

WHAT HAVE WE LEARNT FROM TEN YEARS OF PERFORMANCE MANAGEMENT IN THE HEALTH SECTOR?

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OUTLINE

What is performance management

PM Enduring dilemmas – Accountability vs Learning

PM in the New Zealand health sector

Health Targets (2009-17)

System Level Measures (2016 -)

Can we have our cake and eat it?



WHAT IS PERFORMANCE MANAGEMENT?

Performance management – “a type of management that incorporates and uses performance information for decision-making” (van Dooren et al 2010: 30)

- Not just performance measurement
- Must involve (at some level) valued outcomes
- Requires feedback loop (real-time learning)
- Beyond financial performance

HOW TO CATALYSE PERFORMANCE IMPROVEMENT?

Inputs



Processes



Outputs



Outcomes



CHRISTOPHER POLLITT'S PM QUESTIONS

- 1) Who is it for? (the audience)
- 2) What should be measured (outputs, outcomes etc)
- 3) Sanctions/ consequences?
- 4) Who measures? (internal/ external)
- 5) What criteria define good performance?
- 6) How often to change?

(Pollitt 2018)

PERFORMANCE MANAGEMENT: ENDURING DILEMMAS

Hierarchical / Accountability

Purpose: Accountability to External stakeholders (Minister, public)

Indicators: Outputs/Processes

How is Performance Co-ordinated?: Hierarchical (command and control)

Sanctions for (non)performance (Extrinsic motivation)

New Public Management

Network / Learning

Purpose: Learning / improvement, Internal stakeholders (service providers)

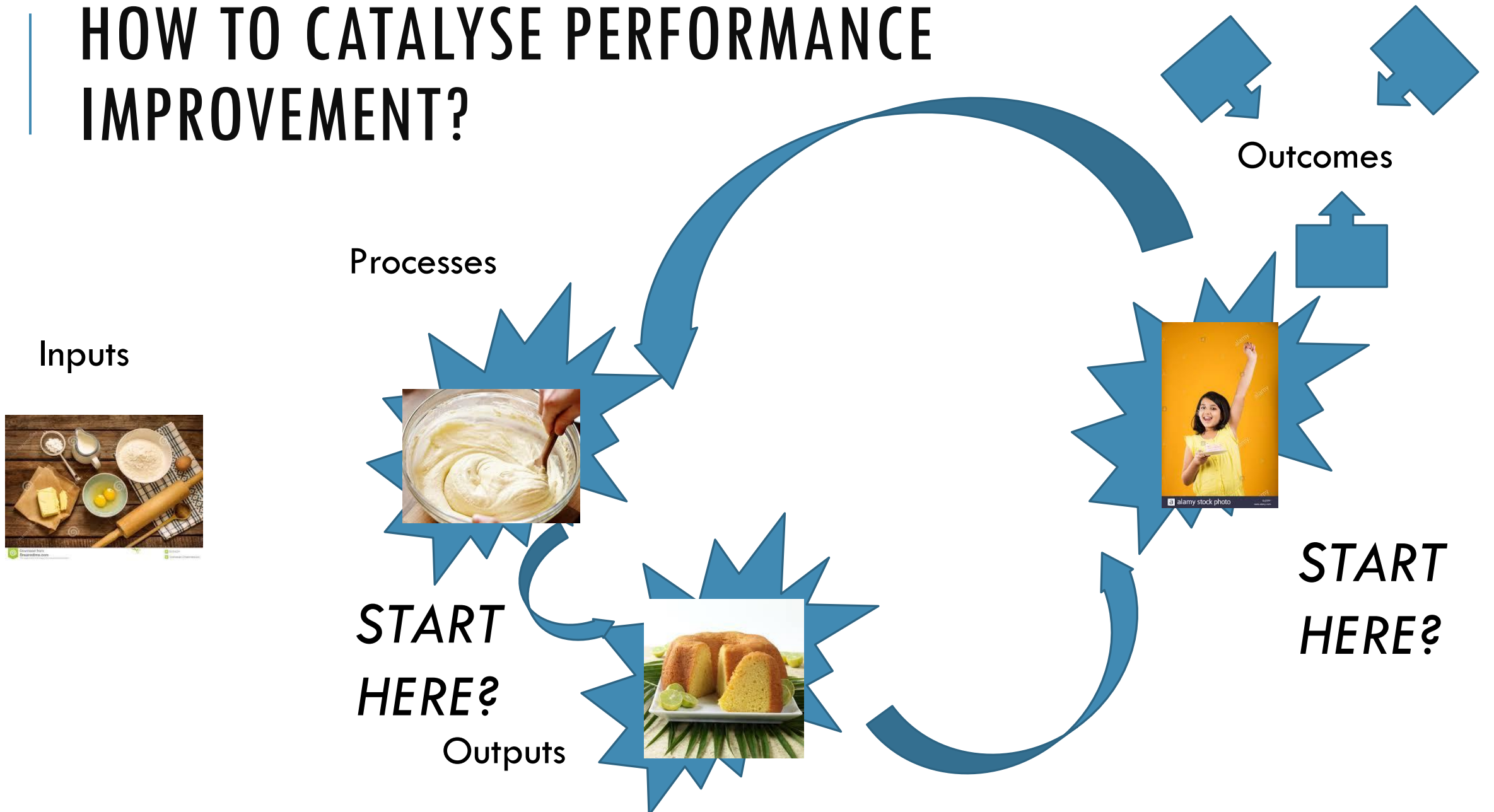
Indicators: More likely to be outcomes

How is performance co-ordinated? Network collaboration

Buy-in, trust, collegiality, not sanctions (Intrinsic motivation)

New Public Governance

HOW TO CATALYSE PERFORMANCE IMPROVEMENT?



