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Gruppo Italiano per la Medicina Basata sulle Evidenze
Evidence-Based Medicine Italian Group

Decisioni Cliniche e Prove di Efficacia
Il Governo Clinico nelle Cure Primarie
Rimini, 3-4 ottobre 2008

Forum

Il Governo Clinico delle Cure Primarie: concreta opportunità o vana illusione?

Conduce: Nino Cartabellotta
Partecipano: Saverio Lo Vecchio, Roberto Nardi, Fernanda Bastiani, Alessandro Di Pasquale

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Il Governo Clinico delle Cure Primarie

1. Di cosa stiamo parlando
2. Quali obiettivi
3. Quali strumenti
4. Cosa misurare
5. Come misurare
6. The next step

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Position Statement
Il Governo Clinico nelle Aziende Sanitarie
Versione 1.3 del 7 febbraio 2008

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1.1. Cosa è il governo clinico?

Buetow SA, Roland M

Clinical Governance
Bridging the gap between managerial and clinical approaches to quality of care

Qual Health Care 1999;8:184-190

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1.1. Cosa è il governo clinico?

Because clinicians are at the core of clinical work, they must be at the heart of clinical governance

Degeling PJ, et al. BMJ 2004

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1.2. Cosa non è il governo clinico?

- Il governo dei clinici
- Il governo dei manager
- Un nuovo modello di "autoreferenzialità" o di "autodifesa" del sistema o dei servizi
- L'ennesima "ghettizzazione" della qualità assistenziale all'interno di uffici dedicati

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Question



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1. Ritieni appropriata la traduzione di “clinical governance” in “governo clinico”?

1. Sì
2. No

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1.3. Una traduzione infelice?

- Il termine inglese **governance**:
 - deve essere inteso come “gestione dei processi di consultazione e concertazione per il raggiungimento degli obiettivi”
 - In tal senso, la governance non può essere imposta dall’alto o dall’esterno, ma consegue all’interazione di molteplici attori che si autogovernano, influenzandosi re-ciprocamente,

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1.3. Una traduzione infelice?

- Il termine italiano **governo**:
 - corrisponde all’inglese **government**
 - definisce il “potere normativo” esercitato dalle Istituzioni

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Clinical Governance
=
Governance Clinico-Assistenziale

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Governance Clinico-assistenziale

Caratterizza:

- La non traducibilità in lingua italiana del termine “governance”
- La maggior riduttività del termine “clinico” rispetto a clinical, aggettivo che nella lingua anglosassone caratterizza tutte le professioni sanitarie e non solo quella medica.

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Il Governo Clinico delle Cure Primarie

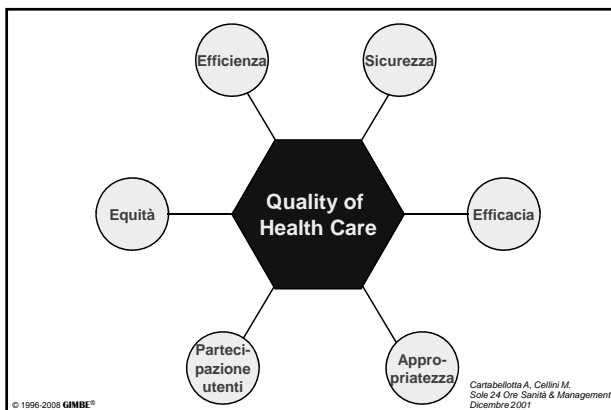
1. Di cosa stiamo parlando
- 2. Quali obiettivi**

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2. Obiettivi

- Governare l'estrema complessità delle organizzazioni sanitarie, orientandola a:
 - la promozione integrata della qualità professionale di servizi e prestazioni
 - l'efficienza, in relazione alla sostenibilità economica
- Nella percezione della qualità assistenziale, ridurre il gap che esiste tra professionisti e manager
- Misurare la qualità dell'assistenza attraverso un sistema multidimensionale di indicatori

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Question



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2. Quale dimensione della qualità assistenziale ritieni più rilevante per la medicina generale?

