

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 'softly hierarchical' 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.

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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 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

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].

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].

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 in general practice. Importantly, there are no sanctions in case of failed accreditation, and the main focus is on quality development.

This contrasts with New Zealand, where the approach is more assertive and where instruments have been characterised by a combination of hierarchy and market features. The dominant flavour of New Zealand’s performance governance in primary care has been hierarchical, through the widespread use of national targets and contractual mechanisms. These hierarchical approaches have been supplemented by a small-scale market instrument in the form of performance incentive payments. Importantly, this hierarchy/market mix applies to intermediate organisations (Primary Health Organisations).

The difference in approach is puzzling, especially since the two countries are similar in relation to broader starting conditions. Beyond the shared propensity for performance governance mentioned by Halligan and colleagues [5], Denmark and New Zealand are both small countries, where many of the

complexities associated with larger countries are not as pertinent [39]. The two countries have health systems that are predominantly funded by taxes, and have also been subject to different waves of reforms inspired by New Public Management [40] which have expanded the scope of hierarchical and market approaches in health. The central aim of our research is to explain the difference between Denmark and New Zealand in their approaches to performance governance in primary care.

3. The Framework for Comparison

The aim of our comparative framework is to systematically account for differences in choice/mix of instruments of performance governance in primary care as reflected in policies and legislation; the outcome of such choices/mixes fall outside the remit of the framework. Like related frameworks in the field [40] we apply a logic of theoretical inference and build on an institutional argument. Our approach is also in the tradition of Tuohy [23], Immergut [41] and Wilsford [42] in adopting small-n country comparisons to pose and solve important puzzles. The institutionalist argument goes hand-in-hand with a most similar cases design, whereby countries differ in relation to theoretically relevant elements – in this case, the specific sector-specific institutions [43] but are similar in relation to the broader starting conditions as outlined above. Together, these two design elements together help avoid many of the potential pitfalls of comparative health policy research by ensuring a tight focus on explaining a single identified difference. This type of approach can then be used to generate questions and hypotheses that can be applied to a larger range of countries. In the following section, we identify the key elements of our comparative framework, namely: institutional context of primary care [23] and related governance processes [44], and the problems that occupy the attention of governments [45].

The Institutional Context of Primary Care

Institutional arrangements in healthcare tend to be understood as systems of funding, provision and formal governance of healthcare [40,46]. To compare primary care institutions and policies, we need to focus our descriptions of funding, provision and formal governance on the specifics of primary care, which may be different from those of hospitals.

The first dimension to consider is *funding*. For most (but not all) countries, the predominant arrangements for raising and allocating financial resources for primary care are the same as those for hospital care. These are based either on taxation, social insurance, and private insurance, with the extent of direct payment from patients also a crucial consideration. A second institutional consideration in primary care is how doctors are paid [47]. As private-for-profit, small businesses, general practice is typically paid in by a combination of capitation and fee-for-service payments. In some countries like Finland and Portugal, general practitioners are salaried [9].

Regarding *provision*, primary care is much more organizationally complex than hospital care [6]. We define the key institutional features of primary care provision as the ownership and relative size of primary care organisations, the relative strength of leadership and the existence of the gatekeeping function [47]. In most high-income countries, general practitioners are independent entrepreneurs working in small organisational units, including solo practices [8,31]. Some jurisdictions such as England have developed larger organisational units.

Formal governance structures refer to the relative authority of governments over private (medical) interests (*public integration*) and the relative concentration of policymaking authority at national levels (*central integration*) [46]. These arrangements can be strongly linked to funding arrangements, because countries

in which services are funded from taxation afford their governments greater leverage over private providers than their counterparts in insurance-based systems.

Governance processes

Policy processes vary substantially in terms of whether and how non-governmental (societal) actors and interests are embedded in processes of deciding and implementing policy. In primary care, while many groups and interests may be present, the central question is how medical professional interests are embedded in policy processes [44].

