England's National Pay for Performance Programme

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The National Health Service (NHS) in England

- Universal population coverage
- Comprehensive benefits package
- Free at the point of use (with limited exceptions)
- Tax funded
- ‘Once the envy of the world, now the envy of the world’s finance ministers’ (Abel-Smith)
- Celebrated 60th anniversary in 2008

Strengths and weaknesses of the NHS

- Strong on financial access and equity – financial barriers to NHS care do not exist
- Weak on speed of access – long wait times for non-urgent care, and hence parallel private sector
- England has often come out in the middle of the pack of OECD systems
- Quality of care is not as good as in the best of these systems

The role of primary care

- All citizens are registered with a general practitioner (GP) – 1700 on average
- GPs work in small groups (3-4 typically) and are supported by nurses and other team members
- GPs use electronic care records but these do not link with hospitals
- Primary care is one of the strengths of the NHS

A decade of reform

- Expenditure on the NHS has increased significantly since 2000
- Investment has been linked to government led reform
- Speed of access has improved in all areas of care
- Clinical priorities like cancer and cardiac care have also improved
- The Commonwealth Fund's most recent assessment ranked England first in a group of six countries

P4P in England

- The main focus has been on primary care
- New contract agreed between government and the British Medical Association (BMA) came into effect in 2004
- The contract rewards practices for the quality of care they provide, as well as retaining capitation payments
- Five years on a number of lessons have been learned

A view from across the Atlantic

‘with one mighty leap, the NHS vaults over anything being attempted in the United States, the previous leader in quality improvement initiatives’

Paul Shekelle, BMJ, 2003; 326: 457-8

The new P4P contract

- The Quality and Outcomes Framework (QOF)
- Around 25% of a practice's income is dependent on performance
- The QOF originally covered 10 chronic diseases, five areas of practice organisation, and patient experience
- 146 quality indicators were included in the QOF, and around half covered clinical care
- Performance on indicators converts into points, up to a maximum of 1050
- Academics advised government on the content of the QOF

Chronic diseases

- Coronary heart disease
- Stroke
- Hypertension
- Epilepsy
- Diabetes
- Asthma
- Hypothyroidism
- COPD
- Cancer
- Mental health

Clinical indicators

- The clinical indicators cover process measures and intermediate outcomes
- Examples of *process measures* are recording of blood pressure and cholesterol among patients on the appropriate disease register
- Examples of *intermediate outcomes* are control of blood pressure and cholesterol in these patients
- Practices earn points depending on their achievements on these measures, up to a maximum of 550
- The higher the proportion of patients who receive care in line with the indicators, the more points that are earned and the higher the income for the practice

Practice organisation and patient experience

- Practice organisation covers records and information about patients, communication with patients, education and training, management of medications, and management of the practice (up to 184 points)
- Patient experience covers the experience of patients as measured in surveys, and the length of consultations (up to 100 points)
- Remaining points relate to preventive care, access, and levels of performance in all areas (216 points)

Other features of the contract

- Practices report their results based on data they collect
- A sample of reports are checked for accuracy etc.
- Practices can exclude certain patients in reporting their performance
- The contract assumes a high level of trust and integrity

The results

- Practices exceeded expected performance under the QOF
- Achievements were around 95% of available points compared with an expected 75%
- There was little variation between practices in performance
- Government expenditure on this area of care was much higher than planned

The results (2)

- Analysis shows that the quality of care was improving before the contract
- These improvements continued after 2004 with some evidence of acceleration for asthma and diabetes
- Research has shown the contract contributed to a reduction in inequalities in the delivery of primary care related to deprivation
- There is also some evidence of benefits in relation to the needs of minority ethnic patients

Quality improvements have been substantial

Patients with CHD	1998	2003	2005	2007
% with blood pressure ≤ 150/90	48%	72%	82%	83%
% with total cholesterol ≤ 5mmol/l	17%	61%	73%	80%

First three data points from Campbell S et al. NEJM 2007; 357:181-190
Fourth data point unpublished.

Lessons learned

- Incentives work – English GPs responded positively to the prospect of extra pay
- The size of the incentives almost certainly made a difference to performance
- Predicting the impact of incentives is difficult, especially when the baseline is unclear
- One of the consequences has been to make primary care an attractive career choice for new physicians but GP partners are employing more salaried physicians

Lessons learned

- Some of these problems might have been addressed through piloting of the QOF
- But negotiation of the new contract was a lengthy and political process
- The BMA is a well organised trade union with a record of getting good deals for its members
- A contract with smaller incentives, and that was piloted before roll out, may never have happened

P4P redux

- Changes to the contract have been agreed since 2004
- New chronic diseases have been added to the list e.g. chronic kidney disease
- New indicators have been added for existing diseases e.g. for mental health
- Data sources for some indicators have been strengthened e.g. patient surveys

Other emerging issues

- A concern was that ‘what gets measured gets done’ and that other diseases not in the contract would be neglected
- Some GPs feared they would become technicians reduced to ‘tick box medicine’
- Nurses in primary care have done much of the work, but GPs receive the financial benefits
- Were the right indicators used, and should more emphasis have been placed on outcomes?

The view of critics

'The QOF diminishes the responsibility of doctors to think…and encourages a focus on points scored, thresholds met, and income generated…the failure to make any allowance for old age means that doctors are encouraged to overtreat hypertension in old people with the danger of causing fainting, falls and fractures. The whole initiative is based on reductive linear reasoning'

I Heath et al, BMJ, 2007, 335: 1075-1076

The view of critics (2)

‘The eight practices participating in our hypertension study…would have achieved near maximum points for blood pressure control despite appreciable therapeutic inertia and missed opportunities for tighter control…incorporating treatment information into intermediate outcome indicators will signpost how practices can improve management of risk factors by identifying and reducing therapeutic inertia’

B. Guthrie et al, BMJ, 2007, 335: 542-44

An independent assessment

'Our results generally support the view of the Institute of Medicine that pay-for-performance programs can make a useful contribution to improving quality, particularly when such programs are part of a comprehensive quality-improvement program'

S. Campbell et al, 2007, NEJM, 357: 181-190

Value for money for taxpayers?

- The National Audit Office found that pre tax pay for GPs increased by 58% between 2002-03 and 2005-06
- GPs were able to give up their 24/7 responsibilities under the contract, for the loss of some income
- The net effect was that GPs received a major increase in income and a reduction in hours worked
- Analysis by the Treasury suggests that England now has the highest paid GPs in the world

The QOF class

Wider issues

- Incentives are only one element in a quality improvement strategy
- Before QOF, quality in primary care was already improving
- Guidelines, audit, feedback, and professional leadership all contributed
- Designing and calibrating incentives is inherently difficult

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In summary

- The world's biggest P4P experiment offers a cautionary tale
- Some benefits have been achieved at high cost
- One view is that GPs are being paid belatedly for their hard work in improving quality pre QOF
- The experiment demonstrates the importance of knowing the baseline and piloting new payment systems where possible

Key references

- T. Doran et al (2006) ‘Pay-for-Performance Programs in Family Practices in the UK’ NEJM, 335: 375-84
- S. Campbell et al (2007) ‘Quality of Primary Care in England with the Introduction of Pay for Performance’ NEJM, 357; 181-90
- R. Galvin (2006) ‘Pay-For-Performance: Too Much of a Good Thing? A Conversation with Martin Roland’ Health Affairs, 25; w412-419

Thank you

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