The Health Foundation
Inspiring Improvement

Improving primary care: the role of financial incentives

Professor Martin Marshall

Clinical Director and Director of Research and Development

Swedish Health Policy Forum, September 2011

The structure of the English NHS

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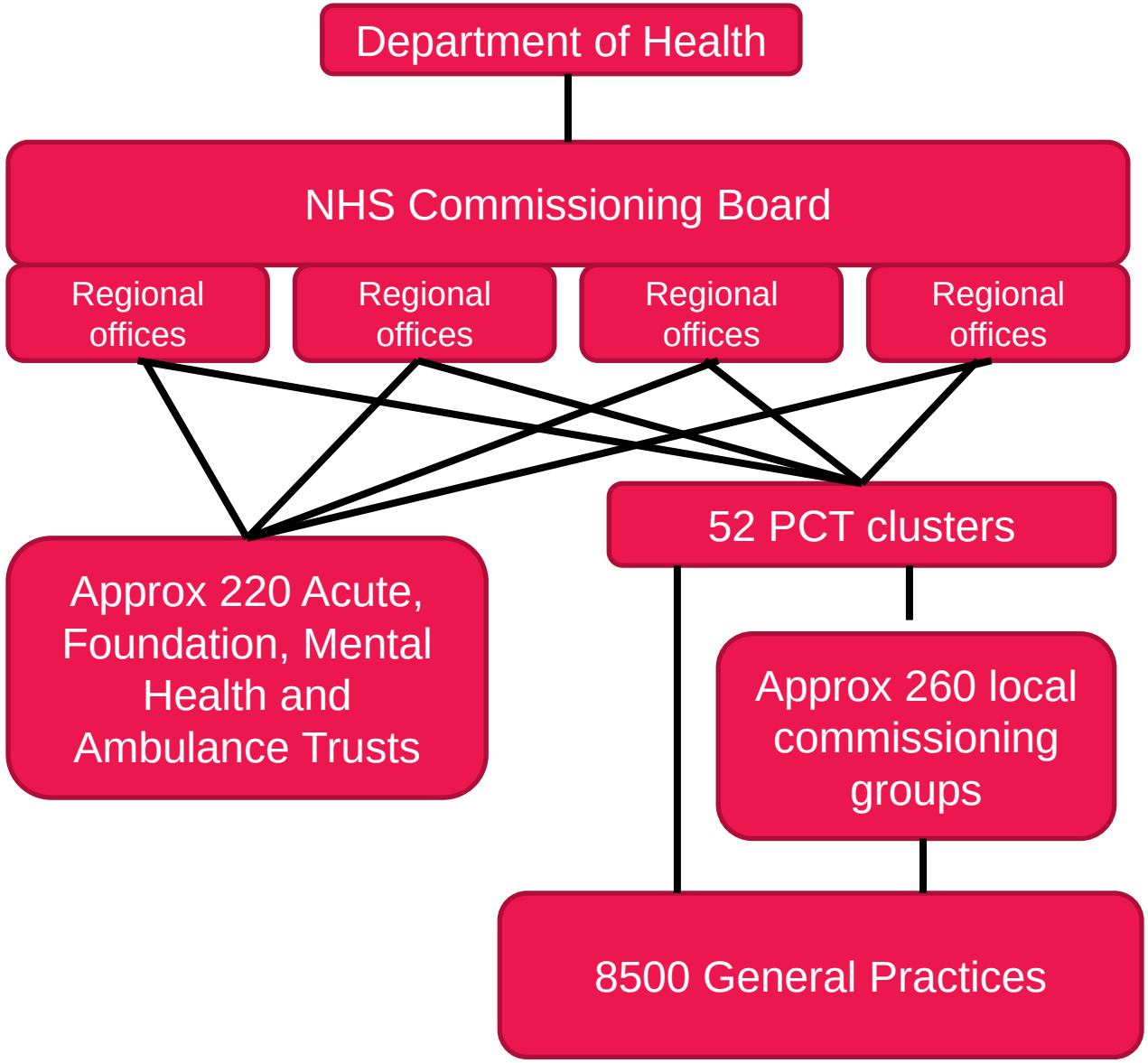
Inspiring Improvement



NHS

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Seven-Nation Summary Scores on Health System Performance

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

Challenges facing primary care in the UK

- Mixed messages from policy makers about its importance in the health system
- Largely regarded as under-managed and under-regulated
- General practice is not good at making its case, specifically the role of the medical generalist
- Risk that policy changes may damage strengths of traditional general practice
- Slow progress being made on dealing with poor performance and wide variation in performance

What does ‘quality’ mean in primary care?

