Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

Why does the UK keep investing in primary care? Is it really that effective?

Martin Roland
Professor of General Practice
University of Cambridge

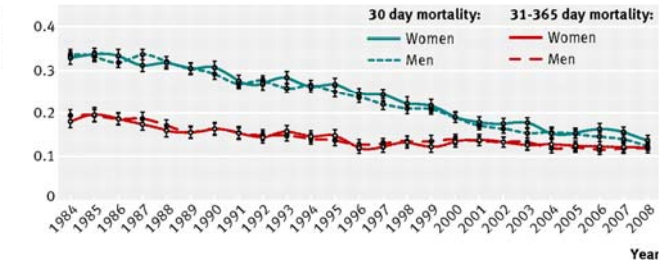
Cambridge Centre for Health Services Research
University of Cambridge

- **What's so good about primary care?**
- **Quality improvement, including financial incentives**
- **Integrated care**
- **Competition in healthcare**
- **Giving more responsibility to primary care**

What's so good about primary care?

The influence of Barbara Starfield:

- **Countries with strong primary care have cheaper health care systems**
- **Countries with strong primary care have more equitable provision of health care**
- **Countries with strong primary care have better health outcomes**



Is this evidence of the impact of primary care?

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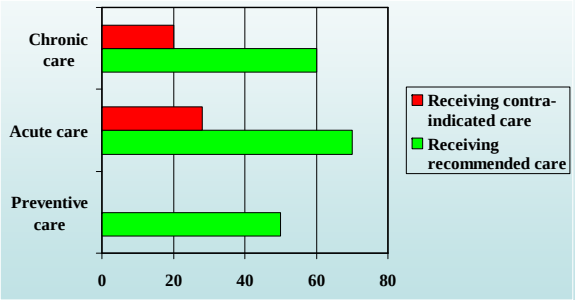
Traditionally a tidy division of roles meant primary care provided a personal, caring and supportive service for the majority, whilst hospitals provided lifesaving care for the minority.

The greatest potential for saving lives has now become decentralised and lies in primary not secondary care.

Pereira Gray D. Role reversal between primary and secondary care. Medical Education 2003; 37: 754-5

Quality of care for 30 conditions + preventive care: 439 quality indicators developed by 49 panels applied to 6712 randomly sampled US adults



McGlynn et al New England Journal of Medicine 2003; 348: 2635

How should doctors be paid?

Salary	Pay independent of workload or quality
Capitation	Pay according to the number of people on a doctor's list
Fee for service	Pay for individual items of care
Quality	Pay for meeting quality targets

What would you get without professionalism?

Salary	Pay independent of workload or quality
Capitation	Pay according to the number of people on a doctor's list
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What would you get without professionalism?

Salary	Do as little as possible for as few people as possible
Capitation	Do as little as possible for as many people as possible
Fee for service	Do as much as possible, whether or not it helps the patient
Quality	Carry out a limited range of highly commendable tasks, but do nothing else

Financial incentives to improve quality of care

- UK Quality and Outcomes Framework (QOF)
- Introduced 2004
- Complex set of clinical, organisational and patient experience indicators which account for ~25% of GPs' income

CHD 7 The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months.

Point score: from 1 point (25%) to 7 points (90%)

CHD 8. The percentage of patients with coronary heart disease whose last total cholesterol (measured in the last 15 months) is 190mg/dL or less

Point score: from 1 point (25%) to 16 points (60%)

Roland M. NEJM 2004; 351: 1448-54.

Financial incentives 2011/12 (Clinical indicators)

Coronary heart disease – secondary prevention
Cardiovascular disease – primary prevention
Heart failure
Stroke and Transient Ischaemic Attack
Hypertension
Diabetes mellitus
Chronic obstructive pulmonary disease
Epilepsy
Hypothyroid
Cancer
Palliative care
Mental health
Asthma
Dementia
Depression
Chronic kidney disease
Atrial fibrillation
Obesity
Learning disabilities
Smoking