PERFORMANCE MANAGEMENT FOR ACCOUNTABILITY (PM-A)

The Case For

Can stimulate real performance improvement

- Where links between PM outputs/processes and valued outcomes are possible

Provides clarity of expectations

Indicators (outputs, processes) within the control of single organisations

The Case Against

Futility

- Lack of feedback loop

Jeopardy

- Gaming / Cheating

Perversity

- Myopia, hitting targets, missing the point, effort substitution

PERFORMANCE MANAGEMENT FOR LEARNING (PM-L)

The Case For

Stimulates inter-organizational collaboration
(necessary for achieving outcomes)

Builds on intrinsic motivation

Open dialogue, problem-solving, spirit of
enquiry

PM for learning facilitates virtuous circles of
trust

Double loop learning, fits with complex
adaptive systems

The Case Against

Good performance is voluntary

Why assume intrinsic motivation? (there are
'knaves' as well as 'knights')

Diffused responsibility = no accountability

Problems in attributing change (or lack of
change) of outcomes

Good practice/performance unlikely to scale
up and spread

ACCOUNTABILITY AND LEARNING — CAN YOU HAVE YOUR CAKE AND EAT IT?

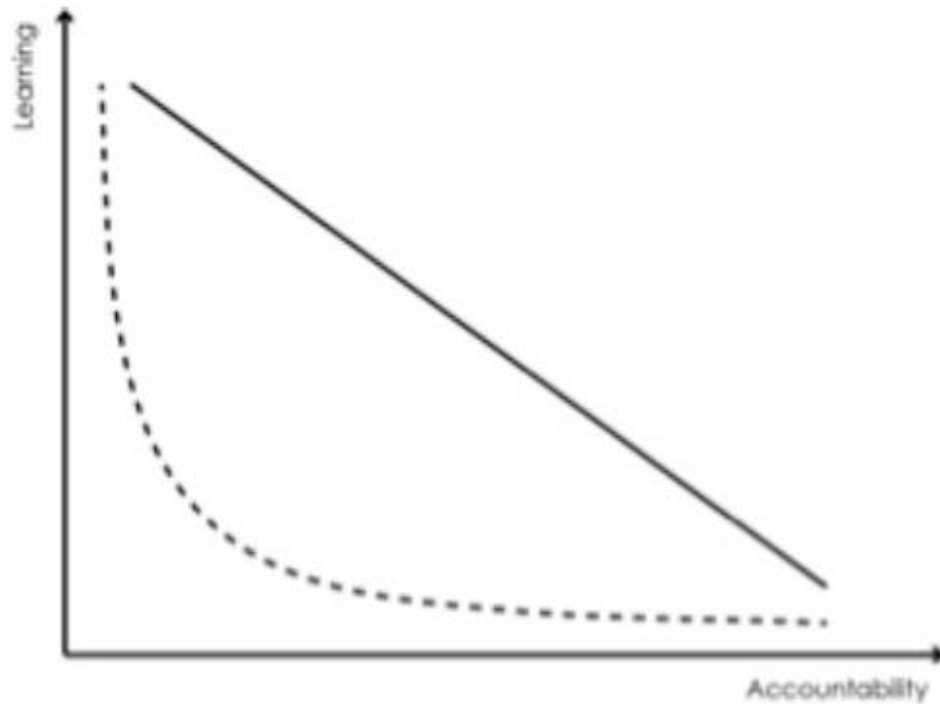


Figure 1: Trade-off between accountability and learning (Hoffmann, 2010,

Van Dooren and Hoffman (2018)

