The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

ORIGINAL RESEARCH PAPER

ORIGINAL RESEARCH: HEALTH POLICY

Like using a refrigerator to heat food: capacity and capability funding in primary care and the legacy of the Primary Health Organisation Performance Programme

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J PRIM HEALTH CARE
2020;12(4):345–351.
doi:10.1071/HC20012
Received 30 August 2020
Accepted 2 November 2020
Published 9 December 2020

ABSTRACT

INTRODUCTION: In 2016, the New Zealand Ministry of Health introduced the System Level Measures (SLM) framework as a new approach to health system improvement that emphasised quality improvement and integration. A funding stream that was a legacy of past primary care performance management was repurposed as 'capacity and capability' funding to support the implementation of the SLM framework.

AIM: This study explored how the capacity and capability funding has been used and the issues and challenges that have arisen from the funding implementation.

METHODS: Semi-structured interviews with 50 key informants from 18 of New Zealand's 20 health districts were conducted. Interview transcripts were coded using thematic analysis.

RESULTS: The capacity and capability funding was used in three different ways. Approximately one-third of districts used it to actively support quality improvement and integration initiatives. Another one-third tweaked existing performance incentive schemes and in the remaining one-third, the funding was passed directly on to general practices without strings attached. Three key issues were identified related to implementation of the capacity and capability funding: lack of clear guidance regarding the use of the funding; funding perceived as a barrier to integration; and funding seen as insufficient for intended purposes.

DISCUSSION: The capacity and capability funding was intended to support collaborative integration and quality improvement between health sector organisations at the district level. However, there is a mismatch between the purpose of the capacity and capability funding and its use in practice, which is primarily a product of incremental and inconsistent policy development regarding primary care improvement.

Keywords: Primary health care; funding incentives; performance; quality improvement; integration

Introduction

Funding is one policy tool that has been used extensively as a way of achieving primary healthcare policy objectives such as improved integration and quality.[1] Yet, funding can be used in different ways: to punish organisations for poor performance, to reward them for good performance through incentives or to stimulate better collaboration between health sector organisations.

WHAT GAP THIS FILLS

What is already known: In the health-care sector, funding has been used as a mechanism to stimulate performance and improve quality of care.

What this study adds: This research demonstrates the difficulties associated with repurposing a pre-existing funding mechanism based on a stick-and-carrot approach to one that is intended to foster and support collaboration and integration between primary and secondary health-care services.

Box 1. New Zealand's System Level Measures

- Ambulatory Sensitive Hospitalisation rates for 0- to 4-year-olds (keeping children out of hospital).
- Acute hospital bed days per capita (using health resources effectively).
- Patient experience of care (person-centred care).
- Amenable mortality rates (prevention and early detection).
- Babies living in smoke-free homes (a healthy start).
- Youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported).

Since approximately 2000, many jurisdictions have used funding to reward or punish primary care providers for achieving levels of performance on clinical and population health indicators. The English Quality and Outcomes Framework is the most prominent international example and it has attracted both support and condemnation.[2–7] Over the past 10 years, there has been increasing interest in alternatives to the stick-and-carrot approach to improving primary care quality.[8,9] An extensive body of research has also highlighted that funding, and particularly pooled or integrated funding, is an important facilitator of more integrated approaches to health service delivery,[10–12] and funding fragmentation constitutes a significant barrier to integration between primary care and other health services.[13,14]

In New Zealand, the health system is primary care led. There are Primary Health Organizations (PHOs) that provide primary health-care services through their member general practices. The activities of PHOs are publicly funded through District Health Boards (DHBs) that are responsible for the health needs of the people in their geographical locations. The Ministry of Health exercises a supervisory and oversight role over the activities of DHBs. In 2016, the Ministry of Health introduced the System Level Measures (SLM) framework as a new approach to health system improvement.[15] This marked a significant change in direction from national health targets and pay-for-performance schemes towards a collaborative approach to improving health system outcomes. The SLM framework was designed to facilitate a shift from focusing on specific organisations to whole system integration, and a shift from performance management based on rewards and sanctions to a framework based on quality improvement. The SLM framework established six 'system-level' outcome measures, which are outlined in Box 1.[15]

Improvements in these indicators require District Alliances of DHBs and PHOs to work collaboratively to develop their own 'contributory measures' and implement local improvement plans and activities.[16] There are currently 20 District Alliances that have emerged from the existing 20 DHBs.

