

Paying for performance: understanding the impact of the UK NHS GP contract Quality and Outcomes Framework

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Outline

- Description of 2004 UK GMS contract
- Description of Quality and Outcomes Framework (QoF) component of contract
- Initial practice response
- Concerns about the QoF's impact
- Evaluation of the impact of the QoF
- Assessment and significance of the QoF



Description of 2004 general practice contract and the Quality and Outcomes Framework (QoF)



New NHS GMS contract, April 2004

- Practice contract with local NHS purchaser (PCT)
- ‘Blended’ payment system comprising:
 - Weighted capitation payment for essential services
 - Weighted capitation for additional services (normally provided but practices can opt out)
 - Enhanced services (voluntary) – responsibility of PCT, may be commissioned locally from practices, paid FFS
 - Infrastructure payments (premises and IM&T)
 - Quality and Outcomes Framework (QoF) (voluntary)



New NHS GMS contract, April 2004

- Minimum practice income guarantee (MPIG)
- Increased funds flow to practices
- Supported by 79% of GPs (turn out 70%),
June 2003



Background to QoF

- Previous successful use of more modest incentives targeted on particular activities
 - 1992 contract led to increase in immunisation rates, cervical cytology rates, health promotion
- In NZ, focus to date on modest incentives for PHOs related to a small number of performance measures



Quality and outcomes framework

‘...a proposed new contract ...contains an initiative to improve the quality of primary care that is the boldest such proposal on this scale attempted anywhere in the world.’

Shekelle (2003) BMJ 326: 458-9



Objectives of the QoF

- To improve the general quality of primary health care
- To eliminate variation between providers by resourcing and rewarding 'best practice'
 - clinical aspects largely focused on secondary prevention



Quality and outcomes framework

- Voluntary
- Rewards practices for quality of clinical care and organization – typically ~ 25% of income
- Practices awarded points for achieving certain standards
- Total of ~1000 points available (~£130k per practice, 05/06)
- 1 point = £125 on average (05/06), plus 50 bonus points for hitting 24/48 hour national access targets
- Four domains (>150 indicators)
 - Clinical (65 indicators)
 - Organisational
 - Additional services
 - Patient experience



Achievement and 'exceptions' reporting

Achievement = $N/D = N/(P-E)$

between upper & lower threshold on sliding scale

N = treated

D = suitable for treatment

P = prevalence

E = 'exceptions' (to reduce risk of inappropriate treatment or practice refusing 'difficult' patients)

- Patient refuses offer of screening, FU, etc
- Clinically inappropriate (specific reasons)
- Newly diagnosed/recently registered
- No scope for improved care



Assumptions underpinning the QoF

- Value of improvements is linear (no diminishing returns) within limits – no payment for *improvement* per se
- GPs are quasi-altruistic
- ‘Gaming’ has a cost in terms of penalties and psychic loss
- There are genuine ‘exceptions’



Clinical domain: ten chronic conditions (points)

- Coronary heart disease (121)
- Hypertension (105)
- Diabetes (99)
- Asthma (72)
- COPD (45)
- Mental health (41)
- Stroke or transient ischaemic attacks (31)
- Epilepsy (16)
- Cancer (12)
- Hypothyroidism (8)

2006/07 indicators can be seen at
<http://www.bma.org.uk/ap.nsf/Content/qof06>



Example of clinical indicator and points

- The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the last 15 months) is $\leq 150/90$ (max 19 points)
- A proportion of the points score awarded in a direct linear relationship to achievement between the minimum (25%) and the maximum (70%)



Organisational domain (points)

- Records and information (85)
- Medicines management (42)
- Education and training (29)
- Clinical and practice management (20)
- Communication with patients (8)

- Example
 - The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day (1 point)



Additional services domain (points)

- Cervical screening (22)
- Child health surveillance (6)
- Maternity services (6)
- Contraceptive services (2)
- Example
 - The practice has a system to ensure abnormal smears are followed up (3 points)

