



Pay for performance: Australian landscape, international efforts, and impact on practice

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Fee-for-service (FFS) funding continues to dominate primary health care in Australia despite calls for reform. FFS, where providers bill for each service they provide, rewards increased activity. This may lead to over-servicing, increased costs (with no controls on prices charged), and negative impacts on quality of care. In contrast, pay-for-performance (P4P) approaches refer to payments to general practitioners (GPs) or practices, according to the number of times a certain standard of performance is met, and have been shown to improve quality.^{1;2} Blended funding models have been trialled in Australia, with the 2011-14 Diabetes Care Project (DCP) incorporating P4P and flexible funding, while retaining FFS components. This *RESEARCH ROUNDup* will examine P4P in the Australian primary health care context and provide lessons from both systematic reviews and international experiences of P4P in primary health care.

Australian experience of P4P

P4P aims to encourage practitioners to provide better quality care. Such incentives define performance in terms of reaching a minimum threshold for quality of care provided; including the way treatments are provided as well as improvements in clinical measures related to health outcomes.² Australia's first experiments with P4P began in 1999 with the introduction of (voluntary) Practice Incentive Payments (PIP) and Service Incentive Payments (SIP) to improve the quality of care for groups at risk of poor health outcomes (Indigenous Australians and those with asthma, diabetes or mental health conditions) as well as rates of cervical cancer screening. The PIP include infrastructure payments (e.g. for becoming a teaching practice) and sign-on payments for having registers in place; while the SIPs are related to specific conditions.³ For example, GPs receive PIP for each person with diabetes or moderate-to-severe asthma they 'sign on' to a programme of care; and an annual SIP for each completed 'cycle of care'. Practices can claim an additional payment if they complete cycles of care for at least 20% of their patients with diabetes.⁴

As with other P4P schemes, PIP and SIP are used as levers to effect change in general practice. Examples include a PIP after-hours incentive that was introduced in July 2015; and from 1 May 2016, new eligibility requirements for eHealth PIP payments require GPs to upload a minimum number of shared health summaries to *My Health Record*.⁵ However, a recent review identified serious limitations in the current incentive payments, including: high administrative burden; non-specified performance outcomes; payments not adjusted for patient age, risk factors, more advanced disease or comorbidity; and payments not well targeted to the complexity and intensity of services that are required.^{4;6}

The DCP was a multi-centre cluster randomised trial that incorporated P4P as part of a comprehensive intervention to improve glycaemic control in patients with diabetes. Practices in one arm of the trial received quarterly payments and flexible funding for allied health (based on risk stratification) as well as funds for care facilitation and quality improvement support payments (QISP).^{7;8} Participants in this arm showed a statistically

significant improvement in glycaemic control (HbA1c), blood pressure, blood lipids, waist circumference and depression, compared with participants in the control group. However, cost-effectiveness of the model was not established in the 18 month trial, or with extrapolation of benefits and costs over an extended period.⁸

Lessons from systematic reviews

Several systematic reviews have examined the impact and effectiveness of P4P and reported mixed effects.⁹⁻¹⁵ In general, reviews have raised concerns about the quality of the included studies, including difficulty disentangling the effect of P4P from other quality improvement initiatives, and selection bias (e.g. if people with multimorbidity were excluded, does this lead to over or under-estimates of effect?).⁹ Evidence of unintended consequences has also been reported, including less attention to care processes that were not incentivised.¹⁴ Design elements, including performance targets that are achievable and easy to track; strong infrastructure; alignment with organisational goals; and public reporting have been identified as contributing to positive effects.^{13;14}

Lessons from international experiences

P4P was implemented as part of the Quality and Outcomes Framework (QOF) in the UK and is used by public and private health insurers in the US. P4P is also part of the US Patient Centered Medical Home model. In general, most developed countries use a combination of P4P, FFS, capitation or salaries (i.e. blended payments) to compensate for weaknesses associated with single payment approaches.¹⁶ The UK experience of the QOF has relevance for Australia as it represents a system-wide reform that incentivises GPs to meet specific outcomes related to clinical targets (covering a comprehensive list of chronic conditions) as well as organisational quality indicators.¹⁷ Evidence-based indicators were developed by the National Institute for Health and Care Excellence¹⁷ and adjusted through negotiation with the relevant GP body.⁴ Twenty per cent

of indicators relate to medications (e.g. influenza immunisation for patients with diabetes and other conditions) and other indicators require drug treatment in order to meet targets (e.g. blood pressure targets).¹⁸ As a result, the QOF has led to increased prescription rates for antidepressants, statins and other drugs.¹⁷ Similarly, the Australian DCP evaluation reported that Pharmaceutical Benefits Scheme and National Diabetes Services Scheme costs rose by \$158 per person per annum as a result of changes in prescribing behaviour during the trial.⁸ In the US, attention has turned to the alignment of P4P incentives with expected health gain¹⁹ and value-based payments that aim to reduce spending while improving quality and outcomes (accountability for cost).²⁰

As a system-wide initiative, the QOF underscores the importance of standardised approaches for reporting activity and outcomes in general practice.²¹ As part of the Australian Primary Health Care Advisory Group's recent proposal for *Health Care Homes*, the development of a national minimum dataset for primary health care, as well as automated extraction of de-identified information from clinical software programmes, has been recommended.⁸ Addressing professional and organisational barriers to information sharing as well as investment in both a wider quality improvement programme and the technology to rapidly feedback performance to providers are required.^{21,22}

Linking P4P to achieving clinical targets (such as HbA1c) raises equity concerns. Socioeconomic factors such as out-of-pocket costs for prescriptions and tests may impact on treatment compliance and thus performance metrics and payments. GPs may also be reluctant to enrol patients with advanced or comorbid disease, unless P4P recognises the additional time and resources needed for these patients, as well as improvements in clinical measures. For example, the DCP included risk-adjusted payments to ensure that patients with the highest levels of need would not be excluded from participation and tracked improvement in glycaemic control rather than achievement against a specific target.⁸ In addition, the QISP included a balance of process of care indicators, clinical outcomes and patient experience, to recognise that patient factors as well as quality of care, influence clinical indicators.⁷

Conclusion

Australia has adopted a cautious approach to P4P, drawing on lessons from the international experience of P4P and circumventing some of the problems commonly cited in relation to P4P. While the evidence for the cost-effectiveness of P4P remains equivocal, Australia is contributing to the development of comprehensive models of care to improve quality and outcomes in primary health care.

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