www.bma.org.uk/images/qofguidancefourthversion2011_v2_tcm41-205262.pdf

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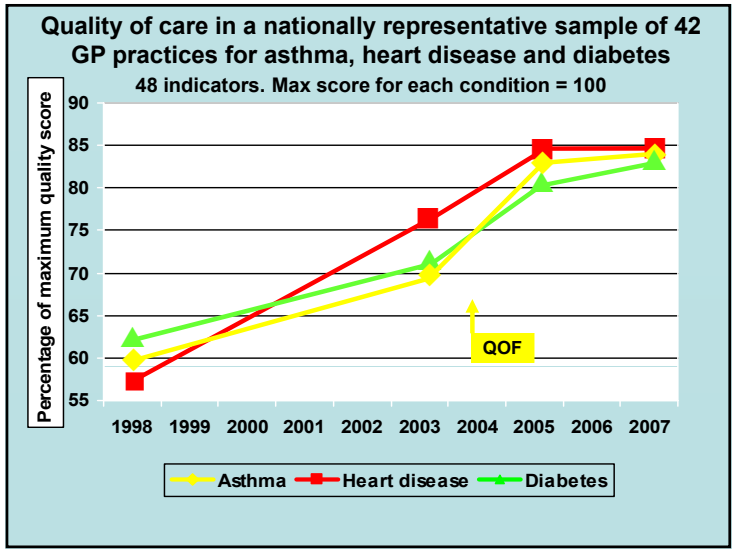