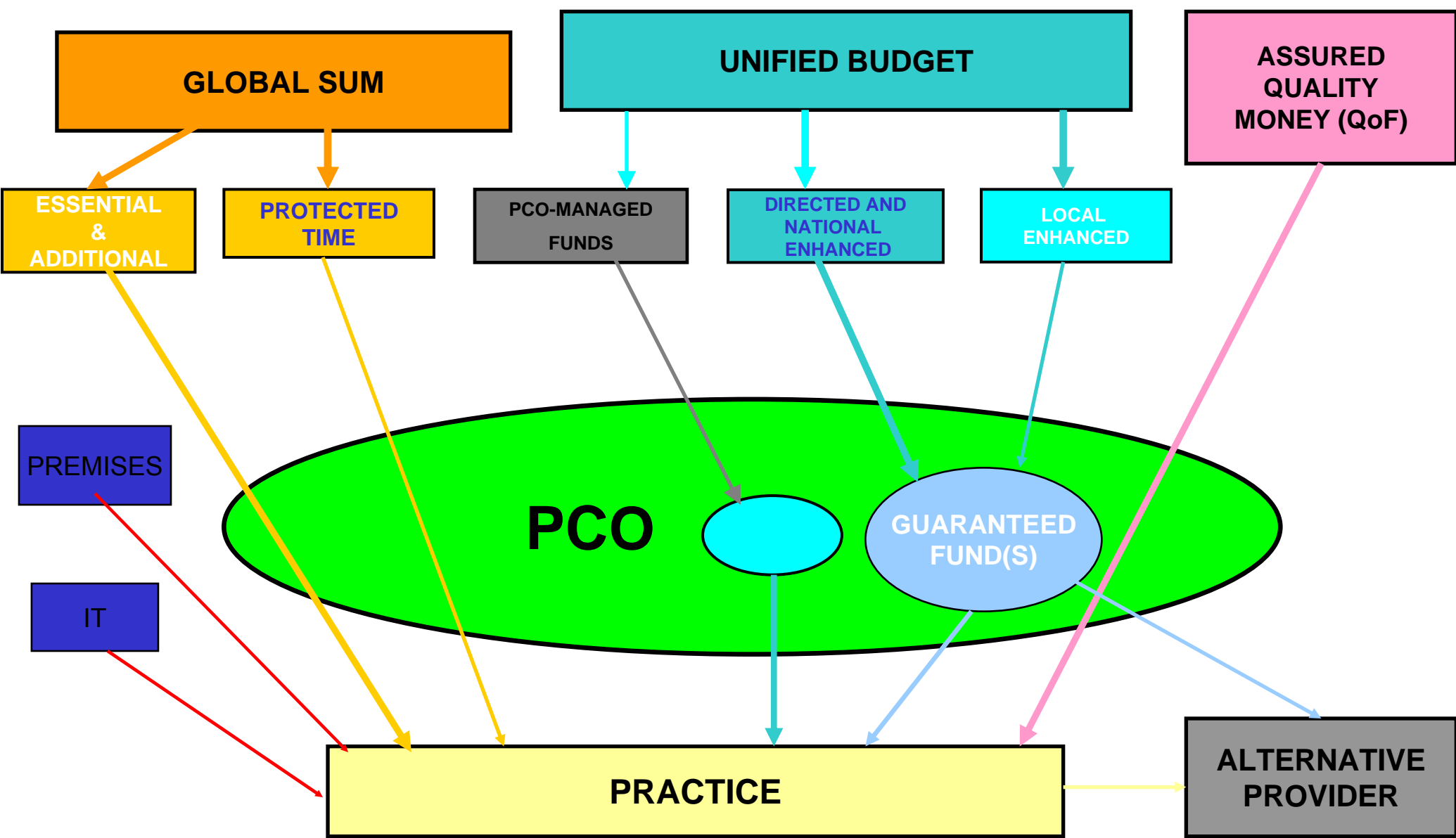


Patient experience domain (points)

- Patient survey (70)
- Consultation length (30)
- Holistic care payment (100)
- Quality practice payment (30)
- Access bonus (50)

- Example
 - The practice will have undertaken approved patient survey each year (40 points)





How the QoF is audited

- PCTs (statutory NHS purchasers) inspect all practices
- Detailed audits of random sample of practices & those suspected of errors or fraud
- Audits are confidential