In primary care policy, the distinction between pluralist and corporatist structures of interest mediation remains highly relevant [46,48-49]. Many countries have pluralist processes in which inclusion of medical interests are more fluid and ad hoc and change from issue to issue. This contrasts with corporatist structures such as in Germany, where organised medicine always has a seat at the policy table. In both types of processes, the fragmentation of professional interests is a salient challenge, which may be heightened when funding for primary care is tight. The implications of interest fragmentation are particularly problematic in corporatist processes, where legitimacy is built on the ability to deliver on collective decisions [50]. Path-dependence in health policy processes means that countries with well-developed corporatist processes are unlikely to rapidly change to a pluralist mode, although such change may occur more gradually.

Governance problems

The final element of our comparative framework is governance problems. Comparative health policy scholars typically identify three, potentially competing, health system goals that can also be understood as broad types of problems requiring policy attention in health systems [46,51-52]. *Quality in primary care* has traditionally been a problem to be addressed by the medical profession through GP accreditation and disciplinary mechanisms. However, concerns about quality – more broadly defined to include evidence-based medicine (EBM) bodies of research, and patient expectations and satisfaction, are now firmly part of government agendas. In Germany, for example, poor quality of care for chronic conditions was a major driver behind the introduction of disease management programmes [53]. Most countries have also recognised a number of important barriers to *access* for parts of their populations, particularly in rural areas and with respect to costs for patients (be they direct or indirect). Finally, concerns about *efficiency* are often at the forefront of policymakers' motivations to develop regimes of performance governance.

Two further policy problems for health services generally, and primary care specifically, have become more prominent since the 1990s. While changes in *population health outcomes* can rarely be attributed to health services alone, there has been increasing attention given to the specific ways in which health systems and services do influence these outcomes [54] with stronger primary care posited as a crucial factor [11,55]. Finally, *inequities* of access, quality and outcomes can also motivate efforts to govern primary care through performance measures [56]. A focus on inequities is dependent on the presence and availability of data comparing population groups defined in various ways (e.g. socio-economic status, ethnicity, or geography).

In the following accounts of the two country cases, we begin by describing the institutional context of primary care, then outline key governance processes and problems, and end with a fuller account of policy instruments used for performance governance.

4. The Danish case

Institutional Context of Primary Care

Denmark has a national health service and *funding* comes from national and, to a lesser extent, local taxation. General practitioners are remunerated based on a combination of capitation and fee-for-service payments [57]. In terms of *provision*, general practitioners are independent, private entrepreneurs. They typically work in single-handed or small-group practices, and the development of leadership functions remains limited. General practice has a gatekeeping role and refers to specialist and hospital services.

As for *governance*, public integration of primary care is relatively weak. Despite its gatekeeping role, general practice emerges as a satellite service which is poorly integrated into the healthcare system and is difficult to govern [58]. Regional government and general practitioners have primarily related to each other as payers and providers [58]. There are also few formal connections between general practice and the local authorities responsible for home care, rehabilitation, prevention and health promotion services [60]. The regional and local healthcare agreements are an exception, but these have a broad focus on organising the coordination of health services between the hospitals, general practice and local authorities.

Regarding central integration, the health system is relatively decentralised [61]. Regional governments are responsible for securing the provision of hospital and GP services. This is done based on formal agreements with the Association of General Practitioners (*Praktiserende Lægers Organisation*), which acts both as a trade union and a specialist professional organisation.

Governance processes

Governance processes are embedded in a system of public corporatism [61]. This applies across the health system, but is particularly strong for primary care. At the centre is the national collective agreement between the umbrella organisation of regional governments (*Danske Regioner*) and the Association of General Practitioners [58,62]. This is the framework for the instruments of performance governance presented below. The national collective agreement is complemented by more specific agreements, at the local level. Each of the five regions also has a joint committee to deal with issues in general practice.