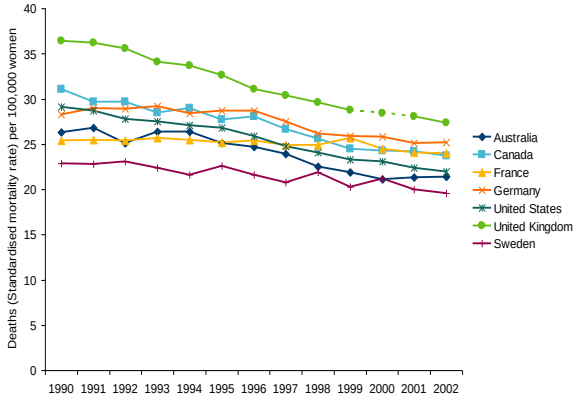
Need to achieve a balance between

Health orientation:

- Biomedical/clinical responsibilities
- Population health responsibilities
- Psycho-social responsibilities

Different dimensions of quality:

- Access/timeliness
- Safety
- Patient centeredness
- Effectiveness
- Equity
- Efficiency




Governmental
Infrastructural change
Regulation
Performance management
Legislation
Professional
Education and training
Clinical audit
Peer review/ collaboration
Guidelines
Economic
Incentives/sanctions
Patient choice
Competition
Commissioning
'Industrial'/ organisational
Organisational development
Continuous quality improvement
Lean, 6 Sigma

The Quality and outcomes framework

- Introduced in 2004 following intensive negotiations
- 25 - 30% of GPs' income relates to a complex set of 136 quality indicators in 3 domains:
  - Clinical
  - organisational
  - Patient experience
- £2 billion additional funding per annum

The Quality and outcomes framework

76 clinical indicators:

- Coronary heart disease and heart failure (15)
- Stroke and transient ischaemic attack (10)
- Hypertension (5)
- Diabetes (18)
- Epilepsy (4)
- Hypothyroidism (2)
- Mental health (5)
- Asthma (7)
- Chronic obstructive pulmonary disease (8)
- Cancer (2)

CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months.

Point score: from 1 point (25%) to 7 points (90%)

CHD 8. The percentage of patients with coronary heart disease whose last total cholesterol (measured in the last 15 months) is 5 mmol/l or less