The funding used to support SLM implementation is a legacy of past primary care policy. In 2005, the PHO Performance Programme was established to facilitate clinical quality improvement.[17–19] Under the PHO Performance Programme and the Integrated Performance and Incentive Framework that superseded it in 2014,[20] PHOs and their member practices were incentivised through a small pay-for-performance scheme to achieve clinical and population health targets. From 2016, however, three-quarters (75%) of the funding was repurposed to build 'capacity and capability' in primary care for implementation of the SLM framework; the remaining one-quarter (25%) remained tied to the achievement to specific performance measures. The specific information provided on the Ministry's website is as follows:

> 'The 75% capacity and capability payment is to build quality improvement and analytic capacity and capability in primary care that may include clinical and non-clinical infrastructure (e.g. building 'continuous quality improvement' competencies and culture, implementation of primary care patient experience survey, improving information technology and

analytics, enabling clinical leadership and outreach services). At least 50% of the funding must have direct financial benefit to general practice.'[15]

Of the capacity and capability funding, one-third is paid automatically to PHOs whereas the remaining two-thirds are paid subject to the Ministry of Health's approval of SLM Improvement Plans developed by District Alliances.[15,16] This approval depends on District Alliances adopting a collaborative approach, choosing appropriate milestones, contributory measures and quality improvement activities.[15]

In this study, we assess how 'fit for purpose' this funding is for the facilitation of quality improvement and integration at the district level, drawing on research into the implementation of the SLM framework. We explore issues and challenges that have arisen from the implementation of the capacity and capability funding.

We focused on two research questions: (1) what has the capacity and capability funding been used for?; and (2) what issues and challenges have been identified in the use of the capacity and capability funding?

Methods

The research team conducted semi-structured interviews with 50 key informants from 18 of New Zealand's 20 districts. We interviewed between two and four participants from each district who were purposively selected because of their direct involvement in implementing the SLM framework. Participants were asked for their perceptions and experiences regarding the overall design logics of the performance framework and its fit with other planning and funding processes in the district; structural and functional aspects of the District Alliance; collaborative capacity of organizations in the District Alliances in developing and implementing the SLM Improvement Plans; usage of the PHO capacity and capability funding; and data capacity of the individual organizations and the District Alliances. Among other questions, participants were asked about their perceptions and experiences regarding the use of the capacity and capability funding.

Interviews were conducted in person, over the phone or through a video link and respondents were asked direct questions about the use of the capacity and capability funding. Interviews were audio recorded and interview transcripts were transcribed verbatim. We developed an initial coding scheme that was adapted from the semi-structured interview schedule to categorise the data using NVivo qualitative data analysis software Version 12 (QSR International, Melbourne, Australia). Interview material relating to the capacity and capability funding was coded deductively from the specific interview question, and inductively from material throughout the interview transcripts.

The research was approved by the University of Auckland's Human Participants Ethics Committee (UAHPEC Reference No. 01976 on 8 July 2017).

Results

Use of capacity and capability funding

We identified three broad ways in which the 'untied' 75% of capacity and capability funding was used at the district level. Although our three categories are not mutually exclusive, our sites were almost evenly distributed between these three 'types of use'. Altogether, seven districts invested the funding in resources to support quality improvement, six used the funding to incentivise practices, and it was unclear in five districts what the funding was used for.

Investment in resources to support quality improvement

There were examples of capacity and capability funding being used to enhance service integration. This was done by using the funding to incentivise the activities of working groups responsible for planning and implementing SLM Improvement Plans. In some districts, capacity and capability funding was invested in training sessions for primary care practice staff:

> 'We've got a whole list of what we'd spend the SLM on. On education for GPs and nurses, you know, so it all goes back really into the community in terms of the care of the patients. I think that's exactly what it is. It's for capacity and capability, cos we're trying to build them up and give them the funding in various ways to actually do that.' [District J, PHO]

In some districts, funding was used to provide equity training for personnel in general practices to strengthen expertise in addressing inequities, as this is a key feature of the SLM framework:

> 'We're using some of the under-spend from incentives that weren't reached, to fund the equity training as well. Because it became clear that not all of the … in general practices were able to apply that equity really well. So, we see that as a really good investment in making those things happen going forward.' [District E, PHO]

The capacity and capability funding was also spent by some districts on data management and information systems, including investing in electronic data management systems to enhance information sharing within alliances.

