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Review

Contrasting approaches to primary care performance governance in Denmark and New Zealand

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ABSTRACT

In high-income countries, the arena of primary health care is becoming increasingly subject to 'performance governance' – the harnessing of performance information to the broader task of governance. Primary care presents many governance challenges because it is predominantly provided by sole practitioners or small organisations. In this article we compare Denmark and New Zealand, two small countries with tax-funded health systems which have adopted quite different instruments for performance governance in primary care. Denmark has adopted a 'soft hierarchy' approach to primary care performance based on accreditation processes but few strong sanctions, whilst New Zealand has relied on a combination of explicit hierarchical targets and financial incentives. These differences are attributable to: primary care institutional arrangements, – specifically, the presence or absence of 'intermediate organisations'– ; the degree to which policy processes are corporatist or pluralist; and the mix of objectives of primary care policies. We conclude that New Zealand's approach has relied heavily on 'extrinsic' incentives, whereas Denmark exhibits the opposite problem of overreliance on intrinsic motivation to improve quality, without 'extrinsic' instruments to address other important goals such as population health and equity. Our comparative framework has the potential to be applied across a wider range of countries.

1. Introduction

Within the governance of healthcare systems in industrialised countries, primary care occupies a highly ambivalent position. Governments can be expected to have a strong interest in governing primary care: general practitioners are often the first point of contact for patients, and in many healthcare systems primary care also has a gatekeeping function in relation to specialised hospital care. Primary care is a central switchboard for the allocation of healthcare resources, most of which are public, and this raises a number of governance concerns. Yet primary care is notoriously difficult to govern [1]. In most high-income country health systems, the majority of general practitioners are independent, private entrepreneurs who are contracted for the provision of services in the publicly funded healthcare system.

Governments may be interested in steering primary care systems towards higher quality, improved access, more efficiency and more equitable health outcomes. Each of these domains has been construed as an important dimension of performance that is to be governed. This requires designing mechanisms for the collection and interpretation of performance information. According to Bouckaert and Halligan [2] the basic rationale underlying the notion of performance governance is to harness performance information to the broader task of governance. The ambition is to use quantitative or qualitative performance information regarding primary care professionals and/or the organisations they work for in order to inform, determine and implement policy that addresses perceived health system needs and problems [3] One example is the growing industry of comparative health system performance indicators such as those developed by WHO, Commonwealth Fund or OECD, but there is little evidence to date that these indicators are fine-grained enough to assist governments in steering primary healthcare. Performance governance in healthcare is also inherently challenging as it entails judgements that have tangible consequences for providers such as positive or negative sanctions, financial rewards and new forms of accreditation. Providers are part of an organisational field populated by professional groups whose practice is based on the use of specialised knowledge [4]. Not surprisingly, the practice of performance governance is more modest and the symbolic and organisational elements of performance governance are most prominent. Another important caveat is that it remains to be seen whether regimes of performance governance

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actually succeed in improving health system performance or not. Whether they do or can is beyond the scope of our analysis, and we are simply interested in the *attempt* which is still in its infancy.

In this article we compare and contrast the types of policy instruments used in primary care performance governance in Denmark and New Zealand. These two similar, small high-income countries with tax-funded health systems have been at the forefront of the development of performance governance [2,3,5]. Despite strong similarities, these countries developed significantly different ways of organising performance governance in primary care and we seek to understand why this is the case. Our article begins with an outline of the scope of performance governance. After introducing our rationale for comparison and the elements of our comparative framework we then provide a detailed account of primary care performance governance in each country in order to build our explanation of these different approaches, and we conclude by exploring the implications of our analysis.

2. Comparing primary care performance governance in Denmark and New Zealand

2.1. The particular context of primary care

In most high income countries, primary care is delivered by sole practitioners or small organisations that are only weakly controlled by governments even when such services are publicly funded [6,7]. The decentralisation of important governance functions in many countries has weakened the position of primary care and made it difficult for governments to formulate policy for it [8,9]. However, a range of trends, including shorter lengths of stay in hospitals, increases in chronic disease, and new technologies such as telemedicine have combined to stimulate increased governmental focus on primary care and its performance [10–12]. In the 1990s there were a range of organisational reforms to increase the power and broaden the scope of primary care [1]. In the context of market-oriented reforms, primary care promised to square the circle between efficient and high-quality health care, and thus became a proxy for integrating health services and people-centred care as well as for controlling doctors [13,14]. Since 2000, this has created a platform for turning to performance management, as a way to govern mainstream primary care and its performance [15,16].