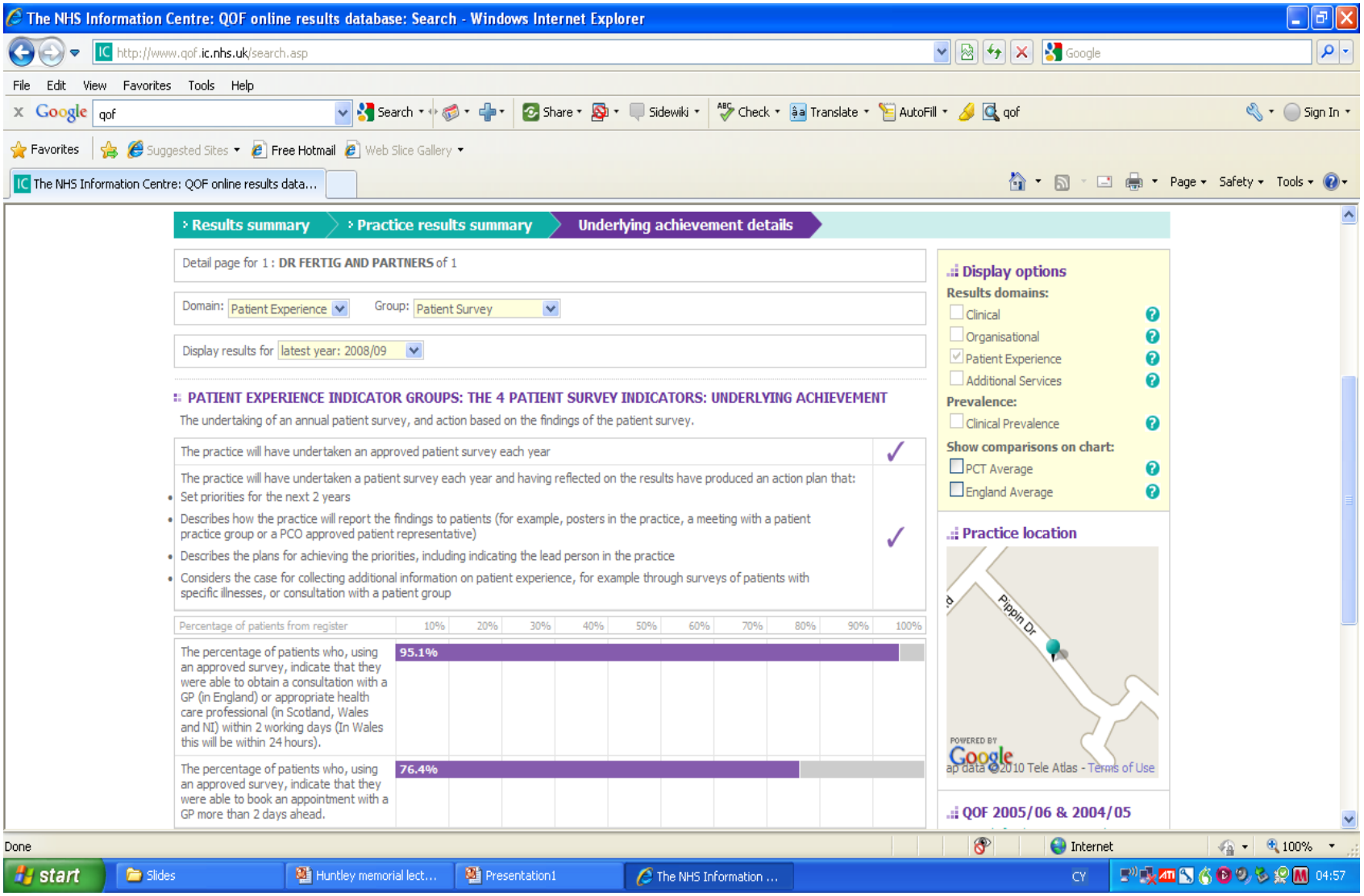
Point score: from 1 point (25%) to 16 points (60%)

Exception reporting

- Patient refused
- Not clinically appropriate
- Newly diagnosed or recently registered
- Already on maximum treatment

Data collection

- All data extracted automatically from electronic GP records
- Diagnoses etc have to be coded by GPs
- Data drives payments
- Information on quality of care publicly available


The NHS Information Centre: QOF online results database: Search - Windows Internet Explorer
http://www.qof.ic.nhs.uk/search.asp
Results summary
Practice results summary
Underlying achievement details
Detail page for 1 : DR FERTIG AND PARTNERS of 1
Domain: Patient Experience
Group: Patient Survey
Display results for latest year: 2008/09
PATIENT EXPERIENCE INDICATOR GROUPS: THE 4 PATIENT SURVEY INDICATORS: UNDERLYING ACHIEVEMENT
The undertaking of an annual patient survey, and action based on the findings of the patient survey.
The practice will have undertaken an approved patient survey each year
The practice will have undertaken a patient survey each year and having reflected on the results have produced an action plan that:
Set priorities for the next 2 years
Describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative)
Describes the plans for achieving the priorities, including indicating the lead person in the practice
Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group
Percentage of patients from register
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
The percentage of patients who, using an approved survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (In Wales this will be within 24 hours).
95.1%
The percentage of patients who, using an approved survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.
76.4%
Display options
Results domains:
Clinical
Organisational
Patient Experience
Additional Services
Prevalence:
Clinical Prevalence
Show comparisons on chart:
PCT Average
England Average
Practice location
Pippin Dr
Google
QOF 2005/06 & 2004/05
Done
Internet
100%
start
Slides
Huntley memorial lect...
Presentation1
The NHS Information ...
04:57