1. Sicurezza
2. Efficacia
3. Appropriatezza
4. Partecipazione degli utenti
5. Equità
6. Efficienza

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Il Governo Clinico delle Cure Primarie

1. Di cosa stiamo parlando
2. Quali obiettivi
- 3. Quali strumenti**

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Clinical Governance Tools & Skills


Evidence-based Health Care

- Evidence-based Practice
- Information & Data Management
- Practice Guidelines → Care Pathways
- Health Technology Assessment
- Clinical Audit
- Clinical Risk Management
- CME, professional training and accreditation
- Research & Development
- Staff management
- Consumer Involvement

Modificata da
Carrabollotta A. et al
Sanità & Management
Novembre 2002


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3. Strumenti



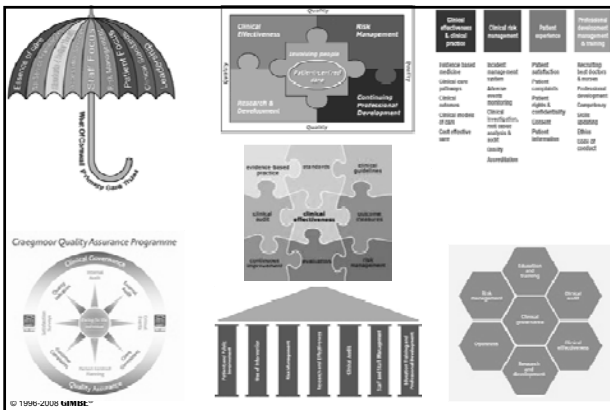
• **Non devono:**

- essere utilizzati in maniera occasionale e/o a finalistica
- essere confinati esclusivamente all'ambito professionale



• **Devono** essere integrati in tutti i processi di governo aziendale: strutturali-organizzativi, finanziari, professionali

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Il Governo Clinico delle Cure Primarie

1. Di cosa stiamo parlando
2. Quali obiettivi
3. Quali strumenti
4. Cosa misurare

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Struttura ↔ Professionisti

↓

Processi

↓

Esiti

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Quali indicatori ?

1. Indicatori strutturali
2. Indicatori di processo
3. Indicatori di esito

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1. Indicatori strutturali

Definizione

Requisiti delle strutture sanitarie, generalmente definite dai programmi di accreditamento*:

- **Strutturali**
- **Tecnologici**
- **Organizzativi**
- **Professionali**

*notevole variabilità regionale e nessun riferimento alla MG

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1. Indicatori strutturali

Esempi in MG

- Informatizzazione
- Partecipazione a percorsi assistenziali integrati
- Registri di malattia
- Segretaria
- Infermiere
- Sistema di reminder appuntamenti
- Ambulatori "dedicati"
- Tecnologie diagnostiche (previa standardizzazione della competenza professionale): ecografo, ECG, spirometro, PoC, saturimetro, etc

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1. Indicatori strutturali

Vantaggi

- Identificano i requisiti STOP di una organizzazione sanitaria
- Misurano l'efficienza

Svantaggi

- Non misurano le altre dimensioni della qualità assistenziale: sicurezza, efficacia, appropriatezza, etc

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5. FORUM

4. Chi costituisce, a tuo giudizio, il maggiore ostacolo alla definizione degli indicatori strutturali in medicina generale?

1. I professionisti
2. I sindacati
3. Le Aziende sanitarie
4. Gli organismi centrali di politica sanitaria

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Quali indicatori ?

1. Indicatori strutturali
- 2. Indicatori di processo**
3. Indicatori di esito

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3. Tra le seguenti categorie di indicatori quali ritieni più "robusti" e misurabili in medicina generale?

1. Indicatori di processo
2. Indicatori di esito

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2. Indicatori di processo

Definizione

- Informano che il processo assistenziale è stato erogato, o meno, in maniera appropriata secondo quanto definito da standard di riferimento: linee-guida, percorsi assistenziali

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2. Indicatori di processo

BPCO

- Spirometry and reversibility testing (all patients)
- Received influenza immunisation
- Registrazione del dato fumo in tutti gli assistiti
- Esecuzione di almeno 1 spirometria/anno

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2. Indicatori di processo

DIABETE

- Periodical record of: BMI, Haemoglobin A1c, retinal screening, peripheral pulses, neuropathy testing, blood pressure, microalbuminuria, creatinine, total cholesterol
- Taking ACE inhibitors/A2 antagonists (proteinuria or microalbuminuria)
- Received influenza immunisation

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2. Indicatori di processo

SCOMPENSO CARDIACO

- Diagnosis confirmed by echocardiogram
- Taking ACE inhibitors or A2 antagonists

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2. Indicatori di processo

IPERTENSIONE

- Blood pressure recorded

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2. Indicatori di processo

Vantaggi

- Misurano direttamente l'appropriatezza dell'assistenza ricevuta dal paziente
- Identificano precocemente le inapproprietezze e suggeriscono le aree di intervento
- Rispetto agli indicatori di esito, sono meno influenzate dalle differenze di case-mix

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2. Indicatori di processo

Svantaggi

- Richiedono un audit clinico strutturato ed un adeguato sistema informativo
- La loro "robustezza" è strettamente correlata alla forza delle raccomandazioni cliniche
- Rispetto agli indicatori di esito, sono ancora considerati di minore importanza

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Quali indicatori ?

