Primary care P4P in Portugal

Country Background Note: Portugal

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OECD Template for Case Studies of Innovative Payment Systems

Primary Care P4P in Portugal

Short description of the new payment scheme	In 2005, the Portuguese Ministry of Health started the restructuring of traditional healthcare centres into small autonomous functional units (teams of Family Doctors, Nurses and Clinical Secretaries), known as Family Health Units (USF) providing services with proximity and quality. The main objectives for this reform were to improve accessibility, efficiency, quality and continuity of care and increase the satisfaction of professionals and citizens. The main features are voluntary adhesion, teamwork, mandatory information system, performance- sensitive payment, contracting and evaluation.
Context and problem the reform aims to address	Portugal has had community healthcare centres since 1971 and a National Health Service since 1979. The Portuguese health system offers universal coverage for a full range of health services, financed mainly through general taxes and relying mainly on public provision of care. In recent decades, the economic and social situation in Portugal experienced significant progress, and the systematic improvement of health services has been internationally recognized. Although in general terms the health system looks good, in fact it continues to face many problems. The NHS is a highly centralized and bureaucratic structure; there are low incentives for good performance or quality. The job dissatisfaction is a challenge and a threat to the development of primary care. Doctors and nurses are public servants with fixed salaries without any incentive for performance. Urban healthcare centres are too large for providing care, taking into account the provision of services with proximity and quality, and too small to generate economies of scale, achieving efficiency gains and improvements in management. The starting point for the reform was therefore a low level of satisfaction of all stakeholders, citizens, professionals and policy makers, driven by low accessibility, inefficiency, bureaucratic barriers and lack of incentives to improve productivity and quality. The Government Program (2005-2009) for health gave special emphasis to primary care. It refers explicitly to primary care as the central pillar of the

	health system and recognizes the development of family health units (USF) as a political priority. Following the establishment of the Government Programme, the Council of Ministers created a Primary Health Care Task Force with the aim of conducting the overall primary care reform, including the implementation of USF. This reform is part of the wider framework of public administration reform, involving the reconfiguration of primary healthcare centres following a double movement: (1) the establishment of small independent functional units - the USF; (2) the creation of regional intermediate management structures, promotion of sharing resources and the development of clinical governance structures. With this movement it was expected to achieve economies of scale and scope. In parallel, to address the historical lack of family doctors, in terms of medical post-graduate training, the Ministry of Health established a minimum 30% annual threshold of vacancies for the family medicine specialty.
Understanding payment reform	The new payment scheme was exclusively developed for USF. Not all USF are at the same organizational development level. The differentiation between the various models of USF (A, B and C) results from the degree of organizational autonomy, differentiation of retributive model, incentives for professionals and the funding model, as well as their legal status. Model A. This model corresponds in practice to a phase of learning and work improvement. It is an indispensable stage to change into a new culture and processes. Professionals are public servants. Annually, they contract with the Regional Health Authority (RHA) representatives. Financial incentives are exclusively used for team investments (e.g. infrastructure improvement, medical equipment, vehicles) or common activities (e.g. training) So, there are no individual incentives to team members. Model B. This model is applied for teams with greater organizational maturity where the work in family health team is in practice. Professionals continue to be public servants. The teams enrolled in this model are willing to accept a more demanding contractual and performance level arrangement. There are two types of financial incentives: i) team incentives (similar to model A) and ii) individual incentives. Besides the current salary, financial incentives to nurses and clinical secretaries are similar and are dependent on the patient list (adjusted capitation), opening hours and achievement of contracted health indicators. Besides a basic salary, family doctors' financial incentives depend on: patient list (adjusted capitation), home visits (fee for service until a maximum of 20 visits per month), pay for performance (i.e. correct surveillance of: women in reproductive age; pregnancy; infant within the first year; infant within the second year; patient with diabetes; patient with high blood pressure) and other components (i.e. supplement for USF coordination, supplement for training residents) or additional activities (e.g.