Impact of the Quality and Outcomes Framework

1. On practice organisation

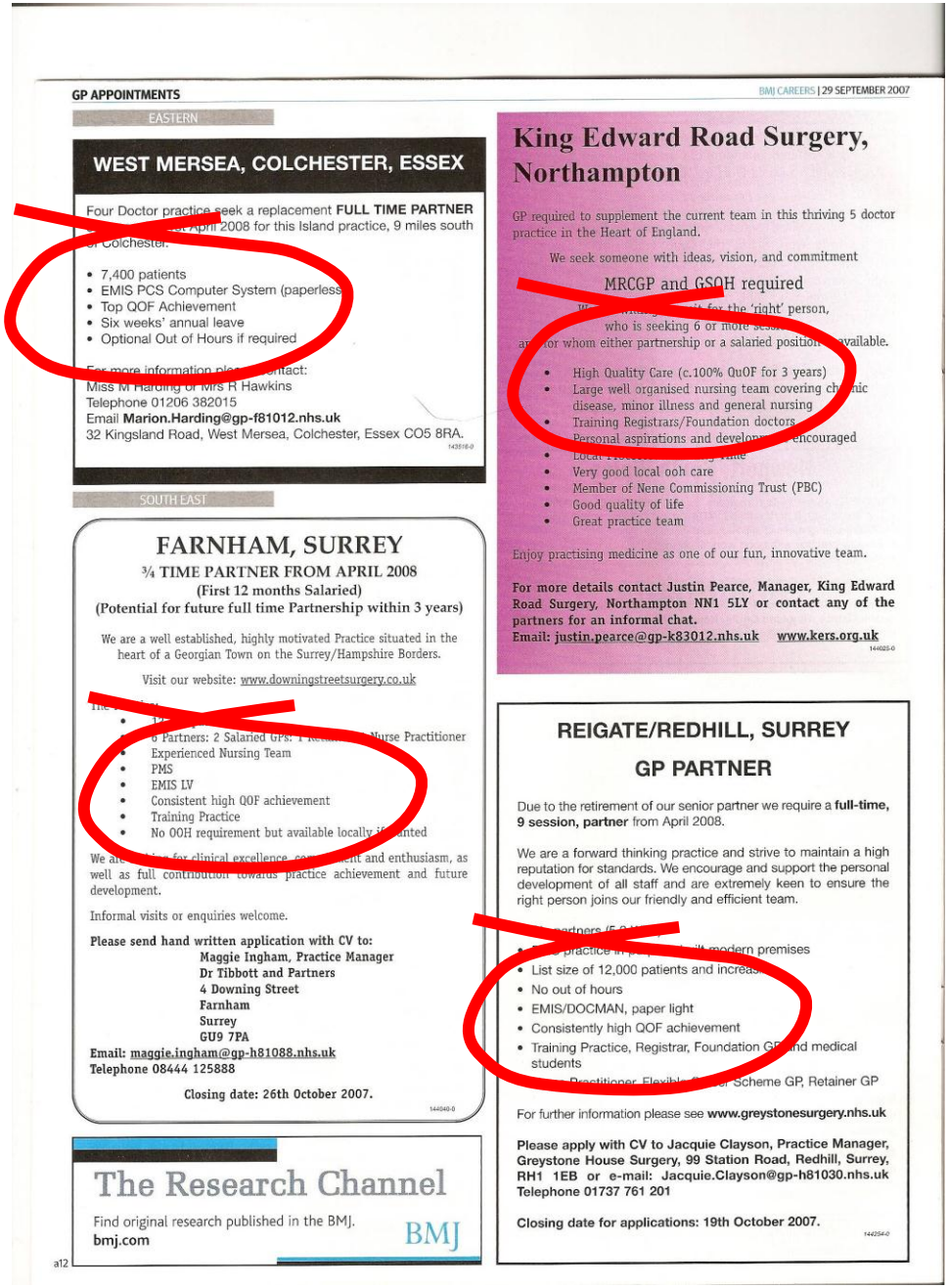
Impact on practice organisation

Practices have significantly changed the way they are organised:

- increased computerisation, focus on recording
- larger teams, more nurses
- increased administrative costs

"This one guy kept letting me down. When we actually got him in and got his blood taken, it was like 'Yeah, yeah', dancing round the room and everything" (Practice nurse)

(McDonald R, Harrison S and Checkland K. Organization, 2008)



GP APPOINTMENTS

BMJ CAREERS | 29 SEPTEMBER 2007

EASTERN

WEST MERSEA, COLCHESTER, ESSEX

Four Doctor practice seek a replacement **FULL TIME PARTNER** [illegible] April 2008 for this Island practice, 9 miles south of Colchester.