1. Indicatori strutturali
2. Indicatori di processo
- 3. Indicatori di esito**

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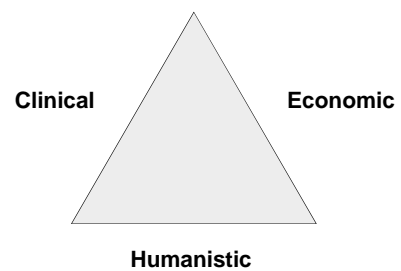
3. Indicatori di esito

Definizione

- Documentano una modifica di esiti clinici, economici, umanistici

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3. Indicatori di esito



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BPCO

- % di pazienti che smettono di fumare
- Riduzione ospedalizzazione per riesacerbazione

DIABETE

- Haemoglobin A1c 7-4% (7-5% in year 3) or less
- Blood pressure 145/85 mm Hg or less
- Total cholesterol 193 mg/dL or less

SCOMPENSO CARDIACO

- Riduzione ospedalizzazioni

IPERTENSIONE

- Blood pressure 150/90 mm Hg or less

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3. Indicatori di esito

Esempi

- Raggiungimento e mantenimento dei target di:
 - Hb1Ac nei diabetici
 - PAO negli ipertesi
 - Colesterolo LDL
- Scostamento del MMG dalla spesa farmaceutica media
- Soddisfazione dei pazienti (qualità percepita)

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Types of outcome measures

Clinical

- Mortality (Death specific cause - e.g. cardiovascular - or total)
- Clinical events (myocardial infarction, stroke)
- Physiologic and metabolic measures (cholesterol levels, blood pressure)

Economic

- Direct medical (hospitalizations, outpatient visit, diagnostic tests, drugs)
- Indirect medical (work loss, restricted activity days)
- Untangible (burn of suffering, psychological distress, "labeling effect")

Humanistic

- Symptoms (AUA symptoms score)
- Quality of life (SF-36 questionnaire, Nottingham Health Profile)
- Functional status (Karnofsky)
- Patient satisfaction (Group Health Association of America Survey)

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Epstein RS, et al. Ann Intern Med 1996

3. Indicatori di esito

Vantaggi

- Soddisfano tutti gli attori di un sistema sanitario: decisori, medici, pazienti
- Utili ("robusti") nelle seguenti condizioni:
 - in malattie acute, dove la distanza (temporale) tra processo ed esito è breve
 - negli interventi dove il processo è condizionato da un elevato livello di competenza tecnica
 - le (poche) misure fisiologico-metaboliche validate

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3. Indicatori di esito

Svantaggi

- Richiedono raffinate tecniche statistiche (*risk adjustment*) per "correggere" differenze demografiche, variazioni random ed effetti di selezione
- Richiedono lunghi periodi di osservazione su numeri considerevoli di pazienti
- Sono influenzati dalle "codifiche opportunistiche" e dal *reverse reporting bias*
- Non è semplice risalire, da scarsi risultati di esito, ai processi/strutture su cui intervenire

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I determinanti degli esiti di salute

Patrimonio
Genetico

Ambiente
(ecosistema)

Cultura + condizioni
socio-economiche

Assistenza
Sanitaria

Esiti

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Domenighetti G. Como, 2002

Use of process measures to monitor the quality of clinical practice

Outcomes of care are a blunt instrument for judging performance and should be replaced, say **Richard J Lilford, Celia A Brown, and Jon Nicholl**

BMJ | 27 SEPTEMBER 2007 | VOLUME 335

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SUMMARY POINTS

Process measures are the most suitable management tool for judging and rewarding quality
 Clinical outcomes are likely to be affected by factors other than the quality of care
 Outcome measures provide insufficient information about how to improve
 Assessment of process encourages universal improvement rather than focusing on outliers
 Selected measures must be valid and important

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Il Governo Clinico delle Cure Primarie

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5. **Come misurare**

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Indicatori di processo o di esito ?