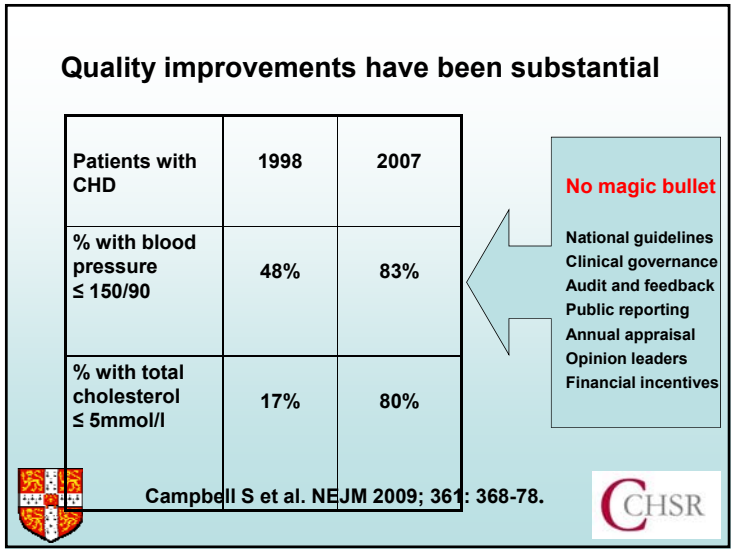

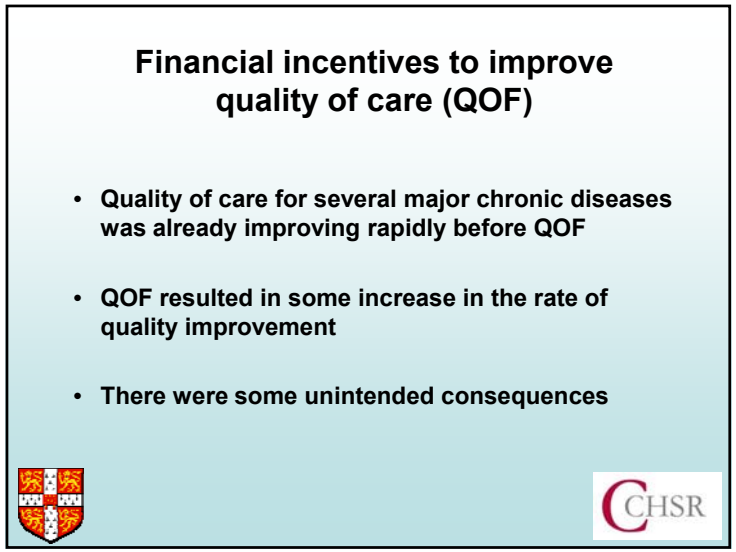

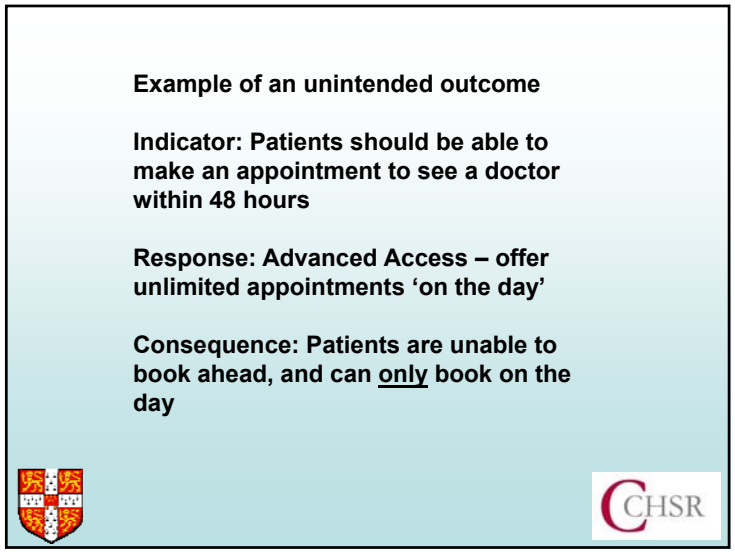

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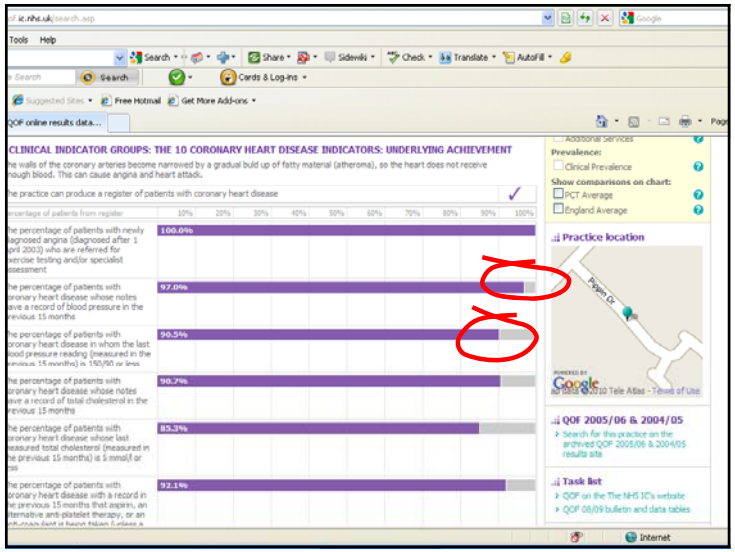
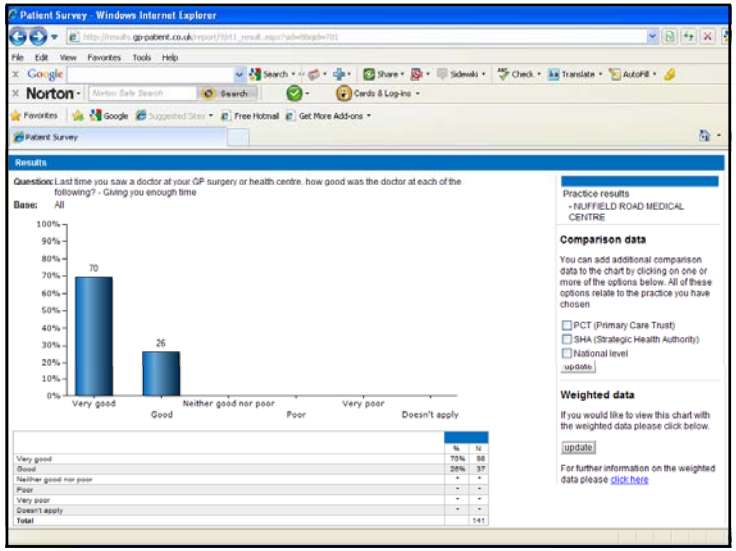
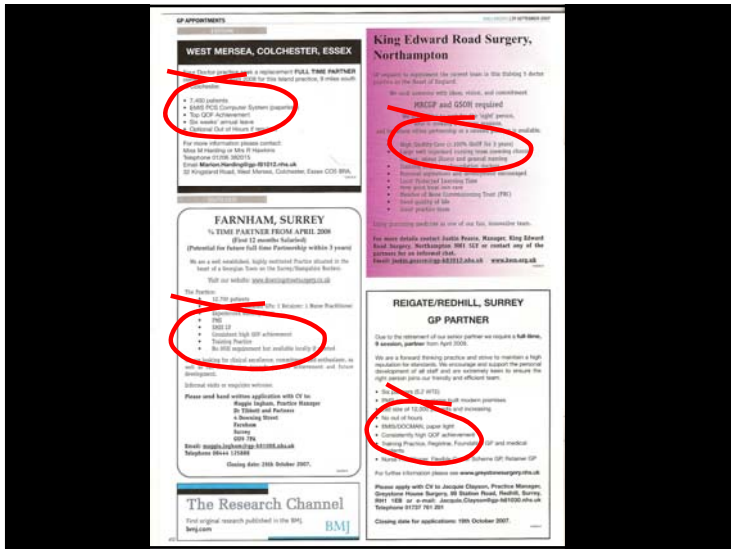
Financial incentives to improve quality of care (QOF)