- 7,400 patients
- EMIS PCS Computer System (paperless)
- Top QOF Achievement
- Six weeks' annual leave
- Optional Out of Hours if required

For more information please contact:
Miss M Harding or Mrs R Hawkins
Telephone 01206 382015
Email **Marion.Harding@gp-f81012.nhs.uk**
32 Kingsland Road, West Mersea, Colchester, Essex CO5 8RA.

King Edward Road Surgery, Northampton

GP required to supplement the current team in this thriving 5 doctor practice in the Heart of England.

We seek someone with ideas, vision, and commitment

MRCGP and GSOH required

[illegible] for the 'right' person, who is seeking 6 or more sessions and for whom either partnership or a salaried position is available.

- High Quality Care (c.100% QuOF for 3 years)
- Large well organised nursing team covering chronic disease, minor illness and general nursing
- Training Registrars/Foundation doctors
- Personal aspirations and development encouraged
- Local [illegible]
- Very good local ooh care
- Member of Nene Commissioning Trust (PBC)
- Good quality of life
- Great practice team

Enjoy practising medicine as one of our fun, innovative team.

For more details contact Justin Pearce, Manager, King Edward Road Surgery, Northampton NN1 5LY or contact any of the partners for an informal chat.
Email: justin.pearce@gp-k83012.nhs.uk www.kers.org.uk

SOUTH EAST

FARNHAM, SURREY

¾ TIME PARTNER FROM APRIL 2008
(First 12 months Salaried)
(Potential for future full time Partnership within 3 years)

We are a well established, highly motivated Practice situated in the heart of a Georgian Town on the Surrey/Hampshire Borders.

Visit our website: www.downingstreetsurgery.co.uk

- [illegible]
- 6 Partners: 2 Salaried GPs; 1 [illegible] Nurse Practitioner
- Experienced Nursing Team
- PMS
- EMIS LV
- Consistent high QOF achievement
- Training Practice
- No OOH requirement but available locally if wanted

We are looking for clinical excellence, commitment and enthusiasm, as well as full contribution towards practice achievement and future development.

Informal visits or enquiries welcome.

Please send hand written application with CV to:
Maggie Ingham, Practice Manager
Dr Tibbott and Partners
4 Downing Street
Farnham
Surrey
GU9 7PA
Email: maggie.ingham@gp-h81088.nhs.uk
Telephone 08444 125888

Closing date: 26th October 2007.

REIGATE/REDHILL, SURREY

GP PARTNER

Due to the retirement of our senior partner we require a **full-time, 9 session, partner** from April 2008.

We are a forward thinking practice and strive to maintain a high reputation for standards. We encourage and support the personal development of all staff and are extremely keen to ensure the right person joins our friendly and efficient team.

[illegible] partners (5.0 [illegible]) in [illegible] practice in [illegible] with modern premises

- List size of 12,000 patients and increasing
- No out of hours
- EMIS/DOCMAN, paper light
- Consistently high QOF achievement
- Training Practice, Registrar, Foundation GP and medical students
- [illegible] Practitioner, Flexible [illegible] Scheme GP, Retainer GP

For further information please see **www.greystonesurgery.nhs.uk**

Please apply with CV to Jacquie Clayson, Practice Manager, Greystone House Surgery, 99 Station Road, Redhill, Surrey, RH1 1EB or e-mail: Jacquie.Clayson@gp-h81030.nhs.uk
Telephone 01737 761 201

Closing date for applications: 19th October 2007.