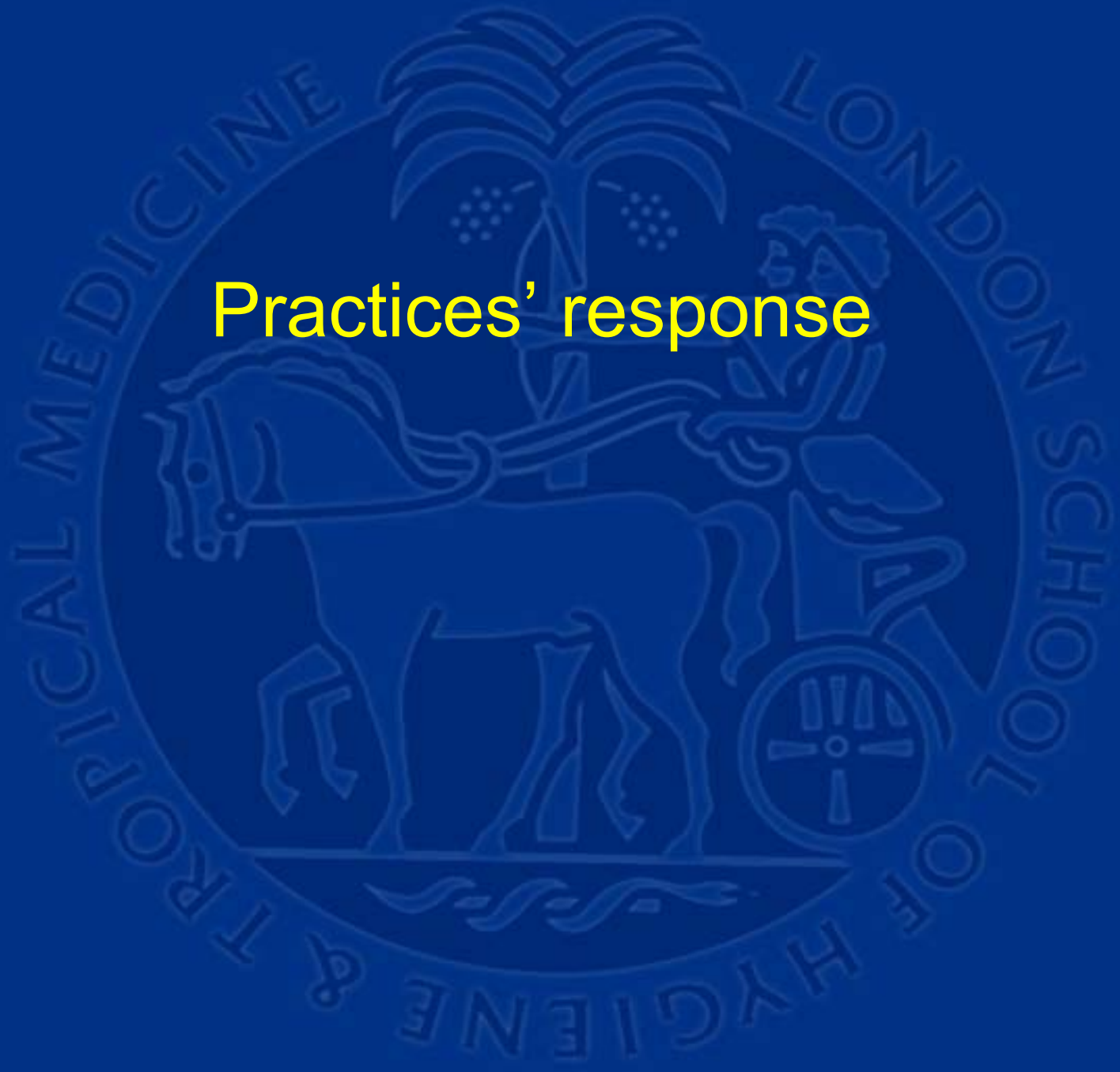


Resources and support for the GP contract, including QoF implementation

- In the first 3 years, £2 billion extra for PHC in general
- For IT systems, new database to capture QoF activity/performance, extra admin & nursing staff, 12% increase in GPs, increased GP incomes



Practices' response



Practices' responses to the QoF

- By year 3, almost all practices opted in
- Increased activity and more staff, especially nurses (uncovering unmet need with knock-on costs)
- Average achievement 959 points (91%) 05/06, 96% in 06/07, ~ 25% gross income
- 2.2% 100% points, 04/05; 15% 100% points, 05/06
- 1% did not achieve any points in specific domains in year 1