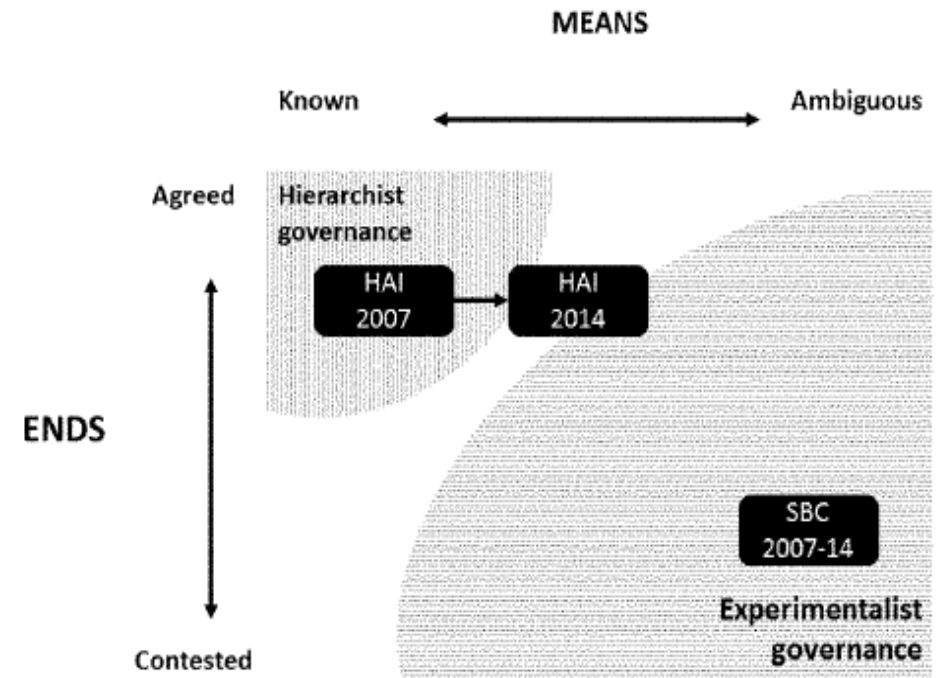


Figure 1. Ambiguity over goals and means in relation to governance style. HAI = health care-associated infections; SBC = shifting the balance of care.

Schang and Morton (2017)

KEY CRITERIA FOR EVALUATING PM

- Does it work (improve valued outcomes)?
- If so, how?
- Did it change behavior?
- Is it able to generate a performance feedback loop?
- What *other* consequences does it produce?

THE PM DILEMMA IN THE NZ HEALTH SECTOR

Health Systems

- Historically dominated by professional power (particularly medical profession)
- Professionalism and the issue of intrinsic/extrinsic motivation
- Growth of Quality Improvement as an 'internal movement'
 - Appears consistent with PM for learning

New Zealand public sector

- Highly extensive reach of NPM (in its more hierarchical form)
- Move to NPG varies across state sector

The Health System in 2020

The two contrasting models of PM are manifest in MoH structure!!!

the language of the Simpson Report is accountability for outcomes – is this the worst of both worlds?

BRIEF HISTORY OF PM IN NZ HEALTH SECTOR

Pre 2005, performance *measurement* without management

2005-8 beginnings of Pay for Performance in primary care

2007: Health Targets I (McKernan)

2009: Health Targets II (Ryall)

(2012): Better Public Services

2014: Integrated Performance and Incentive Framework (IPIF) Proposal

2016: System Level Measures

2021: ????

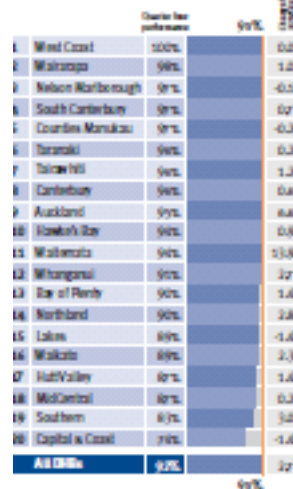
How is your DHB performing?

2010/11 QUARTER FOUR RESULTS

www.moh.govt.nz/healthtargets



Shorter stays in
Emergency Departments



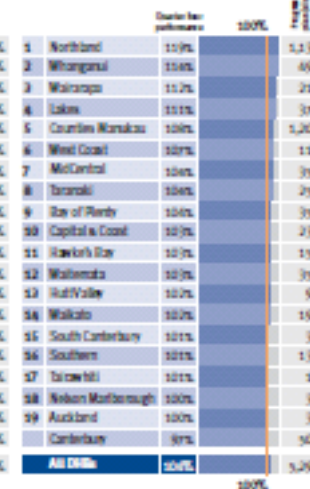
Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

Improved access to
Elective Surgery



Elective Surgery



Improved access to elective surgery

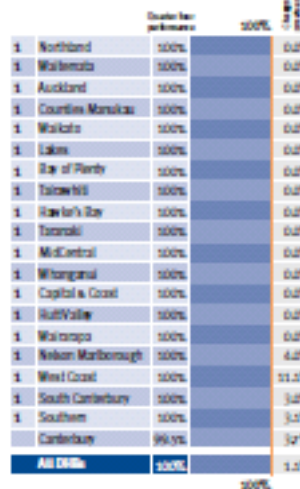
The target is an increase in the volume of elective surgery by an average of 4000 discharges per year.

DHBs planned to deliver 140,000 discharges per year to date, and have delivered 290 more.

Shorter waits for
Cancer Treatment



Cancer Treatment



Shorter waits for cancer treatment

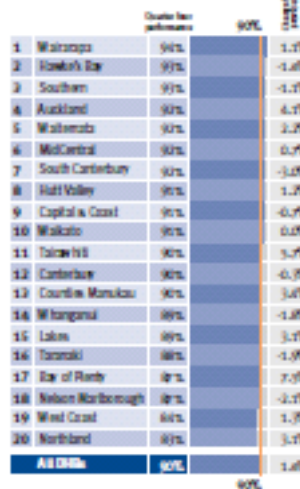
The target is everyone needing radiation treatment will have this within four weeks. Six regional oncology centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

Canterbury DHB's result is 99.9 percent. One patient waited three days longer than target as a result of earthquakes.