- Financial incentives are fully justified to cover the additional costs of providing good care: doctors should not be out of pocket for providing good care
- No magic bullet
- So far as possible, financial incentives should be aligned with professional incentives
- All incentives can have unexpected consequences
- Importance of population base and EMRs
- Reputational incentives may be as important as financial incentives







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- **Integrated care**
- Competition in healthcare
- Giving more responsibility to primary care

Evaluation of English 'Integrated Care Pilots'

- **16 sites which aimed to provide more integrated care**
- **6 sites focused specifically on case management of frail elderly people**

Evaluation of six case management initiatives (1)

i) Staff surveys

- **working more closely with team members**
- **better communication in their organisation**
- **better communication with other organisations**
- **more interesting jobs (staff closely involved)**
- **care for patients improved (36.9% 'too early to tell')**

Evaluation of six case management initiatives (2)

ii) Patient surveys

- **More likely to have received a care plan**
- **Clear follow up arrangements after leaving hospital**
- **More likely to know who to contact with questions about treatment following hospital discharge**

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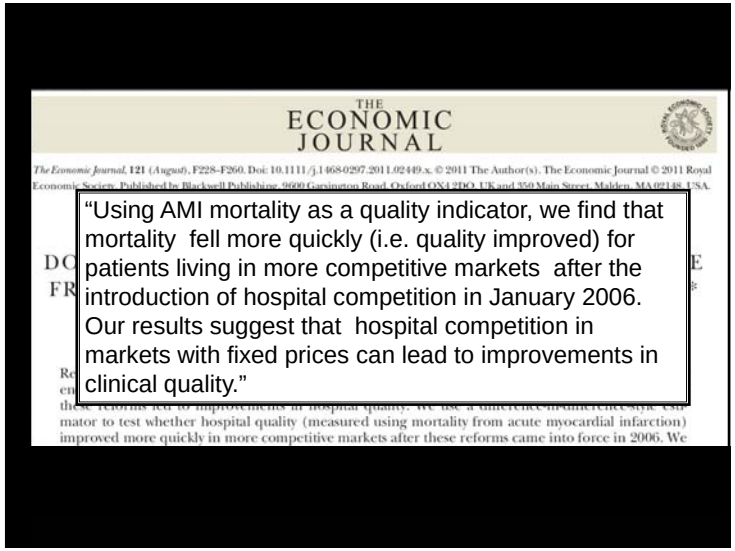
…… but

- Less likely to see the GP they prefer
- Less likely to see the nurse they prefer
- GPs less likely to involve them in decisions about care
- Nurses less likely to involve them in decisions about care
- GPs less good at listening
- Opinions less likely to be taken into account by social services

Integrated care

- We haven't got it right yet
- We may be pursuing precisely the wrong path (by separating purchasers from providers)
- Requires close relationships between primary, secondary and social care
- It takes a long time to reform systems

- Quality improvement, including financial incentives
- Integrated care
- **Competition in healthcare**
- Giving more responsibility to primary care


THE ECONOMIC JOURNAL

"Using AMI mortality as a quality indicator, we find that mortality fell more quickly (i.e. quality improved) for patients living in more competitive markets after the introduction of hospital competition in January 2006. Our results suggest that hospital competition in markets with fixed prices can lead to improvements in clinical quality."