Concerns about the QoF



Concerns and risks raised by the QoF

- Risk of widening quality 'gaps' by deprivation & size of practice
- Value-for-money – large pay rise & monitoring costs, but many quality gains already occurring
 - suggestion that gains could have been made at lower cost with less highly geared incentives
- 'Gaming' – practices only partly altruistic



Concerns and risks raised by the QoF

- Loss of humane, patient-centred care in favour of risk factor monitoring
 - does not measure quality of consultations, continuity, etc.
- Crowding out of intrinsic professional motivation by large financial incentives
- Excessive focus on incentivised areas at expense of areas of potentially greater effectiveness
- Payments do not necessarily reflect likely health gain (Fleetcroft & Cookson, 2006)
- Excessive focus on risk factor *measurement* rather than preventive interventions (Guthrie et al, 2007) – 15% payments related to CVD measurement



Evidence on the impact of the QoF: were the concerns justified in relation to gaming, overall quality and equity?



Evidence on 'gaming' versus altruism

- 'Over-achievement' among high performers
 - suggests a degree of altruism
- Limited 'gaming' of reported prevalence and 'exceptions' (low median rate of 5.3% (inter-quartile range 4.0-6.9), 05/06)
 - some practices with high exception reporting rates (Doran et al, 2008)
 - most likely for providing treatment indicators (12.6%) especially in mental health
 - exceptions beneficial to P4P, little widespread gaming
- Exception reporting rate was strongest predictor of reported performance in yr 1 & 2, but effect was small (Doran et al, 2006)



Overall rates of exception reporting, English practices, 2005/06

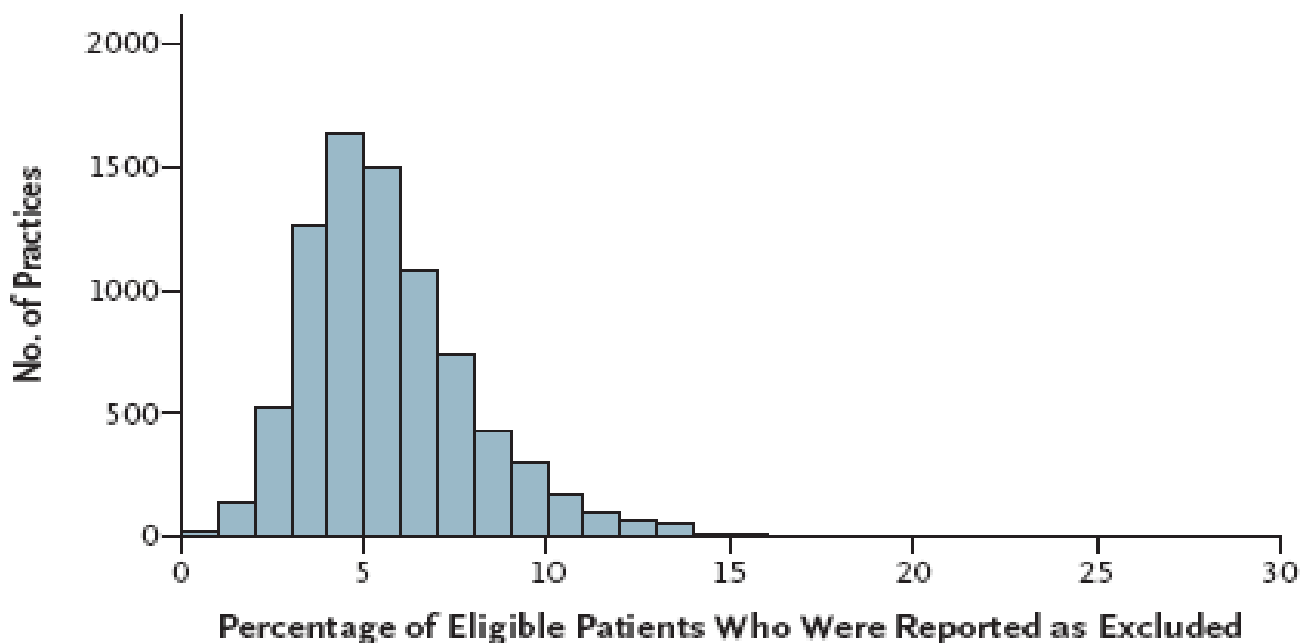


Figure 1. Overall Rates of Exception Reporting by 8105 Family Practices in England.

