additional resources to improve performance? Is it best to pay for the care you want provided then monitor services and/or outcomes, or pay for outcomes?. Payment for outcomes can be made using some graduated algorithm, or for achievement against of targets. With our current state of knowledge, setting targets can be risky (see below).

What form should payments take and how should purchasers or providers be allowed to use the money? Who should have what say in how this is decided and what moneys are allocated? Where should the money for incentive payments come from? Should there be a separate budget for incentives or top slicing of the main budget to

[2] Australian experience with the Asthma 3+ Service Incentive Payment demonstrates that size of payment is not the only issue - providers also have to see some point in what is being incentivised.

create an incentive pool for competitive reallocation, based on achievement? What is the effect of such competition on system transformation? 'Measure and share' arrangements are another option – these bring with them an additional set of questions and issues.

There is a 'responsibility cascade' in health care. Regardless of the kinds of incentives used, how can we ensure that the incentives are reaching the people whose work is responsible for the achievements observed? What about incentives for patients – fly buys points gained for participating in evidence based care protocols or reducing risk behaviours?

Central to the issue of health disparities and equity, how should providers with high need populations be rewarded? What is the fairest way to build in an uneven playing field for uneven need and outcome? A system that funds and monitors care rather than outcomes may be better for addressing health disparities.

### What to measure?

There is multiplicity in what we might *want* to measure – what care is being provided, to whom, by whom, for what purpose, with what outcomes. But there is little certainty about what *should* be measured.

For organisation accreditation, standards relating to structures and processes are set and processes are put in place to determine whether or not they have been met – yes/no/partially.

Processes of care and outcomes are much more complicated. Where there is certainty about good process or desired outcome it is relatively easy to standardise and measure. Where there is uncertainty, it is much more difficult. An example is good coordination of care, an important goal in the management of chronic disease. Should we try to monitor this? What would good indicators be?

Outcome measures will often be clinical measures. This is where PHC system performance assessment crosses into the realm of the clinical encounters between providers and patients, albeit at a population level.

Downstream measures, such as measures of morbidity, including admissions to hospital for ambulatory care sensitive conditions, may not be the best measures of system performance. It may be more important to focus on structure and process. This might show more clearly where action is needed. It may be possible to achieve a great deal with only minor changes to system design.

Targets can be set for process and outcome performance measures. However, targets should only be used where there is certainty about the measures and desired levels of performance. In most instances we do not yet know enough about the system to set targets with confidence. It is better to collect some initial data and begin to understand the patterns observed and the explanations for those patterns. Through this process indicators (and targets) will evolve and change over time.

An important part of good PHC is ensuring that those who need care get into the system. What performance measures can be used to monitor the extent to which this is happening?

## How were the newly introduced indicators in Australia and New Zealand developed?

*Australia*

The NPIs for Divisions of General Practice were developed by a small expert group, with two rounds of national consultation and scientific review. They are fitted to a conceptual framework that has four levels – structures and processes for Divisions; structures and processes for practices; care for patients, families and communities; intermediate outcomes for patients families and communities.
http://www.anu.edu.au/aphcri/Publications/conceptual_framework.pdf

There are 44 indicators (of which 25 are compulsory for all Divisions) in the following domains : childhood immunisation, GP hospital integration, care for patients in residential aged care facilities, diabetes, asthma and mental health.
http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pcd-programs-divisions-rictoolkit.htm
There is also a set of indicators relating to governance which will be made redundant by accreditation. The quality of the indicators is being tested through use over a three year period, during which time they will be reviewed.

*New Zealand*

A national set of 16 clinical indicators for PHOs was initially proposed by the New Zealand Ministry of Health following a sector wide meeting in mid 2002. Further consultation with GPs was undertaken by an independent research team using an internet-based modified Delphi technique.

The New Zealand Performance Management Programme for PHOs is being implemented as a staged process. The first performance period commenced 1 January 2006. http://www.dhbnz.org.nz/ The Programme includes a set of eight Phase One "clinical indicators", in combination with "process/capacity" and "financial" indicators. http://www.dhbnz.org.nz/ The clinical indicators cover the following areas: childhood immunisation, influenza vaccination for the elderly, cervical and breast screening, as well as indicators around laboratory test ordering and prescribing.
http://www.dhbnz.org.nz/

The quality of the indicators has been the subject of an exhaustive review using an innovative theoretical framework and indicator assessment tool developed by Otago University.[3]

## Information infrastructure and information flows

In both Australia and New Zealand, information systems are under-developed and/or not designed for monitoring performance. Performance assessment is already driving, and will continue to drive, improvements in information systems. However, their establishment and/or refinement will take years and considerable financial and other resources. Electronic clinical systems will need to develop in such a way that they help providers deliver good care as well as allow data capture, extraction and compilation. The administrative burden and costs of data collection have to be considered and kept within reasonable bounds. Patient consent is important.

Performance information has to be available to those who need to act, so consideration has to be given to how this is achieved. And what information in what form should be made available to consumers?

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[3] Perera R, Dowell A, Crampton P, Kearns R. Panning for gold: an evidence-based tool for assessment of performance indicators in primary health care. *Health Policy* in press.

## Implementation – the here and now and the future

There are some key principles that should underpin the introduction and development of PHC performance assessment. These include mutual trust, tolerance, and consumer engagement. Education is an important part of implementation.

The need and demand for PHC performance monitoring will only expand. There will inevitably be improvements in information systems, in data quality and availability and in our understanding of what to monitor and how. Consumers will become increasingly interested in the results and there will be demands for greater system transparency and for information to be packaged and presented in such a way that it can inform consumer choice. This process is already well established in the USA and UK.

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## Attendance

The meeting was attended by participants from:
***Australia* –** Australian National University, Menzies School of Health Research (Darwin), Australian Government Department of Health & Ageing, ACT Health, National Health Performance Committee, Consumers Health Forum of Australia, Australian Divisions of General Practice, Queensland Divisions of General Practice, Southern Division of General Practice, Royal Australian College of General Practitioners, Australian Medical Association.
***New Zealand*** – Otago University, Ministry of Health, District Health Boards.

This forum was a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Government Department of Health and Ageing.