

National Programmes - Local Networks - effective delivery.....

In July 2008, the Melbourne Institute of Applied Economic and Social Research published a paper on “The Effect of Financial Incentives on Quality of Care: The Case of Diabetes”.

What struck a chord in this paper was not only the discussion on pay-for-performance as a driver to change clinical behaviour, but more importantly for me the critical effect of networks in providing the right incentive framework for driving performance.

We have known for a long time within our IPAs that one of the most potent catalysts for behavioural change is comparison with one’s peers. For a decade my IPA and others in the Midland region enjoyed a RHA funded quality contract. Our IPA Quality team worked relentlessly to choose the measures which we would all aspire to achieve.

Newfound IT tools had unleashed for us the ability to start to measure our population demographics, our immunization rates, smear rates, and smoking rates. The enthusiasm of the quality team was such that each year a quality plan was agreed, and we all aspired to achieve maximum quality points, with a small quality payment as the carrot.

I would argue that the quality payment as we then knew it was hardly enough to drive major changes in our clinical behaviour. It did however give us a sense of being valued; that the endeavour was worth while.

The ability to measure our practice performance against our peers across the IPA network (all numerically coded), had a dramatic impact on our clinical behaviour. Monthly graphs showing where “number 5” (mine) sat in relation to the rest of the group were anxiously anticipated. Jubilation or consternation would follow, depending on where we sat in the bunch.

There was even an era of “chocolate fish” awards. Remedial efforts to regain high achiever status were frantic if we were seen to be dragging the chain, and our IPA would step in to assist any practice in need of help. Low ratings on the regular feedback graph could be attributed to many things, and notably were seldom the product of poor effort.

Hard to reach populations, technology problems (and there were many in those times), staff illness or crisis were far more often the cause of a lapse in performance by any given practice. Brief intervention by way of assistance from the IPA was the most effective means of raising the standard again. This QA cycle resulted in performance across the IPA network that far exceeded national averages for a number of years.

At about the same time, peer review groups were appearing across the country, and became part of the core functions of the networks. Meeting regularly with a trusted group of peers rapidly became a safe haven for comparing performance, supporting one

another, and changing behaviour. I have more often tried a new clinical approach or changed a prescribing habit the day after a peer review group, than at any other time. Most of those changes then became part of my regular clinical toolkit.

It was no great surprise to read in the Melbourne paper that incentive payments for diabetes care had a significant impact on clinical behaviour, much as we have witnessed in the UK QOF programme.

However it was affirming in this paper to note that our Australian counterparts , the Divisions of General Practice, are credited with playing “a major role ...on the effects of the reform on quality of care”. “The strong influence of Divisions’ activities highlights the importance of a supporting regional infrastructure when a complex payment system is introduced to remunerate GPs”

I am increasingly impressed with the work our networks are doing. The IPAC CEOs group is a dynamic group of network CEOs who meet regularly. This special group of highly talented managers is the “virtual management team” that also supports our Wellington office, and their organisations, with strong clinical input, deliver a huge array of services to the practices within their jurisdiction.

That we are now having discussions with national sister organisations about delivering their services via these networks, is not only a no-brainer, but acknowledges the importance of delivering national services and programmes through local and regional networks. It also acknowledges the common sense and efficiency of having a single series of networks serving general practice at locality level.

May the trend continue.