	smoke cessation). Model C. This model was prepared for private providers, for or not-for profit. In 2012, a task force prepared the legal and economic framework for this model. Nevertheless, the Ministry of Health (MoH) never implemented Model C. The initial phase was the creation of USF, small multi-professional teams, voluntary, self-organized and composed of three to eight family doctors, as many family nurses and clinical secretaries, covering from 4,000 to 14,000 people. The creation of new USF was sustained by a substantial financial support for facilities, IT and general work conditions. Initially, contracting only considered 15 national indicators for USF Model A (team financial incentives) and 14 indicators for USF Model B (team financial incentives to nurses and clinical secretaries). The definition of targets depended on the negotiations between USF and RHA representatives and should take into account the behaviour of the indicators in each USF and surrounding health centres. The Central Administration of the Health System produces guidelines to the RHA that define negotiation boundaries (i.e. minimum and maximum). Those boundaries are determined according to a cluster analysis that group USF with similar population characteristics. Targets should be challenging but feasible based on best practices, in order to ensure better health outcomes - without jeopardizing the implementation and team development. Indicators and remunerations were negotiated with different trade unions involved. In 2014, following public open discussion and negotiations with different trade unions, indicators and achievement measurement were changed. A set of 22 contracted indicators were selected from a national set of more than 100 indicators. Targets are defined by national health objectives, good practices, available resources and historical data.

Table 1. Contracted set of 22 indicators, Portugal

Number	Level	Type	Weight
2	National	Access	7,5%
7	National	Clinical Performance	26,0%
2	National	Efficiency	24,0%
1	National	Perceived quality	5,0%
4	Regional	Any	15,0%
2	Sector	Any	7,5%
2	Local	Any	15,0%

The national set of indicators common to all USF from 2014 to 2016 is the following:

Table 2. National set of indicators common to all USF from 2014 to 2016

Indicator	Area	Type	Weight	ID
Utilization rate of medical consultations in the last 3 years	Horizontal	Access	4.5%	6
Rate nursing home visits per 1,000 patients	Horizontal	Access	3.0%	4
Proportion of pregnant women with adequate follow-up	Women Health	Clinical Performance	4.5%	51
Proportion of women in reproductive age with appropriate monitoring in family planning	Women Health/ Family planning	Clinical Performance	5.0%	52

Proportion of Infants within the first year of life with adequate follow-up	New-born, child and adolescent care	Clinical Performance	6.0%	58
Proportion of seniors without prescription anxiolytics, sedatives and hypnotics	Mental Health	Clinical Performance	2.0%	56
Proportion of patients with more than 13 years old characterized with smoking habits in the last three years	Horizontal	Clinical Performance	2.5%	47
Proportion of hypertensive patients younger than 65 years old with controlled blood pressure	Chronic diseases - High blood pressure	Clinical Performance	3.0%	20
Proportion of controlled diabetics (HgbA1c <= 8,0 %)	Chronic diseases - Diabetes	Clinical Performance	3.0%	39
Proportion of patients satisfied and very satisfied	Horizontal	Perceived quality	5.0%	72
Pharmaceuticals expenditure per user	Horizontal	Efficiency	16.0%	70
Ancillary exams expenditure per user	Horizontal	Efficiency	8.0%	71

Regional, sectorial and local indicators are chosen from the national indicators set according to health priorities and performance of providers.

The achievement for each indicator is measured as a relative attainment, which contributes to the construction of an overall score for each USF: overall team performance as a percentage. The percentage achieved is multiplied by the potential performance bonus. The result of this formula constitutes the team remuneration.

In 2014, to address conflicts between RHA and USF during the negotiation, monitoring and evaluation steps, the MoH created by law Regional Arbitration Commissions that include trade union representatives and RHA officials.

Annually, according to standard of care, providers' behaviour or IT system developments, indicators' definition can change or be clarified.