Increased
Immunisation



Immunisation



Increased immunisation

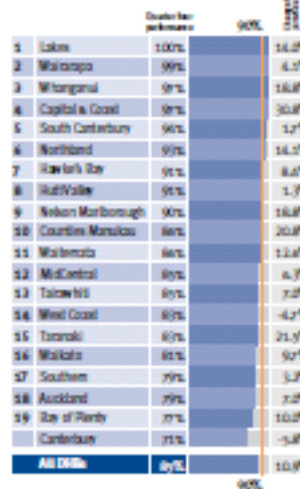
The national immunisation target is for 90 percent by July 2012, and 95 percent by July 2013.

This quarterly progress result includes children who turned two years between April and June 2011 and who were fully immunised at that stage.

Better help for
Smokers to Quit



Smokers to Quit



Better help for smokers to quit

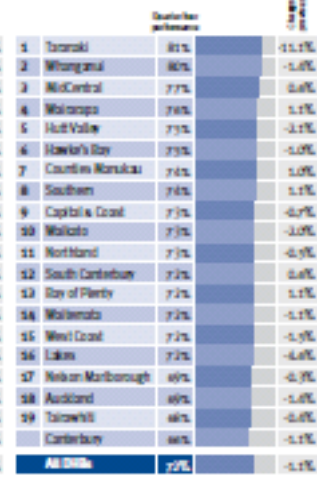
The target is that 90 percent of hospitalised smokers will be provided with advice and help to quit by July 2012, and 95 percent by July 2013.

The data covers patients presenting to Emergency Departments, day stay and other hospital based interventions.

Better
Diabetes and Cardiovascular Services



Diabetes and Cardiovascular Services

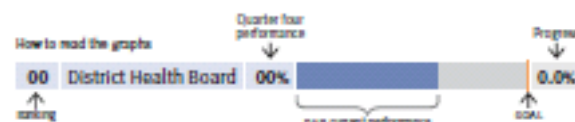


Better diabetes and cardiovascular services

This graph represents the average progress made by a DHB towards three target indicators:

- (a) an increased percent of the eligible adult population will have had their cardiovascular disease risk assessed in the last five years;
- (b) an increased percent of people with diabetes will attend free annual checks;
- (c) an increased percent of people with diabetes will have satisfactory or better diabetes management.

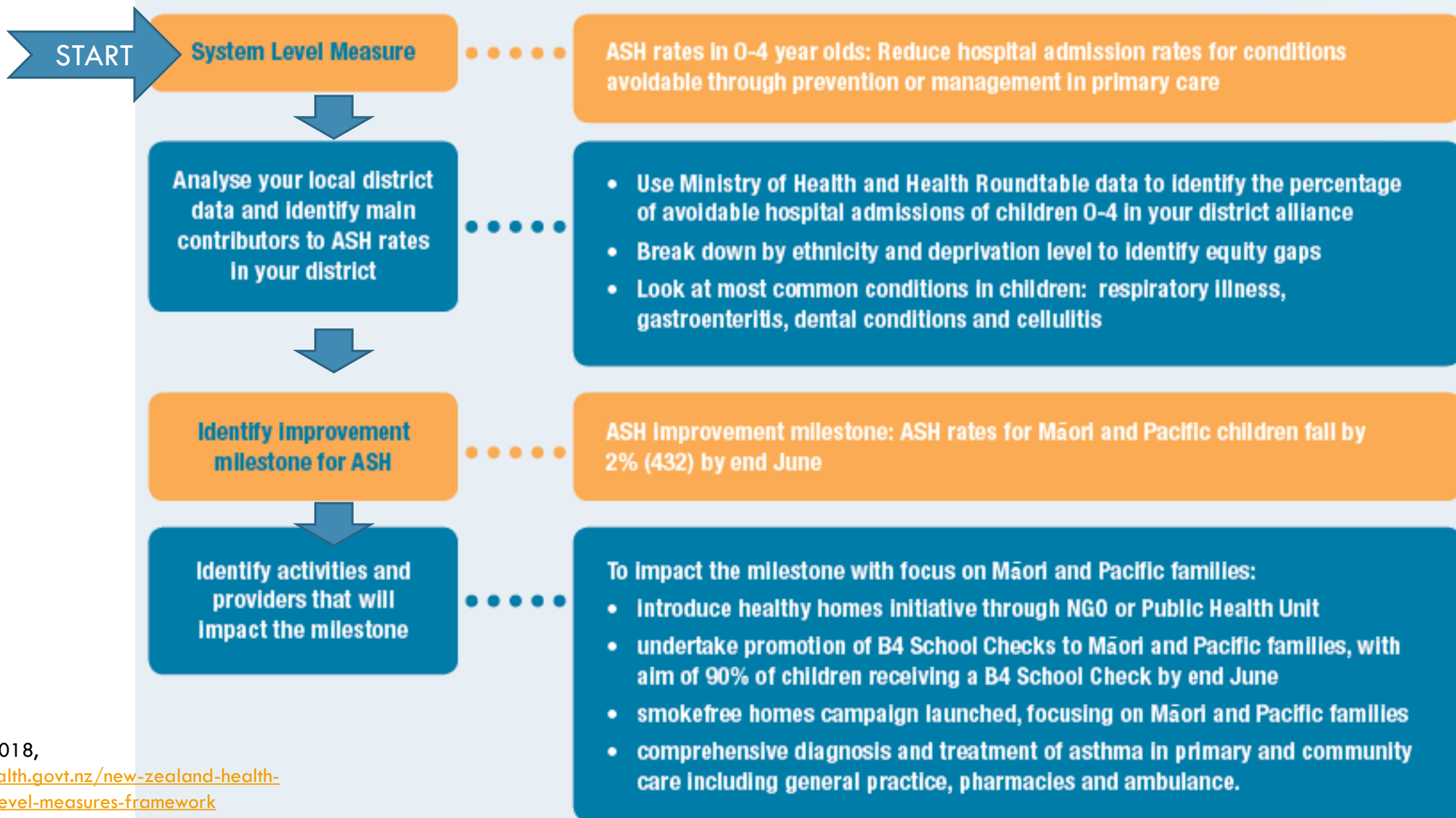
Canterbury DHB's performance has not been ranked in four of the six health targets in acknowledgment of the impact of the earthquakes on the DHB's year-end results.



