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

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?

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

Presented by
Australian Primary Health Care Research Institute, ANU
Thursday 8 March 2012, 2 – 3pm, ANU
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

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
- **Fee for service**: Pay for individual items of care
- **Quality**: Pay for meeting quality targets
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

What would you get without professionalism?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salary</strong></td>
<td>Do as little as possible for as few people as possible</td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
<td>Do as little as possible for as many people as possible</td>
</tr>
<tr>
<td><strong>Fee for service</strong></td>
<td>Do as much as possible, whether or not it helps the patient</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Carry out a limited range of highly commendable tasks, but do nothing else</td>
</tr>
</tbody>
</table>

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

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
- Hypothyroidism
- Cancer
- Palliative care
- Mental health
- Asthma
- Dementia
- Depression
- Chronic kidney disease
- Atrial fibrillation
- Obesity
- Learning disabilities
- Smoking

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.

Presented by
Australian Primary Health Care Research Institute, ANU

Thursday 8 March 2012, 2 – 3pm, ANU
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

Quality of care in a nationally representative sample of 42 GP practices for asthma, heart disease and diabetes
48 indicators. Max score for each condition = 100

Quality improvements have been substantial

<table>
<thead>
<tr>
<th>Patients with CHD</th>
<th>1998</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with blood pressure ≤ 150/90</td>
<td>48%</td>
<td>83%</td>
</tr>
<tr>
<td>% with total cholesterol ≤ 5mmol/l</td>
<td>17%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Campbell S et al. NEJM 2009; 361: 368-78.

Financial incentives to improve quality of care (QOF)

- Quality of care for several major chronic diseases was already improving rapidly before QOF
- QOF resulted in some increase in the rate of quality improvement
- There were some unintended consequences

Example of an unintended outcome

Indicator: Patients should be able to make an appointment to see a doctor within 48 hours

Response: Advanced Access – offer unlimited appointments ‘on the day’

Consequence: Patients are unable to book ahead, and can only book on the day

Presented by
Australian Primary Health Care Research Institute, ANU

Thursday 8 March 2012, 2 – 3pm, ANU
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

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

Presented by
Australian Primary Health Care Research Institute, ANU

Thursday 8 March 2012, 2 – 3pm, ANU
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

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

---

**...... 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**

---

“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.”

---

Presented by
Australian Primary Health Care Research Institute, ANU

Thursday 8 March 2012, 2 – 3pm, ANU
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

I don’t know about you. Zacch, but why would you want to back plans when less than 1.3% of nurses really know their stuff about the NHS agree with you?

The real issue is that this is simply a Trojan horse for mass privatisation of health care. And that will kill people. Just look at the vastly higher death rates of young diabetics in the USA. We understand the idea being presented. We just don’t like them - please stop adding insult to injury by pretending there is a problem with our intelligence rather than your ideas.

Marketisation didn’t do much for cleanliness in hospitals did it?

Driving down costs via competition drove up the bug population.

Choice: Do I want to be eaten alive whilst some fat cat organisation makes a profit from my illness?

Answer = No

Presented by
Australian Primary Health Care Research Institute, ANU

Thursday 8 March 2012, 2 – 3pm, ANU
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

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

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

History
- 1990 – purchaser provider split – hospital care is purchased (or commissioned) by a payer
- 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

Presented by
Australian Primary Health Care Research Institute, ANU
Thursday 8 March 2012, 2 – 3pm, ANU
Public Lecture: Why does the UK keep investing in primary care? Is it really effective?
Professor Martin Roland, University of Cambridge

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