The system of public corporatism is complex and over recent years has turned out to hamper rather than facilitate primary care performance governance [60]. The focus of the collective has been on remuneration rather than services, and on completing agreements rather than monitoring them. But recently regional government has become interested in defining the substance of services and quality standards and in terms of monitoring performance [59]. Yet, the Association of General Practitioners has frequently had difficulties securing the support of its members, including in relation to collective agreements [58]. One explanation is a high level of distrust as regional governments move away from their traditionally passive role as payers. In 2013, this culminated in a major conflict over the national collective agreement, resulting in the national government intervening through legislation [63]. The lack of trust has knock-on effects on the work of the joint committees in the individual regions. A report on the governance of primary care commissioned by the national Ministry of Health identified the joint committees as a key barrier to regional control over how money is spent (including sanctions) [64].

Governance problems

In principle, it is not surprising that the Danish institutional context and governance processes outlined above leads governments to identify problems of *efficiency*. For example, in connection with the introduction of a system of accreditation in 2011, reports by the OECD and the National Audit Office charge that regional government lacks control over the activities and expenditure in primary care [64,65].

Problems of efficiency are combined with problems of *quality* and *access*, reflecting a number of broader challenges the healthcare system is facing [58]. This includes: a shortage of GPs, especially in rural areas; demographic changes and the increase of elderly patients; the growing delegation of care tasks from the specialist hospital sector; and variations in service quality [66].

Performance Governance instruments

The predominant instruments of performance governance in Denmark can be characterised as ‘softly hierarchical’, in which there are formal, state-initiated requirements of primary care providers and organisations, but there are no sanctions or consequences for providers if these are not met.

Besides the national framework legislation for healthcare services (*Sundhedsloven*), the national collective agreements between regional government and the general practitioners are the key platform for defining services instruments [58,62]. Importantly, there are no sanctions built into the individual instruments and extra payments offer weak incentives, as they are related to covering extra costs related to quality management rather than to rewarding performance. However, there are plans to develop a new payment system that more explicitly supports the focus on quality and documentation in general practice [67].

The key instruments are accreditation of individual general practices together with a database to collect data about needs, service provision and some outcome measures. Accreditation is based on the same model as in hospitals (*Den danske kvalitetsmodel*) [61]. Assessment occurs on a tri-yearly basis and also includes a half-way control visit and ongoing quality assessment. The standards were developed in collaboration with general practitioners (and other stakeholders) and relate to four areas: quality (best practice, medical error, patient evaluations); patient safety (identification of patients, medicine management, patient journals), patient care pathways (access, referral, coordination), and management and organisation (hygiene, leadership, training). Accreditation lies in the hands of an arm’s length public body and the visits are conducted jointly by a quality consultant and a general practitioner. An important base for the accreditation was supposed to be a database, that collects data about patient needs, services provided in general practice and some outcome measures (*Datafangst*) [68]. There are no defined sanctions if accreditation fails. The main focus of the system is on quality and evaluation. While implementation was formally completed in 2013, the low level of trust between general practitioners and the regions has meant that especially the issue of the regions’ access to the data base has proven to be highly controversial [58,64]. The actual use of the database was put on hold in 2014, so that it could be revised to conform to privacy legislation. In the end, the database was deleted except for a few disease specific indicators [60].

There are further, minor governance policy instruments, but which at present are not necessarily used in full, also because they exist side-by-side with accreditation and there is no overall framework of performance governance that integrates all instruments. Firstly, the collective agreements include the

option of fee-for-service payments for specific services (*\$2-Aftaler*). These are a potentially powerful instrument, but at present are rarely used in relation to systematic quality management [58]. One example is a programme for treating chronic diseases in the Central Denmark Region, which combines organisational support, training, covering costs for implementation and some monitoring [58]. In the collective agreements there has also long existed a control on maximum service levels (*\$100/93 Opgørelser*). This occurs once a year and different sanctions come into effect if a practice has exceeded the maximum levels by 25 percent. If connected to quality standards, this could develop into an influential instrument. Secondly, under the joint committee of the individual regions and general practitioners (*Samarbejdsudvalg*) there is the Committee for Quality and Post-registration Training (*Kvalitets- og efteruddannelsesudvalg*) (see *\$104ff*). It has its own budget and therefore is potentially an important instrument to support quality and training activities in general practice as part of GP accreditation. Thirdly, there are regional plans for general practice (*Praksisplaner*), which define the range of services provided by general practice and how these relate to the services provided by hospitals and local authorities. The plans are based on joint decisions by the individual region and the regional representatives of general practitioners and local authorities. Again, the plans do not connect to other performance standards, such as those used in accreditation.