- I sistemi informativi aziendali consentono di rilevare:
 - indicatori di esiti economici: numero di ricoveri, numero di accessi ambulatoriali, consumo di farmaci, utilizzo di test diagnostici, visite specialistiche, etc
 - "grossolani" indicatori di esito clinico rilevabili attraverso l'analisi delle SDO

PROBLEMA: "incomunicabilità" dei sistemi informativi aziendali

*Cartabellotta A, Potena A.
 Il Sole 24 Ore Sanità e Management, 2001*

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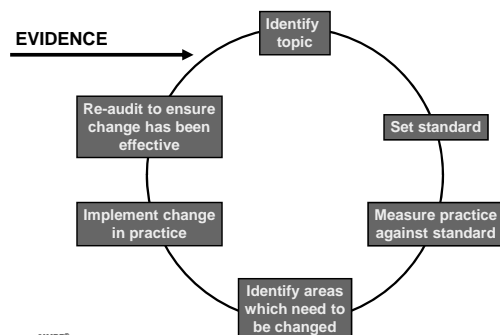
Indicatori di processo o di esito ?

- La valutazione dell'appropriatezza non può prescindere dal clinical audit che permette di verificare:
 - indicatori di processo
 - indicatori di esito clinico più "raffinati"
 - misure di qualità di vita

*Cartabellotta A, Potena A.
 Il Sole 24 Ore Sanità e Management, 2001*

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The evidence-driven audit cycle



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Appropriatezza: problematiche aperte

1. Assenza di consistenti evidenze scientifiche per definire criteri di appropriatezza per tutti gli interventi sanitari



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Da: Muir Graj JA. Churchill Livingstone, 2001

Appropriatezza: problematiche aperte

2. Limitata conoscenza e minima diffusione dell'audit clinico, strumento ideale per misurare l'appropriatezza

What is clinical audit?

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Appropriatezza: problematiche aperte

3. I database amministrativi - in particolare la banca dati delle SDO - sono inadeguati per la valutazione dell'appropriatezza professionale, perché influenzati dalle codifiche opportunistiche.



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Appropriatezza: problematiche aperte

4. I sistemi informativi aziendali hanno, generalmente, una struttura verticale e non comunicano tra loro



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Appropriatezza: problematiche aperte

5. L'appropriatezza riveste ancora un ruolo modesto nella valutazione e finanziamento delle organizzazioni sanitarie, specie se "contrastata" i volumi (ed i conseguenti rimborsi) delle prestazioni



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Inappropriatezza in difetto

- 30-45% of patients are not receiving care according to scientific evidence



Inappropriatezza in eccesso

- 20-25% of the care provided is not needed or could potentially cause harm



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Schuster et al. Milbank Q, 1998
Grol R. Med Care, 2001

Appropriatezza: problematiche aperte

6. La visione dell'appropriatezza si mantiene strabica, ma su posizioni divergenti

- I **manager** sono interessati a ridurre le inappropriately in eccesso, al fine di ridurre i costi
- I **professionisti** vogliono diffondere precocemente troppe innovazioni, appellandosi alle inappropriately in difetto
- In realtà...



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Problematiche aperte

... entrambi vanno in "direzioni pericolose"



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Linking Physicians' Pay to the Quality of Care — A Major Experiment in the United Kingdom

Martin Roland, D.M.

N ENGL J MED 351:14 WWW.NEJM.ORG SEPTEMBER 30, 2004

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Table 1. Clinical Indicators and Assigned Points in the Quality and Outcomes Framework.

Condition	No. of Indicators ^a	Maximal No. of Points ^b
Coronary heart disease	15	121
Stroke, transient ischemic attack	10	31
Hypertension	5	105
Hypothyroidism	2	8
Diabetes	18	99
Mental disorder	5	41
Chronic obstructive pulmonary disease	8	45
Asthma	7	72
Epilepsy	4	16
Cancer	2	12
Total		550

^a Each indicator measures the quality of a specific aspect of clinical care (e.g., regularity of blood-pressure monitoring in the case of hypertension).
^b Points are earned through a complex formula that takes into account both the size of the practice and the prevalence of the conditions at each practice.

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Table 2. Examples of Clinical Indicators and Assigned Points for Patients with Ischemic Heart Disease.

