STARFIELD SUMMIT
...where primary care research inspires policy and practice

Starfield Summit Issue Brief

DISCUSSION TOPIC

- Does pay for performance need a registered population?
- A package of measures for improving chronic disease management, preventive care, and early diagnosis needs a health care setting where planned and proactive care can take place over time. For maximal success, this means everyone needs a named doctor with an ongoing relationship.

Why This Is Important *(brief description)*:

- If patients come only when they experience a specific need, and only attend for follow-up of a recent illness episode, then most of the indicators in the U.K. Quality Outcomes Framework (QOF) could not have been met. If they lack ongoing relationships with their patients, clinics will have difficulty getting patients to obtain needed care. Furthermore, if patients have out of pocket expenses for preventive or chronic care, they may seek care only when acutely ill. Finally, if only some parts of the population have this type of coverage, then only some will benefit. Only clinicians working with these populations will be maximizing their potential to prevent and minimize the impact of non-communicable diseases.

What We Think We Know *(bulleted evidence + seminal references)*:

- Characteristics of a strong primary health care system are its use by patients as first point of care with continuity over time, offering a comprehensive set of services and coordinating different aspects of care. This is associated with lower morbidity and mortality and better health outcomes. (*B. Starfield,, L. Shi, and J. Macinko. Milbank Quarterly 2005;83(3);457-502.)*
- General practitioners (GP) have an important role in population health as well as individual care, but the pay for performance model alone did not adequately address health inequalities. QOF improved practice organization, recording, and administrative support, but did not help with primary prevention. It may also have exacerbated the culture of 'not done if not paid for'. Community public health initiatives do not get full GP engagement because they are 'outside the clinic'. *Dixon A, Khachatryan A, Wallace A, Peckham S, Boyce T, Gillam S The Quality and Outcomes Framework: does it reduce health inequalities? Final report. NIHR Service Delivery and Organisation programme; 2010.*
- Pay for performance can be used to improve the quality of care, but it is not a "magic bullet" and needs to be combined with other quality-improvement initiatives to produce sustained improvements.
- Pay-for-performance administrators need to recognize that large parts of clinical practice cannot currently be measured. It is better to recognize this than to force poorly designed indicators into a program.
- Single-condition indicators do not adequately meet the needs of elderly patients with multiple coexisting medical conditions
- The amount of income attached to pay for performance dictates the level of practitioners' attention to limited areas of clinical practice. Broader payments for population care may work better.

(Roland M, Campbell S. Successes and Failures of Pay for Performance in the United Kingdom. NEJM 2014; DOI: 10.1056/NEJMhpr1316051.)

QUESTIONS FOR GROUP DISCUSSION *(PRECONFERENCE)*

Questions for Group Discussion *(add brief answers post-conference)*

1. What lessons have you learned from the UK's experience with the QOF?
2. What are the characteristics of quality metrics that should be targeted for payment? Would it be possible to develop a uniform data set for quality that aligns with current thinking about how to improve health care value? How could this data set, or associated payments, be constructed such that providers working with less healthy populations are included equitably, and rewarded, in these programs?
3. What governance measures would need to be in place to stop cheating, gaming, and cherry picking?

Ideas Worthy of Policymaker Attention *(lists ideas for policy preconference, refined ones post-conference)*

- Paying for performance can come with unintended consequences.
- A uniform minimum data set for quality could be incorporated into health insurance programs to assure uniformity of collection and to optimize health care quality and value.
- Payment should be linked to the primary care functions (access, continuity, comprehensiveness and care coordination).

Important Unanswered Questions & Ideas Worthy of Research Community Attention

- What quality metrics would be included a uniform minimum data set for quality?
- What metrics should be used to assess the ability of a practice to perform the primary care functions?