5. The New Zealand Case

Institutional Context of Primary Care

Like Denmark, New Zealand's health system is predominantly *funded* from taxation. However in contrast to Denmark, direct payments from patients constitutes a significant share (around 30-35%) of primary care funding [69]. Regarding *provision*, New Zealand's general practitioners predominantly work in independent, for-profit, small businesses. Their income is derived from a combination of direct payment from patient, and capitated payment from government per enrolled patient [70]. GPs also perform a gatekeeping role.

Regarding *governance*, co-ordination, delivery and administration of the public parts of the health system are largely devolved to 20 District Health Boards (DHBs), but which are directly accountable to central government [71]. As such, the health system as a whole has fairly high levels of *central integration*.

Regarding *public integration* of primary care, New Zealand developed some new mechanisms in the early 2000s, when a new organisational layer for primary care - Primary Health Organisations (PHOs) - of which there are 32 as of March 2017 - were introduced as a consequence of government policy. PHOs are non-government organisations of primary care providers that enter into contracts with DHBs, and DHBs carry out their centrally-mandated responsibilities for primary care primarily through the PHO Services Agreement. However, behind these formal arrangements that suggest that governments have increased leverage over primary care practitioners, a more complex dynamic and the degree to which primary care is publicly integrated varies according to issue and context.

Governance processes

New Zealand has no tradition of corporatist arrangements in primary care policy. This can be traced back to the 'foundational struggle' that shaped New Zealand's health system in the late 1930s when organised primary care interests successfully fought government attempts to guarantee universal access to healthcare, and 'enshrined' the right of GPs to charge patient co-payments. In more recent waves of reform affecting primary care in the 1990s and 2000s, GP interest groups were deliberately excluded from

policy formulation [71]. The New Zealand state has considerable autonomy to make policy independently [72], but in health policy has typically lacked power over implementation, where policy goals have been either actively resisted or eroded by the effects of 'passive' professional power [71].

New Zealand's style of primary care interest participation has, therefore, been pluralist, ad hoc and fluid. Smith [73] notes that 'much effort in New Zealand was directed at demonstrating a new collaborative approach and seeking win/win solutions to policy dilemmas, but in a context of consultation with stakeholders in primary health care, not negotiation with appointed representatives of general practice' [73]. Since the early 2000s, there have been multiple organisations representing primary care interests.

Primary care sector organisations such as the General Practice Leaders Forum (GPLF) and the Royal New Zealand College of General Practitioners (RNZCGP) have been active in developing and proposing their own frameworks for the management and improvement of quality and have collaborated with the Ministry to progress these and incorporate them into new iterations of primary care performance management [74]. However, these collaborative policy processes have not, to date, shaped the architecture or content of performance management in primary care.

Governance problems

The key emphases in initial (1990s), sector-led efforts to develop performance information were clinically-defined quality and efficiency [73]. The Primary Health Care Strategy introduced in 2001 placed great emphasis on access, equity and population health outcomes. The creation of PHOs was the central element of this policy, and these non-government organisations were charged with the responsibility of addressing financial and non-financial barriers to primary care access and improving the health outcomes of the enrolled population. While policy discourse since 2008 has shifted markedly to an emphasis on quality, the early 2000s emphasis on equity and population health has become firmly embedded in subsequent developments in performance governance.