From April 2005 through March 2006, physicians excluded a median of 5.3% of patients (interquartile range, 4.0 to 6.9) from quality calculations in the pay-for-performance program (mean \pm SD], 5.3 ± 2.5). The percentages of exclusion reporting in the practices ranged from 0% to 28.3%.

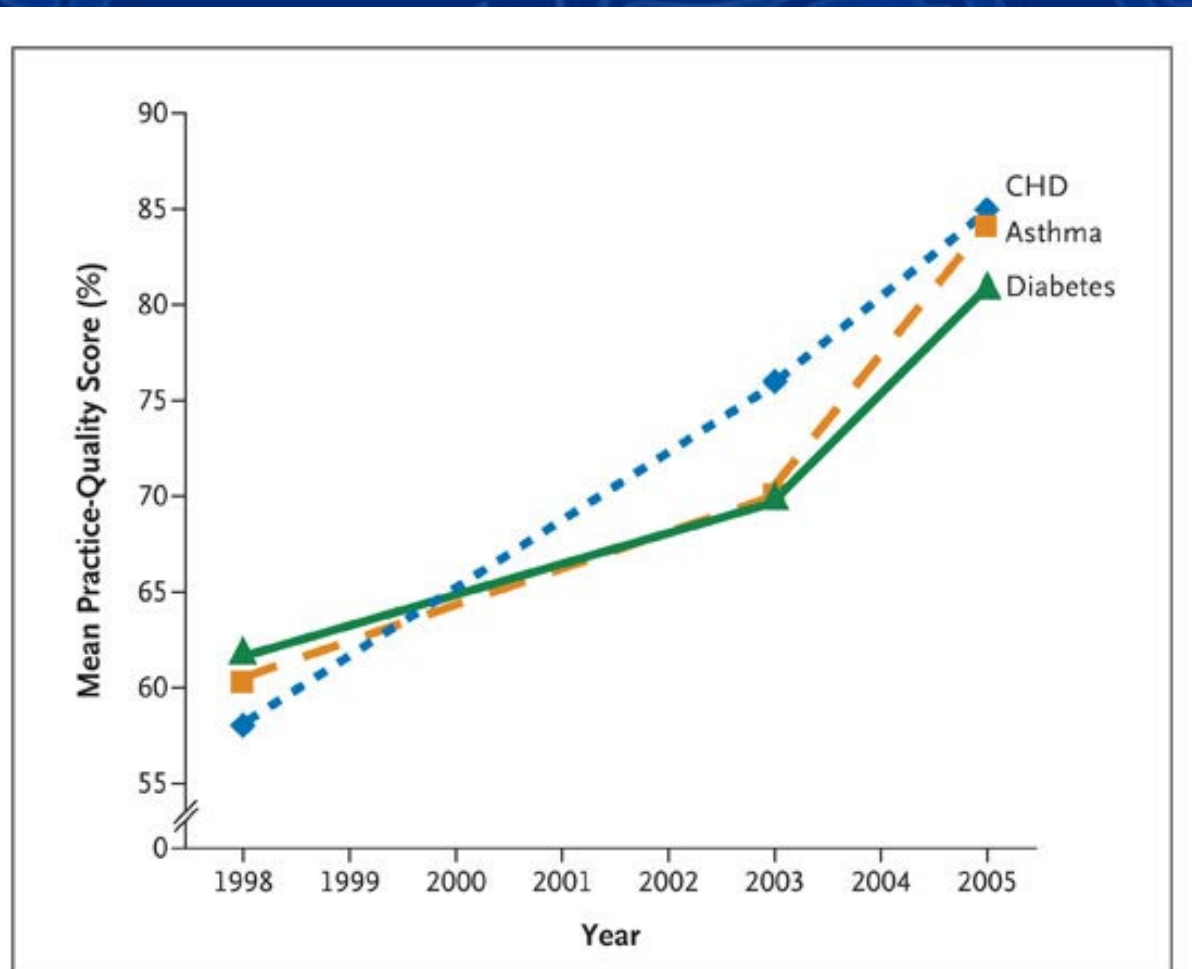


Impact of QoF on independently assessed clinical performance (Campbell et al, 2007)