This information should be read in conjunction with the details on the Website www.moh.govt.nz/healthtargets

SYSTEM LEVEL MEASURES FRAMEWORK

Headline Measure	Health System Objective and Explanation
Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds	Keeping children out of hospital
Acute hospital bed days per capita	Using health resources effectively
Patient experience of care	Person-centred care – this is made up of adult inpatient and primary care patient experience surveys
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. –consists of 5 domains.



HEALTH TARGETS AND SYSTEM LEVEL MEASURES: A SERIES OF NATURAL EXPERIMENTS?

Health Targets (combined with P4P in primary care) as a classic example of 'PM for accountability'?

- Yes, but some would argue that they could also facilitate learning

System Level Measures as a classic example of 'PM for learning'?

- Definitely, according to architects of SLMF

What can we learn for future regimes of Performance Management in health?

Can we have our PM cake and eat it (and if so, under what circumstances)?

RESEARCH INTO HEALTH SECTOR PM IN NZ

Health Targets

ED Target (Chalmers, Jones, Tenbensen et al)

Child Immunisation Target (Willing)

Elective Surgery (Gower)

More Heart and Diabetes Checks (Allen + Clarke)

(Advice on Smoking Cessation (Vaughan-Jones))

System Level Measures

SLM Implementation Processes (Tenbensen, Silwal, Walton, Ayeleke)

- Policy Formulation Process
- Implementation Processes at the District Level
- Capacity and Capability Funding

SHORTER STAYS IN ED TARGET

Did it catalyse improved performance (outcomes)?

- Yes, hundreds of lives saved

If so, how?

- Reduced ED Length of Stay facilitated by improving patient flow, more resources for EDs

Did it change behaviour in the system?

- Definitely, both positively and negatively – buy-in from ED docs, managers, some resistance from inpatient medical staff

Did it establish feedback loops between outputs/processes and outcomes?

- Difficult to establish, but gains appeared to be time limited (accrued before 2011)

What else happened (other consequences)?

- Jeopardy (widespread gaming/cheating via clock-stopping, use of short stay units)

Other comments

- Improvements happened early (and plateaued), gaming and cheating took hold from 2011

CHILD IMMUNISATION TARGET

Did it catalyse improved performance (outcomes)?

- Almost certainly yes

If so, how?

- Outreach services, close monitoring of eligible children by PHOs and DHBs

Did it change behaviour in the system?

- Definitely, enhanced co-operation and collaboration between DHBs and PHOs, and between districts

Did it establish feedback loops between outputs/processes and outcomes?

- Outcomes are too distant for this to be possible

What else happened (other consequences)?

- Collegial competition; inter-district learning, reduction of inequities, target fatigue

Other comments

- In retrospect, ceiling effect detectable – few primary care practices developed their own outreach, or alternatives

ELECTIVE SURGERY TARGET



Did it catalyse improved performance (outcomes)?

- That would require different research

If so, how?

Did it change behaviour in the system?

- Definitely, both positively and negatively – considerable changes in data management, management/clinician interface

Did it establish feedback loops between outputs/processes and outcomes?

- Difficult to establish without information about outcomes

What else happened (other consequences)?

- Futility, jeopardy and perversity

Other comments

- System highly complex, key role of service managers in 'buffering' tension between senior clinicians and senior managers

MORE HEART AND DIABETES CHECKS TARGET



Did it catalyse improved performance (outcomes)?

- None detected (statin prescribing as proxy)

If so, how?

Did it change behaviour in the system?

- Mostly positive –improved data management, buy-in from clinicians,

Did it establish feedback loops between outputs/processes and outcomes?

- No, (although some loops re outputs and intermediate outcomes?)

What else happened (other consequences)?