Performance Governance instruments

The overarching story is that primary care performance governance has gradually evolved in a more hierarchical direction over time. The key site of performance governance in primary care in New Zealand is the PHO Services Agreement. This is a standard national service contract which is administered locally by DHBs. Since 2005, an important part of this Agreement has been a system of pay-for-performance, originally known as the PHO Performance Programme (PPP). This was a market-type instrument based on principles similar to the UK Quality and Outcomes Framework [16,73]. The scale of the incentives was quite small, at just over \$6 per enrolled patient. This amounted to about 1% of primary care funding and was made available for meeting performance benchmarks [74]. Importantly, the government rewarded Primary Health Organisations, rather than individual practices, for meeting these benchmarks [73]. Some PHOs collect performance data for comparing practices internally and pass on the incentive to individual practices. Others retain the payment to develop initiatives and strategies for the PHO as a whole [75]. A common theme of reviews and evaluations of the PHO Performance Programme was that such incentives make little difference to individual provider behaviour, although they constituted significant incentives for larger PHOs [16,76]. However, in conjunction with the broader regime of health targets, this approach to performance management in primary care has contributed to improvements in equitable access to specific services such as immunization [75].

The original PPP was introduced in 2005 after the establishment of PHOs [16,73]. The first list of indicators reflected a pragmatic compromise between the Ministry of Health and sector participants [73] and contained a mix of clinical, administrative process and financial indicators [77].

In a separate process beginning in 2007, the government introduced a system of headline health targets to prioritise its energies across the sector and sharpen the accountability of DHBs [78,79]. Three of these targets – child immunisation, heart and diabetes checks, and the provision of smoking cessation advice – were then applied to PHOs when the targets were incorporated into the PHO Performance Programme in 2011. These targets have become significant drivers of change in primary care practices, and in each case PHO management has invested considerable time and effort in facilitating individual practices to improve their performance on these measures [75,80].

In July 2016, the PHO Performance Programme was superseded by a new framework for performance management. This ‘System Level Measures’ framework requires DHBs and PHOs to work together to meet a broad range of system measures, including rates of amenable mortality and ambulatory sensitive hospitalisation for young children, acute hospital bed days and patient satisfaction [81]. The new framework clearly incorporates a strong emphasis on inter-organisational networks in combination with existing hierarchical approaches. The market element has been weakened as the funding for pay-for-performance has been reduced from nearly \$6 to around \$1.50 per enrolled patient.

What is most intriguing about the New Zealand case is that the measures defined as part of performance management in primary care have been almost exclusively defined by state actors rather than by primary care organisations. This is not because general practice interests haven’t tried to establish a framework for performance governance based on collegial, professional foundations. Internally, the Royal New Zealand College of General Practitioners has developed its own set of quality standards and accreditation [82], but these have not been linked to government frameworks. In 2015-16, an attempted redesign of primary care performance management begun by general practitioner representatives and actively encouraged by government [83] but was eventually shelved because it did not fit well with the recommendations from a wider system review which emphasised attention to system goals such as population health and equity [84].

6. Summary

To summarise, New Zealand’s development of performance governance has expanded the reach of extrinsic (hierarchy and market) mechanisms whereas Denmark’s ‘soft hierarchy’ denotes a fusion of professional network and hierarchical mechanisms in which professional considerations predominate. Table 1 below highlights the comparisons between Denmark and New Zealand across the four dimensions of our framework.

Table 1 about here

Our explanation of the difference between Denmark and New Zealand regarding primary care performance governance instruments starts with the *institutional context of primary care*. These differences in institutional contexts in turn shape the differences in governance processes, and the differences in governance problems that are then addressed through performance governance instruments.

In New Zealand, two distinguishing institutional features are supplementation of tax-funded primary care by patient co-payments, and the presence of intermediate organisational structures. New Zealand has taken steps towards public integration by establishing an intermediate organisational layer for primary care. This situation contrasts with Denmark, where there are no co-payments, and where primary care is more fragmented as it is dominated by sole and small group practices without an intermediate organisational layer.