> 'How we use this particular funding is for the direct benefit of, financial benefit of practices. But it is to purchase things in a collective manner that contribute to the overall strategy and the delivery of the performance goals. So, examples of that are we provide some of the technology infrastructure for hosting the databases of our practices.' [District X, PHO]

Funding passed on to general practices based on performance incentives

In some districts, the capacity and capability funding was used to incentivise practices and reward them for performance against specific targets. This represented a continuation of the PHO Performance Programme and the Integrated Performance and Incentive Framework schemes, both preceding the introduction of the SLM framework:

> 'So, we have a pot of, say, $400,000. Each quarter, we put $100,000 into the pot and whoever achieves the targets, gets a share of that. Yeah. So, we've got some practices always achieve all targets. And we've got a couple actually that achieved none last time.' [District G, PHO]
>
> 'You know, and in part, that's what concerns me about the system level measures, because in the end, we just repackage the same, or it was a bit less I think, it ended up. But we just, we ended up giving them the same amount of money but got them to do something slightly different. But we haven't got them to do anything different. The work that's sitting in here is the work that sits as part of our system level programme. The money that's gone into the $23 million, hasn't gone into resources that support the integration work programme. It's just gone into whatever each PHO was using that money for before.' [District U, DHB]

Funding passed on to general practices unconditionally

Many respondents were unable to identify specific uses for the capacity and capability funding and reported that the funding was passed on to the practices for purposes that were not clearly defined. In some cases, the funding was simply passed on to the practices without being tied to any specific incentives:

> 'I know that there were those earlier discussions around that, but I've not seen any evidence of that funding being used. And I believe that they have an agreement that they talk to each other …. but I don't know that anyone's done anything. And I don't think it's being used for capacity building.' [District P, PHO]
>
> 'We've had some [SLM] payments. I can't tell you how much they've been over the last two years…ours have just gone straight back to the practices. Our PHO doesn't keep any of the funding. It more or less runs as a flat line….' [District R, PHO]

Issues and challenges with administering the capacity and capability funding

Perceived lack of clear guidance regarding capacity and capability funding

Many respondents from both DHBs and PHOs commented that there was not enough information from the Ministry of Health to guide the use of the capacity and capability funding:

> 'We still don't understand or didn't understand how do we use the funding arrangement, how can we be innovative around that funding, extricate it from its current baseline funding that goes through IPIF to primary care. How can we use that for something different and getting buy-in by being consistent? [District K, DHB]
>
> This is a really hard one, cos it's probably something that everyone's grappled with this year. Cos it's not very clear about that funding.

So that is something the IPIF was, it was really clear with what to do, you met the target, you got the money, and it also enabled you to have resources to make sure you met that target. And this is a lot less clear and kind of, amenable mortality has got no money at the moment, it doesn't attract separate funding, or doesn't attract a proportion. So, there's 75% for capability and capacity, and then the 25% for meeting the targets.' [District B, PHO]

Some DHBs considered the funding should be tied to specific standards of PHO performance, even as the Ministry of Health was encouraging a move away from this more transactional approach:

'And there isn't actually any accountability back to the DHB in terms of outcomes. So, we are going to have to have some conversations. In fact, I'm not even allowed to see practice level data.' [District S, DHB]

Respondents from the DHBs often highlighted the absence of transparency and accountability regarding the use of the funding. They also noted the lack of willingness on the part of the PHOs to invest in initiatives that promote quality improvement and better service integration.

A distraction and a barrier to integration

Many respondents from both DHBs and PHOs commented that the capacity and capability funding was a barrier to improved integration between health sector organisations. As only PHOs had access to the capacity and capability funding, other critical stakeholders, including secondary care services and non-government organisations, were not funded to implement SLMs. This was seen as a potential disincentive for better service integration and effective collaboration:

'My point of view would be if we want a truly collaborative environment, then all the players in that system level space need to have some resource that is tagged to that collective effort otherwise you're just gonna have the tail wag the dog.' [District X, PHO]

'Yeah, nothing. I wish it would go away. We don't do anything with that funding. We bulk funded out via the PHOs to support them to have the infrastructure to respond.' [District Y, DHB]