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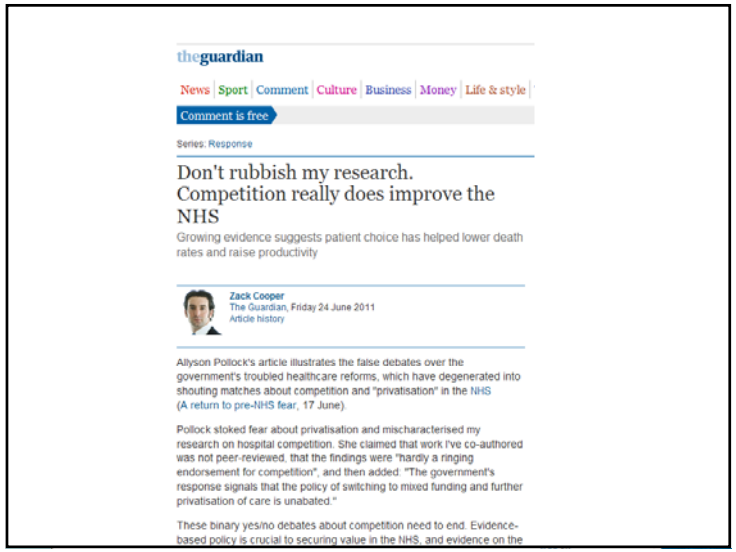

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Series: Response

Don't rubbish my research. Competition really does improve the NHS

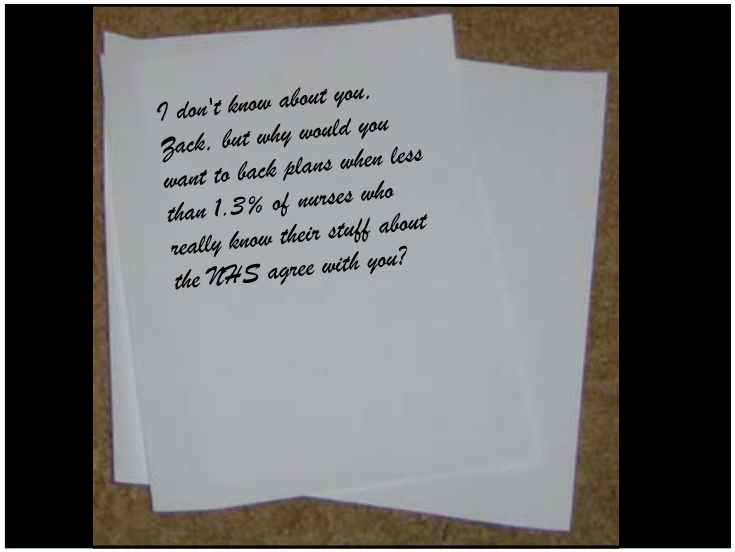
Growing evidence suggests patient choice has helped lower death rates and raise productivity

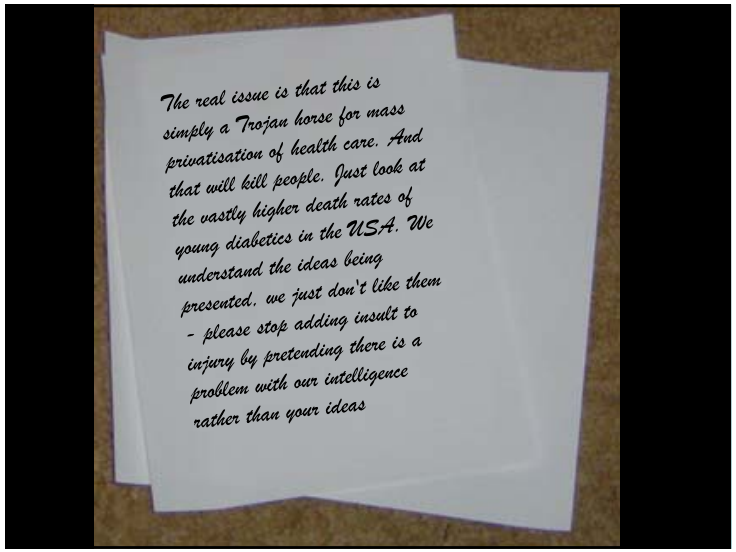
Zack Cooper
The Guardian, Friday 24 June 2011
Article history