The institutional differences in primary care also have a significant effect on *governance processes*, as the two countries respond to the challenge of securing GP legitimacy and buy-in in different ways. Governance processes in Denmark are based on public corporatism, whereas in New Zealand such processes have the character of fluid pluralism. Danish corporatism means intense involvement of the GP interest organisation across levels, potentially enabling more long-term, sustainable policy changes. At least this is the argument in relation to hospital doctors [85]. Yet primary care interests are in fact rather fragmented, reflecting a high level of distrust between GPs and the state over recent years. Under these circumstances, public corporatism in fact holds back the use of more strongly or more encompassing hierarchical governance instruments and initiatives for performance governance in primary care have been rather piecemeal.

In comparison, New Zealand governments have had a comparatively free hand in devising primary care policy options, including for governing performance, although these are then subject to pluralist dynamics which can play out quite differently in varying contexts. New Zealand's style of pluralism is largely reactive in the sense that professional interests typically shape policy through resistance or through implementation processes, rather than by initiating ideas. Primary care professionals' interests in New Zealand have been generally unsuccessful in influencing the content of performance management in primary care despite concerted attempts over the past decade. This can be attributed to the absence of institutionalised channels of influence. Importantly, New Zealand's PHOs have not emerged as a possible site of interest representation. In turn, these differences in governance processes have given the New Zealand state more autonomy in the identification of access, equity and population health as salient *governance problems* in primary care that require policy attention. Indeed, the very creation of PHOs, as the intermediate level of primary care organisation, is a direct consequence of the state having this freedom to move in its attempts to deal with problems that were a consequence of high patient co-payments in primary care. This is different in Denmark, where the more fragmented institutional context makes efficiency and more specifically control over the activities and expenditure in primary care the central governance problem.

7. Discussion

Our analysis suggests important implications for health policy in both countries. If our analysis is correct, then the performance governance dynamics identified in this comparison may be 'locked-in' such that each country's future applications of performance governance will be less than optimal. In Denmark's case, the potential weakness is that governments will not develop some extrinsic instruments to tackle broader systemic issues such as population health, equity and efficiency (as distinct from mere cost-control) in primary care. A potential institutional circuit-breaker from the path of soft hierarchy would be the establishment of intermediate primary care organisations,

In New Zealand's case, the weakness is that its approach to performance governance will continue to be based on rather brittle, extrinsic motivators that may fail to effectively engage providers' intrinsic motivation to improve performance. If our analysis is correct, the recent shift to System Level Measures will gain little traction unless it is connected to deeper institutional changes, particularly in the governance and processes of policy development around performance measurement. This would likely require some move in the direction of corporatist processes, which in turn would require the inclusion of a wider range of primary care professionals and providers.

Our comparison generates some useful working hypotheses for comparative health policy scholars. While some elements of this argument have been advanced regarding whole health systems [23,41-42], they have not previously been applied to the more specific sub-sector of primary care. There are major differences in the nature of primary care performance governance between Denmark and New Zealand, and these are ultimately attributable to different institutional conditions in primary care. This may mean that certain types of performance governance instruments are unlikely to be adopted in particular countries without major (and rare) changes to institutional conditions. An important test of this argument would be to search for health systems that meet both conditions of intermediate primary care organisations and corporatist processes of interest mediation. We suggest that jurisdictions with these characteristics would be more likely to develop more robust institutions of performance governance, which in turn could enable progress towards more accessible, equitable and efficient primary care of higher quality.

8. Conclusion

To summarise our argument, the differences between New Zealand and Danish performance governance instruments can be traced back to key differences in primary care institutions. This link between primary care institutional conditions and performance governance instruments is not direct, but is mediated by the nature of governance processes and governance problems. In New Zealand, the presence of primary care organisations that are of sufficient size and scale makes hierarchical/market mechanisms more feasible, as this scale of organisation is capable of generating the data and management systems that are required. However, New Zealand has not yet been able to incorporate network instruments into performance governance. In Denmark, by contrast, more far-reaching hierarchical governance appears to be precluded by the deep embeddedness of public corporatist processes, and the highly fragmented nature of primary care provision means that the state has less capacity to implement hierarchical instruments of performance governance.

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