- Significant transaction costs, gaming (though treated as legitimate)

Other comments

- Focus on risk assessment, but not on risk management

IMPLEMENTATION CONSEQUENCES OF HEALTH TARGETS

	Did 'real' performance improve?	What else happened?	Other Comments
ED Target (Jones, Chalmers, Tenbensel et al)	Yes, estimated 700 deaths avoided per year (early)	Jeopardy (cheating), Perversity (myopia)	Positive effects early, negative effects later
Child Immunisation (Willing)	Yes, plausible to link increased imms to outcomes (herd immunity)	Better collaboration; negative impact was target fatigue (suggests myopia – effort substitution)	Performance deteriorated after target pressure was reduced Target enhanced equity
More Heart and Diabetes Checks (Allen + Clarke)	Too difficult to judge (synecdoche issues) – some effects on patient behaviour	Jeopardy (gaming – role of PHOs) Providers – buy-in varied significantly	High admin costs
Elective Surgery (Gower)	Too difficult to judge	Jeopardy (gaming) Perversity (myopia)	Variety of complex adaptations (many not that functional)

SYSTEM LEVEL MEASURES FRAMEWORK

Did it catalyse improved performance (outcomes)?

- Mostly – difficult to know

If so, how?

Did it change behaviour in the system?

- Stimulated collaboration at the local level, particularly between middle level management and clinicians,
- deepened and widened collaboration where good DHB-PHO relationships were present,
- not able to catalyse a change when DHB-PHO relationships were less collaborative

Did it establish feedback loops between outputs/processes and outcomes?

- Too early to tell (maybe for contributory measures; less likely for headline measures)

What else happened (other consequences)?

- Frustration with capacity and capability funding,

Other comments

- Potential for disenchantment?

PERFORMANCE MANAGEMENT FOR ACCOUNTABILITY (PM-A) — HEALTH TARGETS

The Case For

Can stimulate real performance improvement?

- Where links between PM outputs/processes and valued outcomes are possible
- YES: SSED and child immunization
- ??: Elective surgery and Heart & Diabetes Checks

Provides clarity of expectations

YES

The Case Against

Futility

- Lack of feedback loop
- In at least 2 of the 4 cases

Jeopardy

- Gaming / Cheating
- In 3 of the 4 cases

Perversity

- Myopia, hitting targets, missing the point, effort substitution
- All of the cases (but less in immunization)

PERFORMANCE MANAGEMENT FOR LEARNING (PM-L) — SLM FRAMEWORK

The Case For

Builds on intrinsic motivation

YES

Open dialogue, problem-solving, spirit of enquiry

YES

PM for learning facilitates virtuous circles of trust

In some places

Double loop learning, fits with complex adaptive systems

Perhaps in some districts

The Case Against

Good performance is voluntary

YES

Why assume intrinsic motivation? (there are 'knaves' as well as 'knights')

Diffused responsibility = no accountability

YES

Problems in attributing change (or lack of change) of outcomes

YES

ACCOUNTABILITY AND LEARNING — CAN YOU HAVE YOUR CAKE AND EAT IT?