Indicator	No. of Points (% of Patients)
Control of hypertension	
Blood pressure has been recorded during the previous 12 months	1 (25) to 7 (90)
Most recent blood pressure reading (measured within the previous 15 months) was 150/90 mm Hg or lower	1 (25) to 19 (70)
Management of hypercholesterolemia	
Total cholesterol has been recorded during the previous 15 months	1 (25) to 7 (90)
Total cholesterol (measured within the previous 15 months) is 5 mmol per liter (194 mg per deciliter) or lower	1 (25) to 16 (60)

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Chronic Obstructive Pulmonary Disease (COPD)		
Indicator		Points
Records		
COPD 1. The practice can produce a register of patients with COPD	5	
Initial diagnosis		
COPD 2. The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003	5	
COPD 3. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	5	
Ongoing management		
COPD 4. The percentage of patients with COPD in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	6	
COPD 5. The percentage of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the past 15 months	6	
COPD 6. The percentage of patients with COPD with a record of FeV1 in the previous 27 months	6	
COPD 7. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 27 months	6	
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	

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Diabetes Mellitus (Diabetes)		
Indicator		Points
Records		
DM 1. The practice can produce a register of all patients with diabetes mellitus	6	
Ongoing Management		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	
DM 3. The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	3	
DM 4. The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months	5	
DM 5. The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months	3	
DM 6. The percentage of patients with diabetes in whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	16	
DM 7. The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	11	

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DM 8. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months	3	
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	17	
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	
DM 14. The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less	6	
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	

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Sub-Section: Left Ventricular Dysfunction (LVD)		
Indicator		Points
Records		
LVD 1. The practice can produce a register of patients with CHD and left ventricular dysfunction	4	
Diagnosis and Initial management		
LVD 2. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction (diagnosed after 1 April 2003) which has been confirmed by an echocardiogram	6	
Ongoing Management		
LVD 3. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction who are currently treated with ACE inhibitors (or A2 antagonists)	10	

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Hypertension		
Indicator	Points	Payment Stages
Records		
BP 1. The practice can produce a register of patients with established hypertension	9	
Diagnosis and initial management		
BP 2. The percentage of patients with hypertension whose notes record smoking status, at least once since diagnosis	10	25-90%
BP 3. The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered at least once	10	25-90%
Ongoing Management		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the past 9 months	20	25-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less	56	25-70%

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Table 3. Categories of Organizational Indicators and Assigned Points.	
Category (total, 184 points)	No. of Points
Records and information about patients (maximum, 85 points) Example: The smoking status is recorded for at least 75% of patients between the ages of 15 and 75 years.	5
Communicating with patients (maximum, 8 points) Example: Patients are able to talk to a receptionist by telephone and face to face at the practice during a period of at least 45 hours from Monday through Friday.	1.5
Education and training (maximum, 29 points) Example: The practice has undertaken a minimum of 12 reviews of clinically significant events in the previous three years, including, if appropriate, any death on the practice premises, two new diagnoses of cancer, two deaths for which care of terminal disease has taken place at home, one suicide, one complaint by a patient, and compulsory hospitalization of one patient under the Mental Health Act.	4
Management of medications (maximum, 42 points) Example: A review of medications has been recorded during the preceding 15 months for at least 80% of patients who receive regular prescriptions but do not need to see the physician each time (excluding drugs available over the counter and topical medication).	8
Management of the practice (maximum, 20 points) Example: There are clearly defined arrangements for backing up computer data, for verification of backup, for safe storage of backup tapes, and for authorization to load computer programs.	1.5

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Table 4. Anticipated Consequences of the New Incentives.

- Rapid expansion of clinical computing systems
- Expansion of the role of nurses in family practice
- Increase in clinics that specialize in the management of specific chronic diseases
- Increased specialization of physicians and nurses in primary care
- Increased biomedical orientation of family physicians
- Improved health outcomes
- Fragmentation of care and consequent poor coordination of care, especially for patients with multiple illness
- Loss of holistic approach to patient care
- Reduction in quality of care for conditions not included in incentive system
- Increased administrative costs

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Quality of Primary Care in England with the Introduction of Pay for Performance

Stephen Campbell, Ph.D., David Reeves, Ph.D., Evangelos Kontopantelis, Ph.D., Elizabeth Middleton, M.Sc., Ronnie Sibbald, Ph.D., and Martin Roland, D.M.

N ENGL J MED 357:2 WWW.NEJM.ORG JULY 12, 2007

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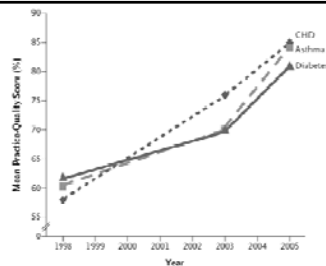


Figure 1. Mean Scores for Clinical Quality at the Practice Level for Coronary Heart Disease, Asthma, and Type 2 Diabetes, 1998 to 2005.