- Representative sample of English practices in 1998, 2003 & 2005; chart review
- Continued improvements in quality post-QoF despite improving trend pre-QoF (CHD, diabetes, asthma)
- Rate of improvement has accelerated post-QoF for asthma & diabetes
- Local studies corroborate these findings



Mean Scores for Clinical Quality at Practice Level for Coronary Heart Disease, Asthma, and Type 2 Diabetes, 1998, 2003 & 2005



Source: Campbell et al
NEJM 2007; 357: 181-90



Impact of financial incentives on quality

Table 4. Mean Difference in Improvement for Indicators with and without Incentives.*

Category	Mean Difference (95% CI)	P Value
Coronary heart disease	0.53 (-0.01 to 1.08)	0.054
Asthma	0.03 (-0.45 to 0.51)	0.904
Type 2 diabetes	0.08 (-0.32 to 0.49)	0.682

* The mean difference is the amount by which the observed difference between transformed overall scores for clinical indicators for which financial incentives were or were not provided exceeded the predicted difference. CI denotes confidence interval.

Source: Campbell et al
NEJM 2007; 357: 181-90



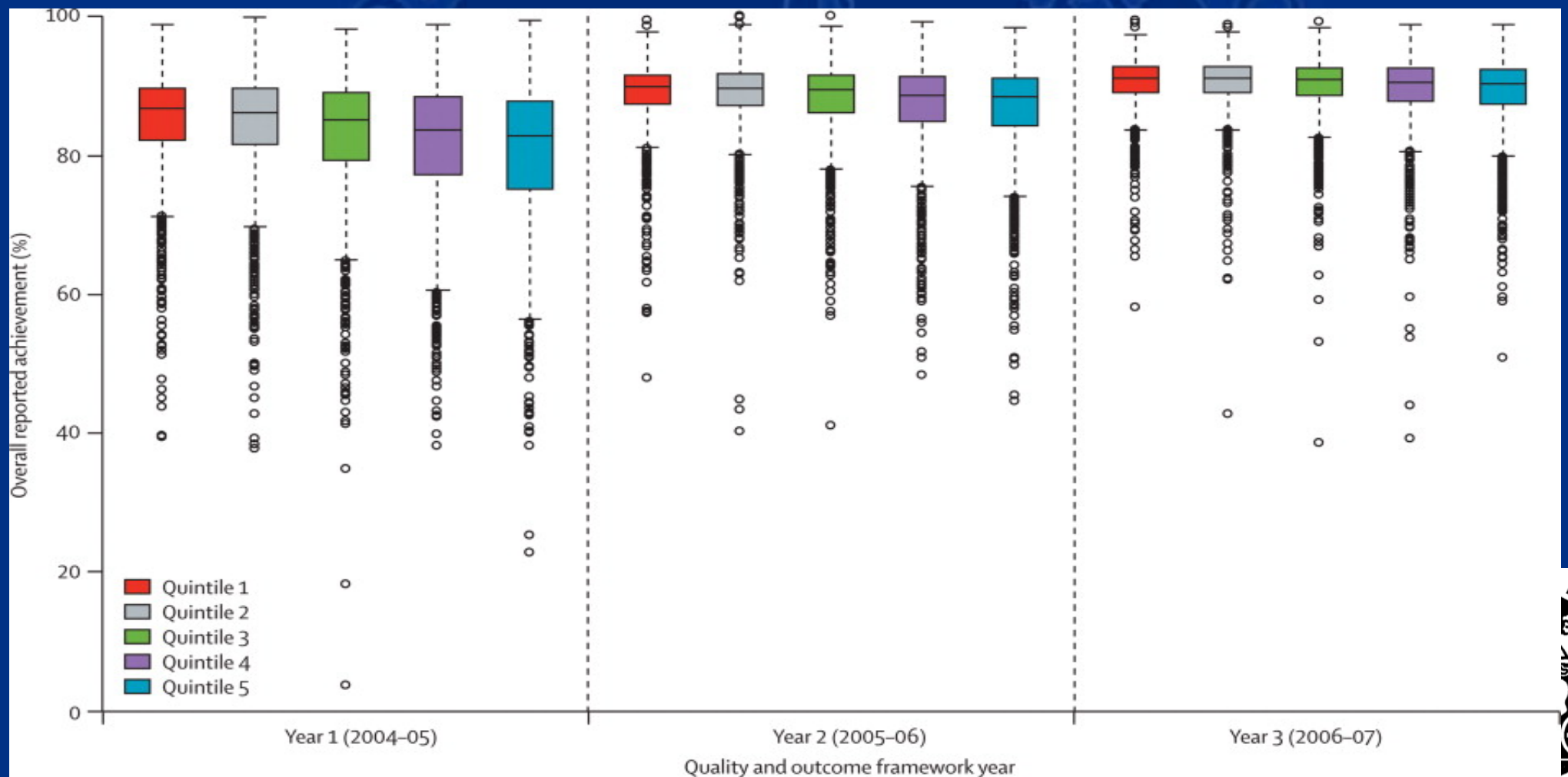
Distribution of QoF reported performance