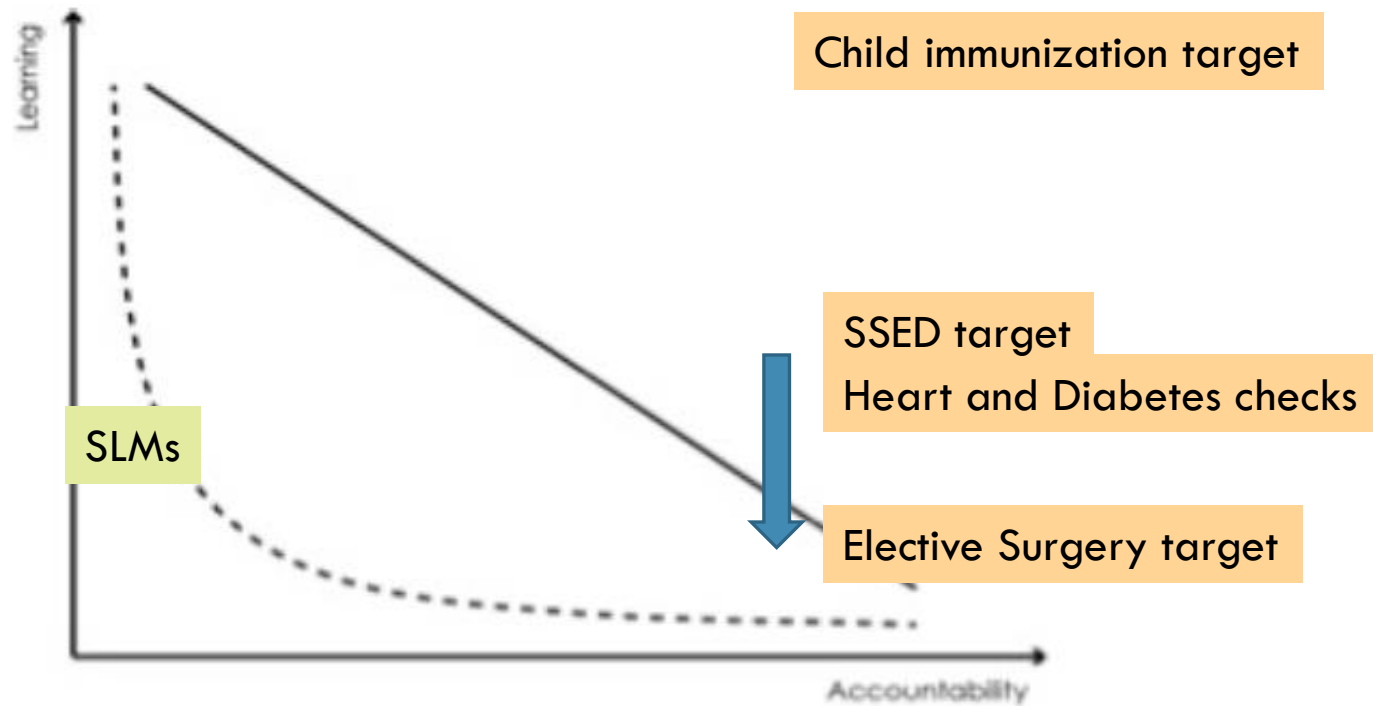


Figure 1: Trade-off between accountability and learning (Hoffmann, 2016)

ACCOUNTABILITY AND LEARNING – CAN YOU HAVE YOUR CAKE AND EAT IT?

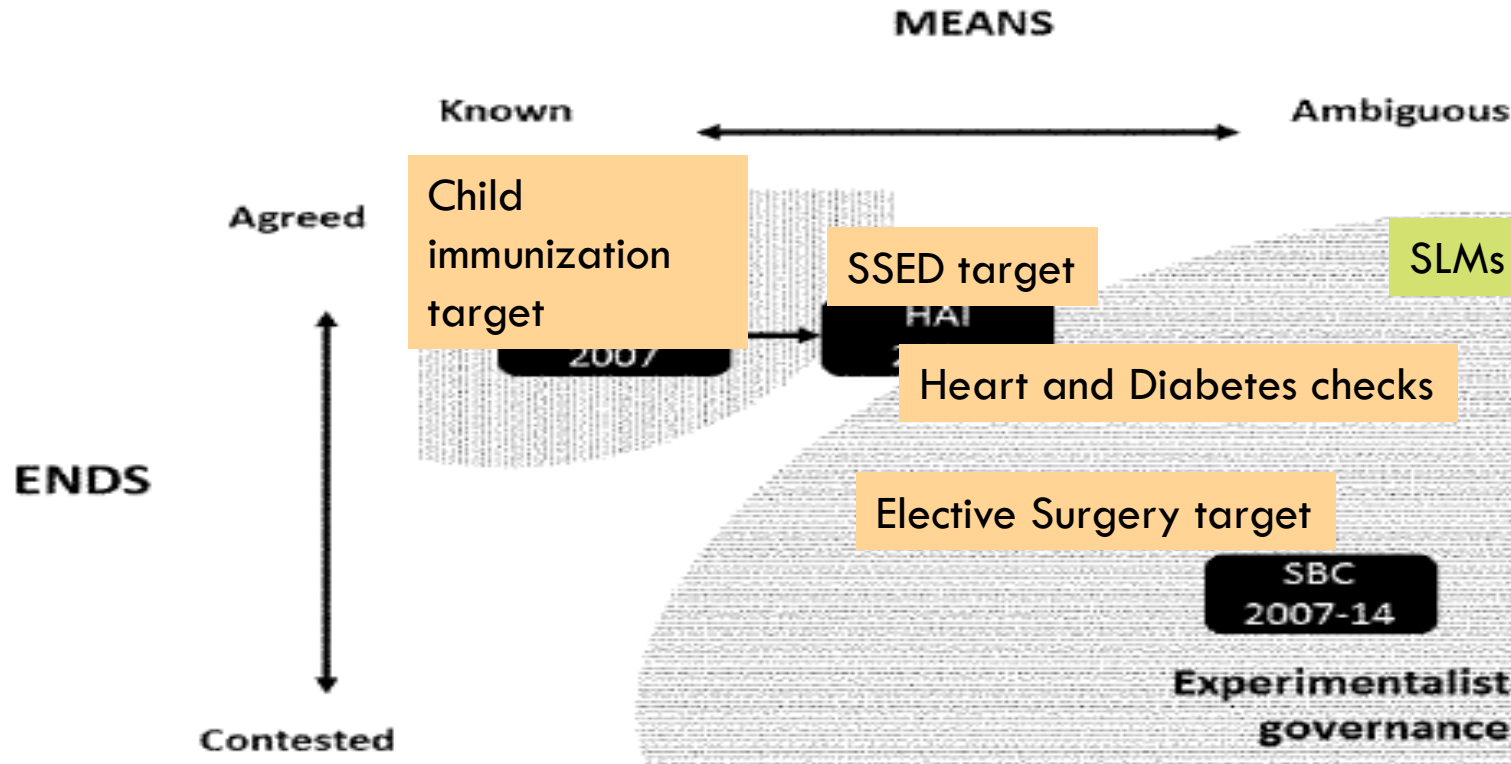


Figure 1. Ambiguity over goals and means in relation to governance style. HAI = health care-associated infections; SBC = shifting the balance of care.