The Research Channel

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BMJ

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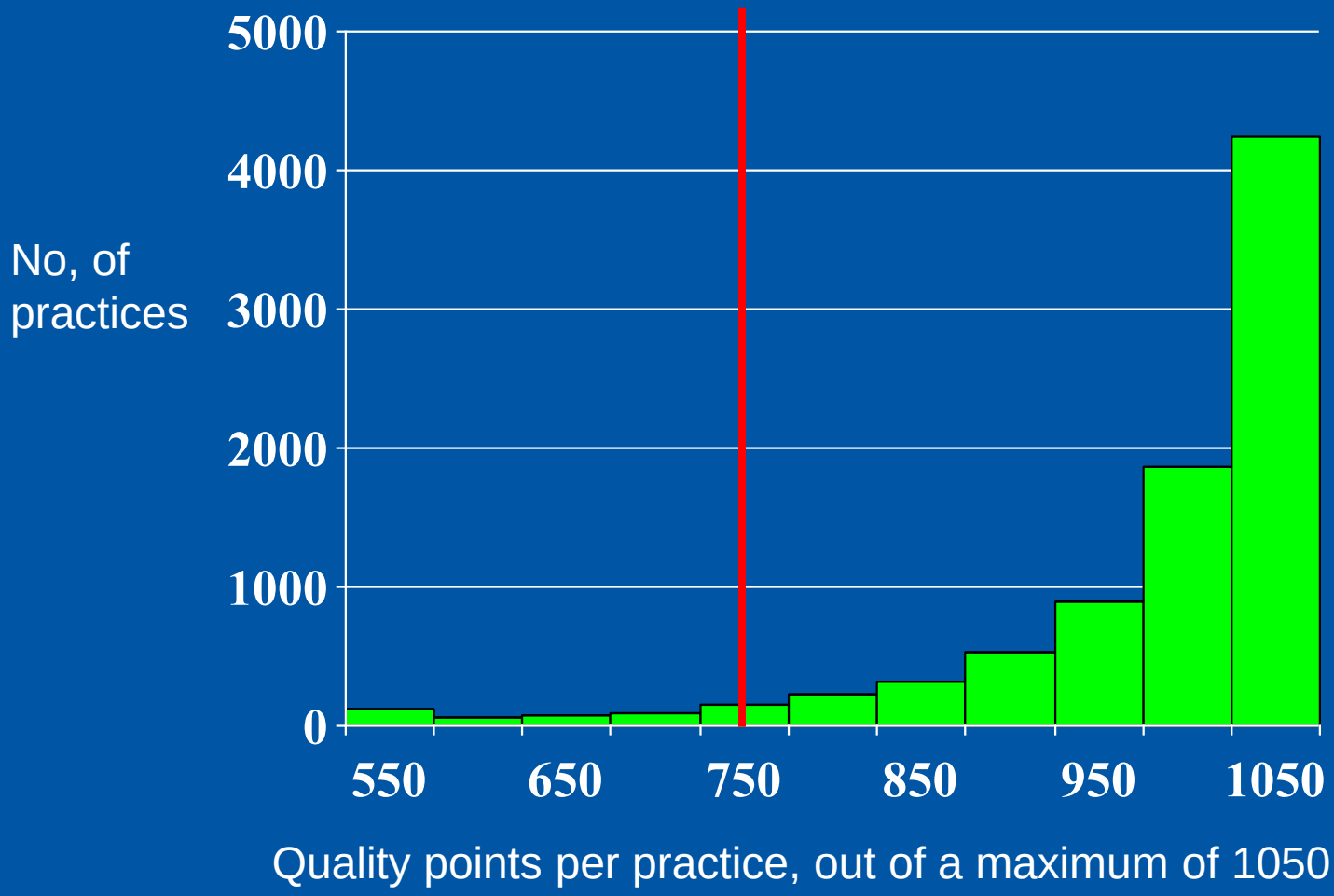
QOF achievement has become part of practice identity

Impact of the Quality and Outcomes Framework

1. On practice organisation
2. On the quality of clinical care

Practice performance in first year of new contract



(Doran et al. NEJM, 2006)