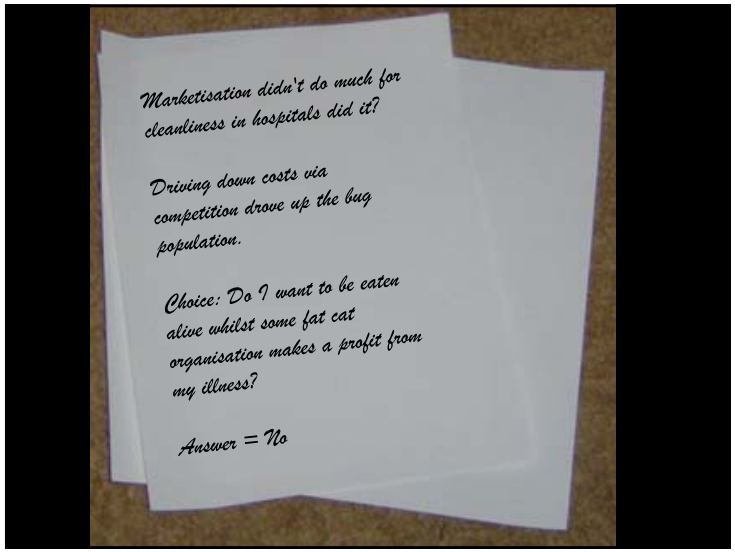
Allyson Pollock's article illustrates the false debates over the government's troubled healthcare reforms, which have degenerated into shouting matches about competition and "privatisation" in the NHS (A return to pre-NHS fear, 17 June).

Pollock stoked fear about privatisation and mischaracterised my research on hospital competition. She claimed that work I've co-authored was not peer-reviewed, that the findings were "hardly a ringing endorsement for competition", and then added: "The government's response signals that the policy of switching to mixed funding and further privatisation of care is unabated."

These binary yes/no debates about competition need to end. Evidence-based policy is crucial to securing value in the NHS, and evidence on the







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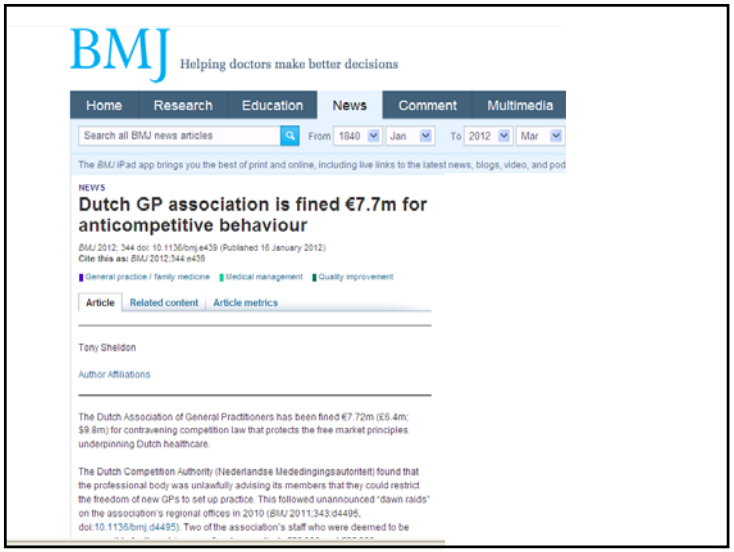
- **Can you combine a competitive market in health care with the integrated care that your increasingly elderly population needs?**



- Quality improvement, including financial incentives
- Integrated care
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History

- **1990 – purchaser provider split – hospital care is purchased (or commissioned) by a payer**
- **1990-1998 – experimented with GP fundholding – abolished by Labour**
- **2004 – GP involvement in budget allocation re-established as 'practice based commissioning'**
- **2013 – Consortia led by GPs to be given 70% of entire hospital budget to commission services from hospitals**

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So what have we learned?

1. Primary care is still seen as the key to high quality cost effective healthcare. A population base is critical.
2. Measures to improve quality have been effective, but don't expect quick solutions – interventions need to be multiple and sustained. Financial incentives have a role.
3. You get what you pay for in healthcare. Especially when it comes to paying doctors. Many countries in the world regard a system based on fee for service as unsustainable in the long term as it usually results in over-provision.
4. All incentives have unexpected consequences. Try and make sure that financial and professional incentives are closely aligned.
5. Clinical engagement is critical to the success of most major healthcare developments. We have relied to much on management and are regretting it.
6. Change comes slowly. Make sure that your changes integrate rather than fragment care. Major changes take several years to bed in. Expect that things won't go smoothly, and allow enough time before assessing whether you have been successful.

Are there any lessons from the UK?

- Successive UK governments have seen primary care as the key to a high quality cost effective health service
- Almost all the reforms have assumed some form of population responsibility by payers and/or GPs

CHSR

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