Schang and Morton (2017)

THIS LOOP IS USUALLY NOT SELF-CONTAINED

Inputs



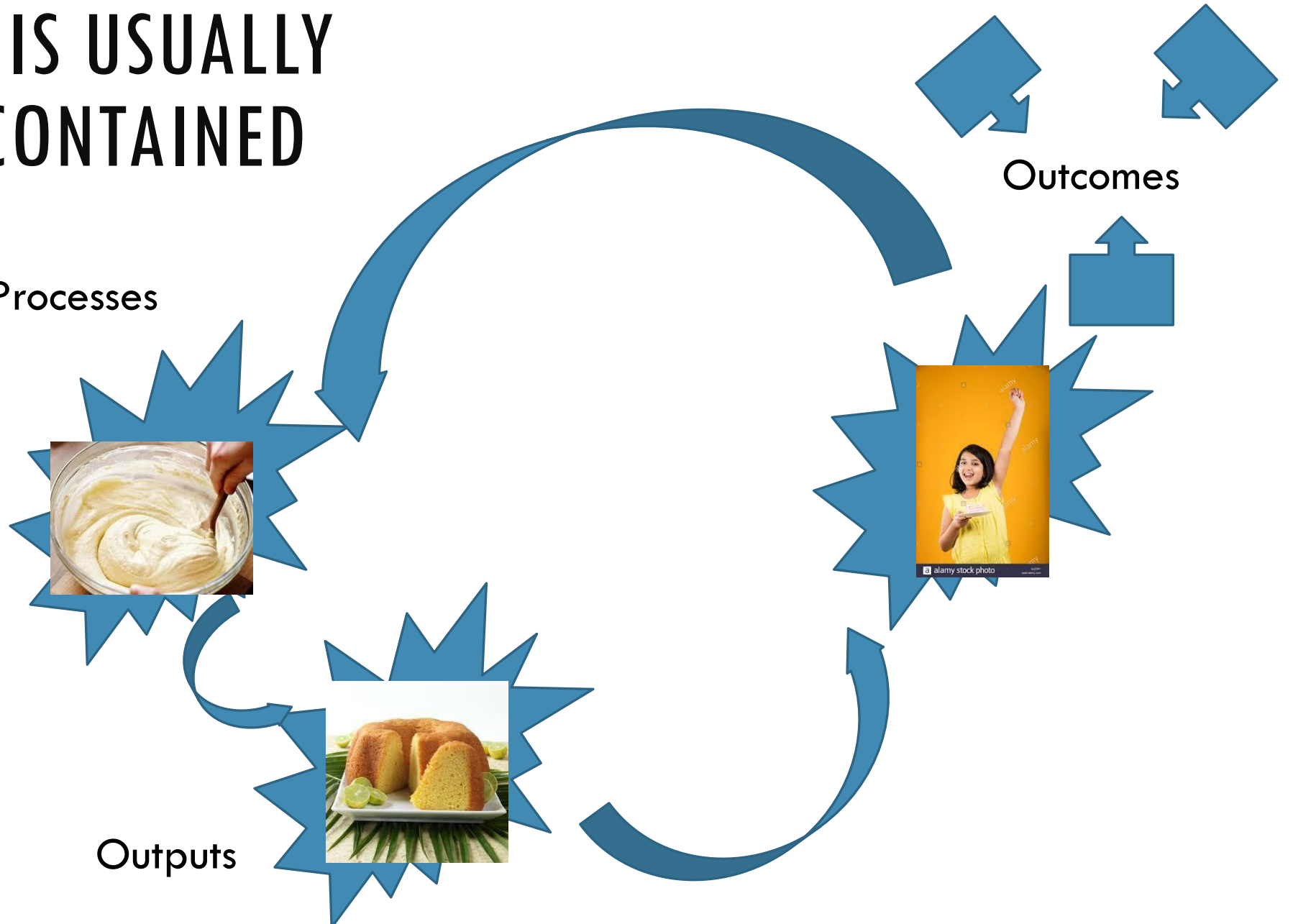
Processes



Outputs



Outcomes



THE CONDITIONS FOR PM FEEDBACK LOOPS ARE RARE

Independent verification of data

Very clear linkage between outputs/processes and outcomes (low ambiguity)

Absence of confounding factors influencing outcomes

WAYS FORWARD

- Where knowledge is limited, build from bottom-up
- Always try to find out what the indicator is doing when its at home
- In most (maybe all) cases, PM is not a substitute for evaluation
- Always be on the lookout for unintended consequences

IMPLICATIONS

The nature of the PM indicator may matter as much (or more) than the regime (ie PM-A or PM-L)

- A good indicator (eg child immunization) likely to ‘work’ whatever the regime

The key questions to ask about any PM indicator

- Can you demonstrate its effectiveness independently of the PM process?
- What are the side effects?
- What does the indicator do when it is at home?

THANK YOU TO:



Pushkar Silwal



Linda Chalmers



Esther Willing



Lisa Walton



Reuben Ayeleke

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