Performance measurement and improvement: issues and challenges

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Why the quest for improved performance?

- Health systems are under stress
  - Increasing expectations
  - Reluctance to pay more
  - Concerns about safety and quality
  - Concerns about equity
Why the emphasis on measurement?

• To improve the decision making of key actors
  – evidence-based consumption
  – evidence-based medicine
  – evidence-based management
  – evidence-based policy

• Applies equally to prevention, treatment and long term care
Chart 1. The performance measurement and management cycle

Adapted from Nutley and Smith, 1998.
## Chart 2.
### Health System Objectives

<table>
<thead>
<tr>
<th></th>
<th>Average level</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health improvement/outcomes (+)</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Responsiveness and access (+)</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Financial contribution/health expenditure (-)</td>
<td>✔️</td>
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Adapted from Murray, C.J.L and Frenk, J. (2000)
Measurement of health improvements/outcomes

- survival rates following life-threatening events
- avoidable mortality
- avoidable morbidity
- process measures (e.g. V&I, screening)
- adverse events
Measurement of responsiveness

- satisfaction versus experience
- patient-centredness
  - e.g. information about choice of therapy
- timeliness
  - e.g. waiting times
Measurement of efficiency

• maximizing the ratio of a weighted sum of health improvements and responsiveness to a given level of health expenditure
  – determined mainly by micro behaviour
• setting the ‘right’ level of health expenditure
  – often determined mainly by governments
• difficult to operationalise either
Measurement of equity

- equity of health
- equity of access
- equity of payment for health care
Analysis

- isolating causes of variations
- risk adjustment
- identifying policy levers
  - level of resources
  - mix of services/real resources
  - institutional characteristics/incentives
  - regulation/self-regulation
- assessing ex ante and ex post the cost-effectiveness of interventions
- setting and reviewing targets
Action

• 4 sets of key actors
  – consumers
  – professional providers
  – managers
    • purchasers
    • providers
  – government
Example: geographical equity in access to hospitals in England

- Little progress first 25 years NHS
- Demonstration of ‘Inverse care law’, 1970
- Resource Allocation Working Party 1975
- Very gradual achievement of equitable funding
- New objective, 2000 - equity of health
Informing actions

- in an ideal market all actors would be perfectly informed
- but incomplete and asymmetric information characterises health care
- hence ‘agency’ role for providers and incomplete contracts
- importance of self regulation
Incentivising actions

- In an ideal world all actors would be properly incentivised
- But public insurance separates the citizen as patient from the citizen as taxpayer
- Insured patients are heavily subsidised
- Because of information deficiencies, it is difficult to pay providers by results
The roles of actors and the nature of incentives differ across OECD health systems

• mixes of 3 main types of sub-system
  – private market
  – public contract
  – public integrated

• Impact of performance measures will vary
  – e.g. consumers in the US versus consumers in the UK
  – e.g. government in the US compared with governments in Canada or the Netherlands
Chart 3.
Type 1 - Health systems with private health insurance and private providers.
Key actors in relation to objectives.

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<tr>
<th>Objectives</th>
<th>Responsiveness</th>
<th>Health Outcomes</th>
<th>Prices and unit costs</th>
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<tr>
<td>Consumers</td>
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Chart 4.  
Type 2 - Health systems with social health insurance and private or mixed providers.  
Key actors in relation to objectives.

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Chart 5.
Type 3 - Health systems with general taxation funding and public providers. Key actors in relation to objectives.

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Case studies of applying performance measures in different systems

- Netherlands
- Sweden
- UK
- US
Be alert for tradeoffs

- quantity at the expense of quality
- efficiency at the expense of equity (and vice versa)
- paperwork at the expense of service delivery
- extrinsic motivation at the expense of intrinsic motivation
Be alert for unwanted side effects

• misrepresentation and fraud
• tunnel vision
• myopia
• complacency
• gaming
Exploiting international comparisons

- OECD’s project on the causes and consequences of different rates of diffusion of technologies for specific diseases
- WHO’s comparisons of performance and what determines the variations
Key questions?

• How do we overcome the lack of health outcome measures?
  – Speed up the introduction of record linkage and electronic patient records?

• How do we better align incentives with policy objectives?
  – pursue payment by results?

• How do we reconcile self-regulation with accountability?
  – Give more support to self-regulation, establish a presumption of ‘no blame’, but require more openness?