2.2. Policy instruments of performance governance

This ambition to govern primary care through the generation, collection and dissemination of performance information can be realised through quite different means [3]. The dilemma for governments is whether (and when) to use sticks, carrots or gentle persuasion, as each of these approaches has a particular mix of benefits and side-effects. The dilemma for primary care professionals is how to initiate, respond and engage with these different approaches. The categorisation of hierarchies, markets and networks is a widely used schema of ideal types of social co-ordination that can be used to map policy instruments generally [17–20], and health policy instruments specifically [21,22]. This system of categorisation provides a framework suitable for international comparison of health policy instruments [23,24].

Hierarchical instruments involve the direct use of state authority to govern primary care performance. A prominent example was the requirement that English Primary Care Trusts meet a range of government-defined targets [25]. Governmental funding of services can be tied to satisfactory performance against these defined criteria. Hierarchical sanctions can be positive ('earned autonomy') as well as negative (reduced funding).

Market instruments are also prominent in the literature on performance management in primary care. These have generally been characterised as 'pay for performance' mechanisms [16]. General practitioners are incentivised by the prospect of increased income and/or increased autonomy to meet specified performance requirements. This is a central feature of the Quality and Outcome Framework in the UK [26,27]. Feedback on performance is incorporated into the funding mechanisms of primary care. Professionals are incentivised, rather than mandated, to meet performance standards.

Professional network instruments involve collegial processes of developing and deciding upon relevant indicators and feedback processes are institutionalised in different forms of professional self-regulation [8,28]. Such peer-based instruments are intended to leverage practitioners' intrinsic motivation, professional identity and clinical research base in order to improve performance. Compared to hierarchical and market instruments, professionals largely control the definitions and indicators of performance, and the ways in which performance information is interpreted.

Inter-organisational network instruments are those that operationalise collective objectives of primary care performance through networks of provider organisations [29]. A suggested advantage of these networks is that they can address the issue of diffuse control over performance by bringing together all the providers that have an impact on the performance goal. In common with professional network instruments, definitions and indicators are defined within the network. However, compared to inter-professional network instruments, network membership extends to a much wider range of provider organisations and professions.

Government initiatives to introduce instruments of performance governance in healthcare often interact with a myriad of already existing instruments, each drawing on different logics of governance [8,30,31]. The challenges of selecting and managing these different instruments of performance governance in healthcare are complex [28,32,33] as each has strengths and weaknesses. Hierarchy and/or market (extrinsic) instruments potentially pull in opposite directions to both types of network (intrinsic) instruments, as Clarke and Newman [34,35] highlight in their concept of the knowledge-power knot. Extrinsic motivators are characteristically brittle and shallow, encouraging 'tick-box' approaches to performance at the potential expense of deeper problem-solving [36]. Intrinsic instruments, on the other hand, privilege the power and preferences of providers (primary care medical professionals) potentially at the expense of broader, system-wide goals [37]. Tensions between extrinsic and intrinsic motivators of performance play out in relations between government and the public and between professions and organisations. Such tensions and dilemmas are not irresolvable, however, and the challenge of performance governance is the development of approaches that establish and maintain 'virtuous circles' of extrinsic and intrinsic instruments [38].

2.3. Denmark and New Zealand – similar health systems, contrasting instrument choices

Denmark and New Zealand exhibit major differences in the types of instruments adopted. In Denmark, the approach to performance governance is cautious and can be characterised as "softly hierarchical" reflecting a combination of network and hierarchical instruments, but without the deployment of sanctions. The national and regional governments, in close collaboration with the GP trade union-cum-interest organisation, initiate and devise various instruments. At the centre is a system of accreditation based on a range of clinical and organisational standards, which is combined with a system of data collection relating to the services provided