- Practices in more deprived areas had lower QoF scores initially, though differences were small (Doran et al, 2006 & 2008; Wright et al, 2006)
 - exclusions & prevalence adjustments may not fully reward additional work required in more deprived areas (McLean et al, 2006; Guthrie et al, 2006)
- But clear evidence of QoF ‘catch up’ among practices in more deprived areas (Doran et al, 2008)
 - difference in mean QoF score in least and most deprived quintiles fell from 64.5 points (04/05) to 30.4 (05/06) (Ashworth et al, 2007)
 - years 1-3, median achievement increased 4.4% for quintile 1 and 7.6% for quintile 5 (most deprived)



Distribution of overall reported achievement by deprivation quintile, year 1 (04/05) to year 3 (06/07)

Doran et al. *Lancet* 2008; 372: 728-36



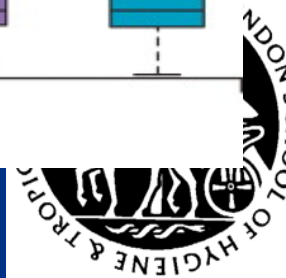
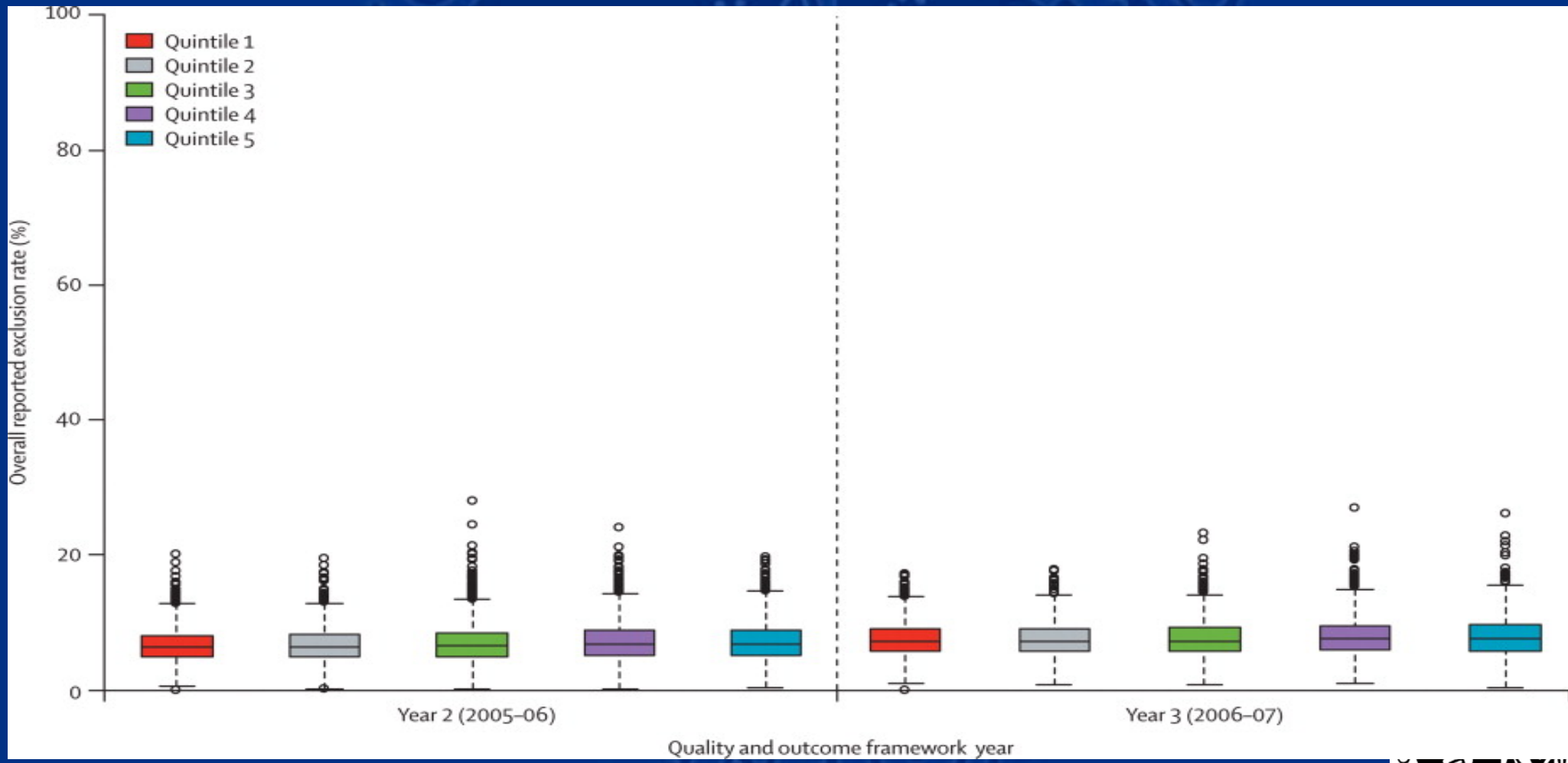
Distribution of QoF reported performance

