UPFRONT

The Integrated Performance and Incentive Framework (IPIF):

What has changed and how does it affect primary care?

On June 30, 2014, the PHO Performance Programme (PPP) ceased and was replaced with an interim arrangement based on five targets previously used by the PPP. This interim arrangement will expand and evolve over the next 12 months into the Integrated Performance and Incentive Framework (IPIF). Like PPP, IPIF is a quality improvement programme. The goal of IPIF is to support the health sector in addressing equity, safety, quality and cost of services. IPIF aims to set high-level directions for improved effectiveness and productivity of health care for all New Zealanders. The development of IPIF and its implementation is an evolving process being led by clinicians, sector leaders and PHOs, that will reflect local and community priorities.

The first measures and targets for IPIF for 2014/15 were selected to provide continuity with the PPP and because reliable data exists to demonstrate performance (Table 1).

As with PPP, payments will be calculated each quarter, on the basis of the PHO's performance commencing on July 1, 2014.

IPIF recently released its second sector update and further updates will be provided at least monthly. In the first weeks of the interim programme, we asked Dr Richard Tyler, co-Chair of the IPIF Joint Project Steering Group, for his personal views on how he sees the implementation and evolution of IPIF affecting primary care.

Table 1: Measures, targets and funding for the Integrated Performance and Incentive Framework as of 1 July, 2014

Measure	Target	Proportion of funding
More heart and diabetes checks	90%	25%
Better help for smokers to quit	90%	25%
Increased immunisation rates for infants aged eight months	95%	15%
Increased immunisation rates for infants aged two years	95%	10%
Cervical screening	80%	25%

What were the key reasons for replacing the PHO Performance Programme (PPP) with the Integrated Performance and Incentive framework (IPIF)?

RT: *The idea of replacing the PPP was to find some measures which were more meaningful to good patient care and could reflect how the whole system was working. If a system is working as one there is a seamless transition from primary care to secondary care and back to primary care. A system that does this is working well for its population, and we want measures that will incentivise this.*

The New Zealand Government's budget for health spending in 2013–14 was $14.65 billion. This has increased steadily as a percentage of gross domestic product (GDP) from 6.8% in 1990 to 10.1% in 2010.* With an ageing population, improved diagnostic techniques, an ever-expanding choice of treatments, combined with a continual need to drive evidence-based improvement this cost will continue to grow. IPIF aims to create efficiency by unifying the health sector, promoting cost-effective use of resources, as well as focusing on reducing waste.

There is also a need for strategic alignment between existing and former programmes, e.g. the DHB Accountability Framework, the PHO Performance Programme, as well as various other programmes.

* Cumming J, McDonald J, Barr C, et al. New Zealand Health System Review. Health Syst Transit;4:xviii.

What are the main differences between how PPP operated and how IPIF will function in the future?

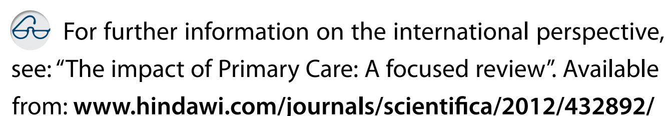
RT: *IPIF is intended to be a whole of system measure so requires the primary and secondary sectors to be working as one. Each will have important targets but the overall goal will be a synergy between the two to the benefit of the patient.*

The current challenges for the New Zealand sector are to: reduce inequalities, manage long-term conditions, reduce waiting times and improve productivity. IPIF hopes to meet these challenges by facilitating greater co-ordination than currently exists between primary and secondary care, and between other social services.

Is IPIF being modelled on international experience? What is the evidence that its implementation will improve outcomes within the health sector?

RT: *International experience is that the more care that occurs in the community the better the outcome. This is perhaps best illustrated in the care of the frail elderly who have been shown to lose condition and have poorer outcomes when hospitalised. International experience also shows much better outcomes and better patient experience when there is a seamless transition in and out of hospitals and the health system is working as one.*

A number of international studies have shown not only that investing in primary care improves patient outcomes, but that the more health care is coordinated by primary care, the better the outcome for patients. We can expect the role of the primary care clinician as "gate keeper" to health sector resources to evolve and expand as IPIF develops.


For further information on the international perspective, see: "The impact of Primary Care: A focused review". Available from: **www.hindawi.com/journals/scientifica/2012/432892/**

What are the immediate changes that clinicians in primary care may see as IPIF is implemented?

RT: *This will depend on how well local alliances are working. Over time clinicians in primary care are likely to be part of a more comprehensive team. There will also be more collaboration and interaction with hospitals and specialist services as primary care becomes better supported and is able to provide more comprehensive home care for patients and deliver more care in the community.*

The recently released sector update states that "much of the detail around IPIF has still to be developed." What changes can primary care health professionals expect to see over the coming years?

RT: *IPIF is a framework which requires the measures to be added to it. Some measures will be common across all communities and others will be specific to those communities and developed locally. Yes, there is still a lot of work to do on the specific measures.*

While many of the specific measures are yet to be announced, it would be reasonable for primary care to expect alignment and synergy with other programmes. For example, the IT Health Board's push to implement patient accessible electronic health records. This allows patient's electronic records to be shared between different areas in the health sector. In the Wairarapa DHB, this technology has been available since 2011. In the Capital and Coast DHB over 80% of patients records are accessible by electronic portal making them available to health professionals in primary care, after-hours clinics and hospital departments.

The first measures of IPIF do not refer to high need populations, i.e. people of Māori or Pacific descent, or people who live in the most deprived socioeconomic areas. How will the IPIF address issues of inequity within the health system?

RT: *I acknowledge this is lacking and this has been recognised by the steering committee as an important issue; a special work stream has been established to address this.*

Despite improvements being made since the mid-1990's, Māori and Pacific peoples continue to experience significantly lower health status than the majority of New Zealanders. With the "whole sector" approach of IPIF, it is hoped that this will result in improved partnerships between primary care and whanau ora services in Māori communities.

What tangible benefits are likely to be experienced by clinicians in primary care as a result of IPIF?

RT: *Benefits will evolve and will take time but they will likely see primary care clinicians have greater professional autonomy accompanied by better access to specialist support and investigative procedures. It is anticipated that they will be working more closely and collaboratively with hospitals, colleagues and other health professions such as Pharmacy. They will likely be part of a larger and more comprehensive primary care team. We also anticipate that primary care clinicians will have greater job satisfaction.*

In the draft IPIF framework, it is stated that it is expected that the implementation of IPIF will allow for:

- A minimum standard for service provision
- Potential support for clinical governance and professional development
- Greater individual influence over service development and priorities for professionals working within organisations that are achieving high levels of performance
- Improved access to referred services on a performance related basis

For further information on IPIF, including sector updates, see: **http://www.hiirc.org.nz/section/35484/integrated-performance-and-incentive-framework/**

Dr Richard Tyler is a General Practitioner based in Wellington. He is co-chair of the IPIF Steering Committee and is also chairman of Compass Health and the Medical Assurance Group of Companies, as well as being on the board of directors of bpac[nz] and an Executive Committee member of General Practice New Zealand.