The quality of care for coronary heart disease (CHD), asthma, and type 2 diabetes was improving between 1998 and 2003, before the introduction of pay for performance. The rate of improvement in quality of care increased significantly for diabetes and asthma between 2003 and 2005, after the introduction of pay for performance; the rate for coronary heart disease, which was increasing most rapidly before pay for performance, continued at the same rate after pay for performance was introduced.

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	Mean Score]			
	1998	2003	2005	
	percent			
Cleated hemoglobin recorded during the previous 15 mo	87.1	91.1	95.4	0.54 (0.20 to 0.80)
Visual examination of feet recorded during the previous 15 mo	57.4	69.6	88.0	0.99 (0.45 to 1.53)
Peripheral pulses or vibration sense recorded during the previous 15 mo	60.0	62.9	90.2	1.58 (0.98 to 2.17)
Serum creatinine recorded during the previous 15 mo	79.6	80.9	96.4	0.11 (-0.08 to 0.73)
Later postmenstrual recorded during the previous 15 mo	66.1	74.8	82.8	0.41 (-0.12 to 0.90)
Examination of fundi or visual acuity recorded during the previous 15 mo	69.4	72.2	82.7	0.58 (0.10 to 1.06)
Weight recorded during the previous 15 mo	80.2	86.5	97.2	0.60 (0.20 to 1.01)
Blood pressure recorded during the previous 15 mo	97.6	95.8	99.0	0.15 (-0.10 to 0.40)
Smoking status recorded during the previous 5 yr	86.5	88.5	98.4	0.58 (0.13 to 1.01)
Serum cholesterol recorded during the previous 5 yr	75.1	97.6	99.4	0.05 (-0.08 to 0.18)
Blood pressure controlled to $\leq 140/85$ mm Hg (recorded in previous 15 mo)	21.8	35.4	49.0	0.49 (0.04 to 0.94)
Total serum cholesterol controlled to ≤ 190 mg/dL (recorded in previous 3 yr)	21.8	32.0	72.3	0.42 (0.03 to 0.81)
Diabetic retinopathy controlled to $\leq 7.4\%$ (as coded in previous 15 mo)	17.8	18.8	50.6	0.60 (0 to 0.81)

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Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework

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Summary

Background The quality and outcomes framework is a financial incentive scheme that remunerates general practices in the UK for their performance against a set of quality indicators. Incentive schemes can increase inequalities in the delivery of care if practices in affluent areas are more able to respond to the incentives than are those in deprived areas. We examined the relation between socioeconomic inequalities and delivered quality of clinical care in the first 3 years of this scheme.

Methods We analysed data extracted automatically from clinical computing systems for 7637 general practices in England, data from the UK census, and data for characteristics of practices and patients from the 2006 general medical statistics database. Practices were grouped into equal-sized quintiles on the basis of area deprivation in their locality. We calculated overall levels of achievement, defined as the proportion of patients who were deemed eligible by the practices for whom the targets were achieved, for 48 clinical activity indicators during the first 3 years of the incentive scheme: (from 2004-05 to 2006-07).

Findings Median overall reported achievement was 85.1% (IQR 79.0-89.1) in year 1, 89.3% (86.0-91.5) in year 2, and 90.8% (88.5-92.6) in year 3. In year 1, area deprivation was associated with lower levels of achievement, with median achievement ranging from 86.8% (82.2-89.6) for quintile 1 (least deprived) to 82.8% (75.2-87.3) for quintile 5 (most deprived). Between years 1 and 3, median achievement increased by 4.4% for quintile 1 and by 7.6% for quintile 5, and the gap in median achievement narrowed from 4.0% to 0.8% during this period. Increase in achievement during this time was inversely associated with practice performance in previous years ($p < 0.0001$), but was not associated with area deprivation ($p = 0.062$).

Interpretation Our results suggest that financial incentive schemes have the potential to make a substantial contribution to the reduction of inequalities in the delivery of clinical care related to area deprivation.

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Question



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5. FORUM

5. Ritieni attuabili in Italia i meccanismi di “pay for performance” in Medicina generale?

1. Si
2. No, contrari i professionisti
3. No, contrarie le Aziende sanitarie
4. No, contrari i sindacati
5. No, sistemi informativi inadeguati

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