Implementation of payment	Before the national process was initiated in 2005, three pilots started respectively in 1996-1998 ("Projeto Alfa"), 1998-2005 ("Regime Remuneratório Experimental" – RRE Experimental Remuneration Scheme) and 1999-2005 ("Projeto Tubo de Ensaio"). The first pilot had 15 teams from the Lisbon

reform

region enrolled and there is documented improvement in access to care, patient and professional satisfaction, and rationalizing of drug prescription. The second pilot was spread nationally and had 228.888 patients enrolled. The evaluation of this pilot showed that each doctor provided more medical appointments (22%) and a 4% cost reduction per user in comparison with the traditional model was achieved. The provision of care model and remuneration scheme from this pilot was the basis for USF. The third pilot consisted of a Health Centre born from the joint venture between Porto Medical School and the Northern Regional Health Authority. This health centre had 20.000 patients enrolled and was financed by capitation. After 2002, medical doctors started to be paid as the RRE model.

In 2005, when the Primary Health Care Task Force was created and started the process of USF implementation there was a large consensus for the reform. Nevertheless, negotiations with trade unions and the Ministry of Finance were challenging. Only in 2008, model B USF (retribution scheme that assures individual incentives) was completely regulated. Being a voluntary process, only the teams interested and prepared in evolving into USF applied for participation in this model. The following table shows the progress since 2006:

Table 3. Progress in USF participation

USF	2006	2007	2008	2009	2010	2011	2012	2013	2014
Model A	43	119	90	128	160	183	195	213	225
Model B	0	0	69	103	117	137	162	181	193
Total	**43**	**119**	**159**	**231**	**277**	**320**	**357**	**394**	**418**

In 2014, 49.4% of the Portuguese citizens were enrolled in USF. Traditional health care centres continue to follow the citizens not enrolled in USF. Patients have the right to choose between traditional healthcare centres and USF. Nonetheless, USF attain quickly the maximum number of patients leaving no vacancies for new patient enrolment.

	As mentioned above, there was a broad consensus in the creation of USF. Even the Economic Adjustment Programme applied from 2011 to 2014 considered –in the Memorandum of Understanding– a specific measure to increase the number of new USF. Nevertheless, the reduction of investment capital and lack of human resources had a deterrent effect in the pace of USF development. The other aspect of the primary care reform, decentralization through the creation of regional intermediate management structures, was not so consensual. There was a strong resistance from the regional health authorities to this decentralization process that culminated in powerless management positions without real autonomy and accountability levels.
Assessing payment reform	The reform was frequently evaluated and analysed from different dimensions. In 2009, EUROPEP (instrument is a 23-item validated and internationally standardized measure of patient evaluations of general practice care) survey was applied to 16,768 patients (12,713 respondents), by an academic institution, showing a global level of patient satisfaction of 73.2%, with 86% of the individuals very or extremely satisfied with the provision of care. 93.7% of the individuals would recommend their USF to friends. An academic institution commissioned by the Ministry of Health now applies the EUROPEP survey annually. Another study conducted in 2009 analysed professionals' satisfaction (2,398 respondents). 72.2% considered the USF as high quality working place. The Portuguese Court of Auditors carried out an audit for the period from 2006 and 2012. This audit was very controversial and almost all stakeholders contested their conclusions. Still, the Court of Auditors concluded that the USF model shows, on average, greater economic efficiency, in the unit cost per medical consultation or user, when compared with traditional health care centres, which have higher unit costs. The MoH considered the issued recommendations and informed the Court of Auditors that several measures to improve the USF model were already in place since 2014 or being negotiated with the trade unions. The Regional Health Authorities and the Central Administration for the Health System produce annual reports showing the results achieved by USF and traditional healthcare centres. Invariably, USF achieve better access to care, improved clinical performance and higher efficiency. As an example, recent data from 2013 show that hypertensive patients and diabetics are better controlled by USF than traditional health care centres:

	Proportion of controlled diabetics: Traditional health care centres: 41,5% USF Model A: 61,6% USF Model B: 70,3% Proportion of hypertensive patients with controlled blood pressure Traditional health care centres: 37,8% USF Model A: 53,8% USF Model B: 65,2% Nowadays, the Ministry of Health and the USF professional association collaborate on a website that regularly publishes data on primary care, allowing benchmarking between providers. www.biusf.pt