- Smaller practices have lower QoF scores tho' in organisational rather than clinical domains (Wang et al, 2006)
- But practices in deprived areas no more likely to report 'exceptions' than other practices (Doran et al, 2006)



Distribution of exclusion rates by deprivation quintile, year 2 (05/06) and year 3 (06/07)

Doran et al. *Lancet* 2008; 372: 728-36



How have improvements been accomplished?

- Changes in practice organization, especially more systematic care and better record keeping
 - Better call/recall systems
 - Risk profiling of enrolled patients
 - Protocol-driven care
 - Templates for recording actions in electronic patient record
- Building on past investment in IM&T
 - Almost all GPs use computers for clinical care
- Increased workload for nurses



Assessment of the QoF



Advantages of the QoF

- Largely evidence-based, negotiated, widely accepted (near 100% uptake)
- Can be altered in response to evidence of impact
- Has likely improved care though no RCTs
- Part of 'blended' payment contract consistent with economic evidence on paying physicians
 - salary, FFS, capitation & P4P have major flaws when used alone
- Better team work, records & organisation
- Accelerated existing changes



Claimed drawbacks of the QoF

- Some commentators still very critical (Mangin & Toop, 2007)
 - lack of evidence base
 - simplistic
 - external, top-down, imposed bribery
 - unquantified opportunity costs
 - loss of professional identity, rule/contract-driven care
- Non-incentivized activities may receive less attention
- Patients' concerns & professional judgement may be subordinated to incentivized activities
- Too much focus on secondary prevention
- Effect of QoF on reporting versus new activity
- Large additional spending may not be value-for-money
 - Incentives may be over-powered



Conclusions: significance of the QoF

- Revolution in GP payment methods tho' some previous experience
- Innovative, world first (largest scheme globally)
- Established P4P principle with GPs because consistent with pre-existing professional activities/role
- Shows that financial incentives can lead to adoption of new approaches that contribute to improved quality without producing major disparities
 - likely reduced inequalities in care quality related to area deprivation, may help reduce health inequalities in time, though not inevitable
- Changes inter-professional relations
- Critical to incentivize valuable activities since it shapes behaviour



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