Insufficient funding for intended purposes

PHO interviewees saw the capacity and capability funding as insufficient to embark on new business models that enhance quality improvement and service integration:

'I'll first make a comment too is that the sum of money that we're talking about is completely inadequate to meet the goals of any of the programmes, is a general observation.' [District X, PHO]

'They very much saw this new pot of money as an opportunity for them to do better integration across the system. But with no additional funding, it meant that the PHOs were going to have to rationalise their funding.' [District K, PHO]

Discussion

Overall, our findings lead us to question the appropriateness of the capacity and capability funding for promoting quality improvement and integration. The Ministry of Health unit responsible for SLM implementation has consistently signalled a move away from a carrot-and-stick approach to health sector performance in favour of persuasion and collaboration, and has adopted a facilitative approach to encourage desired behaviours. Although 50% of the SLM funding is subject to the Ministry's approval of SLM improvement plans, in practice, this funding has not been withheld and rarely delayed. This more permissive funding regime has attracted the attention of the Health and Disability Review. The Interim Report noted that the SLM capacity and capability funding had not been withheld 'despite milestones being frequently missed'.[21]

Our research suggests that districts using the capacity and capability funding for its intended purposes were outnumbered by districts in which pre-existing incentive-based regimes were subject to minor tweaks or where the funding was simply passed on to practices. These behaviours can be understood in terms of historical policy and funding legacies of the PHO Performance Programme and the Integrated Performance Improvement Framework, which cast a long shadow over SLM implementation.

Findings from this study have shown that financial incentives can be catalysts for quality improvement and better service integration, particularly where the funding regime allows flexibility. Organisations and alliances in some districts appreciated the scope for experimentation that had been created; however, in some districts, participants thought there was a lack of clarity regarding the criteria for receiving the funding. Combined with the absence of sanctions, this created space for PHOs in many districts to take the path of least resistance by either largely continuing past incentive-based practices or passing the funding directly to practices. This is consistent with other research into policy settings in which only a minority of implementers are comfortable with ambiguity and the absence of more directive policy requirements.[22]

Second, the fact that only the PHOs and their network of general practices have access to the capacity and capability funding is widely regarded as a major barrier to integration as there is no dedicated funding to motivate other members of the alliances, including secondary care services and non-government organisations. This is a legacy of a ministerial decision in 2016 not to allocate any additional resources to SLM implementation. In theory, DHBs and non-governmental organisations could add to the pool of SLM funding; however, at a time of highly constrained DHB finances and ballooning deficits, none have done so, although they have dedicated significant amounts of staff time to SLM processes. These findings are consistent with other research that shows siloed funding mechanisms hinder effective collaborative working relationships and better service integration, especially when incentives apply to only some actors.[12]

The barriers highlighted above are likely to have been accentuated since 2018 due to the effect of COVID-19. Although there are some indications that the pandemic has had positive effects on collaboration between primary care and DHBs in some localities, it has possibly added a further layer of tensions to PHO–DHB relations. Uncertainty regarding the future status of PHOs as a consequence of the Health and Disability Review's Final Report[23] will also act as an impediment to the type of collaboration envisaged in the SLM framework.

Findings from this study should be interpreted with some caution as we could not capture the views of all relevant stakeholders involved in implementing the SLM framework. In most cases, two participants were interviewed from each district alliance; their views may not adequately reflect the full range of perceptions; however, the convergence of views of DHB and PHO respondents within districts gives us confidence in our interpretations. The study was conducted in 2018, during the bedding-down of SLM framework, so it is possible that some perceptions and practices have changed since that time.

Mismatch between the purpose of the SLM capacity and capability funding and its use in practice is primarily a product of incremental and inconsistent policy development regarding primary care improvement. In an environment in which no additional funding was allocated for SLM implementation, it was a very tall order to take an existing source of 'stick-and-carrot' funding of specific organisations and transform it into a vehicle for building capacity for collaborative, inter-organisational practices of quality improvement and integration. This challenge is analogous to repurposing a refrigerator to heat food. You might get a few creative solutions, but expecting health sector organisations to redeploy an existing technology to achieve the opposite of what it was designed to do is bound to lead to frustration.

Competing interests

The authors declare no competing interests.

Funding

This research was funded by the University of Auckland Faculty of Medical and Health Sciences Faculty Research Development Fund (NZ$168,000).

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