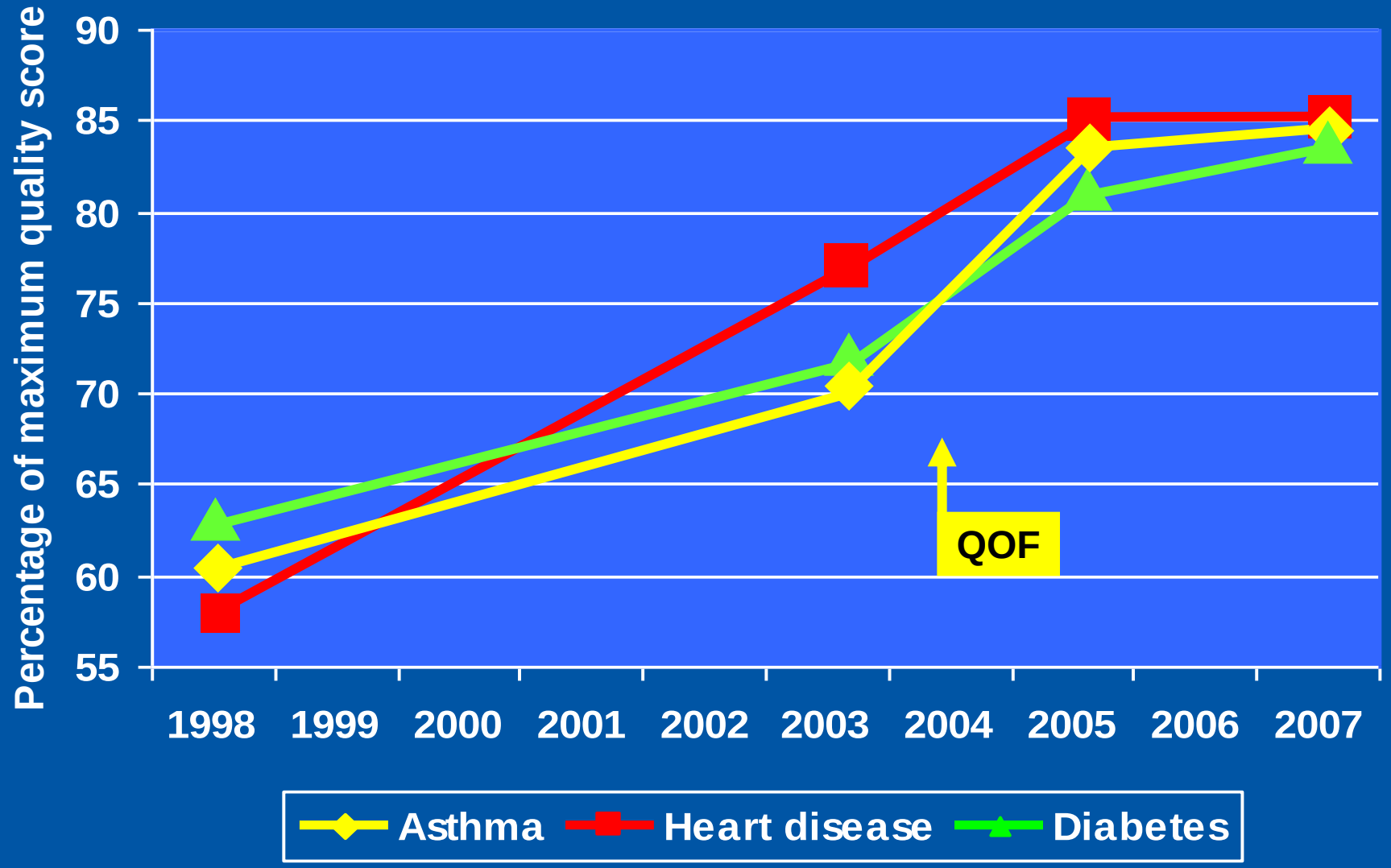
Some quality improvements have been substantial

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%**

(Campbell S et al NEJM 2009)

Quality of care in a nationally representative sample of 42 GP practices for asthma, heart disease and diabetes

48 indicators. Max score for each condition = 100



(Campbell S et al NEJM 2009)

Impact of the Quality and Outcomes Framework

1. On practice organisation
2. On the quality of clinical care
3. On health inequalities

Distribution of QOF scores for overall reported achievement by deprivation quintile, 04-05 to 06-07

(Doran et al Lancet 2008)

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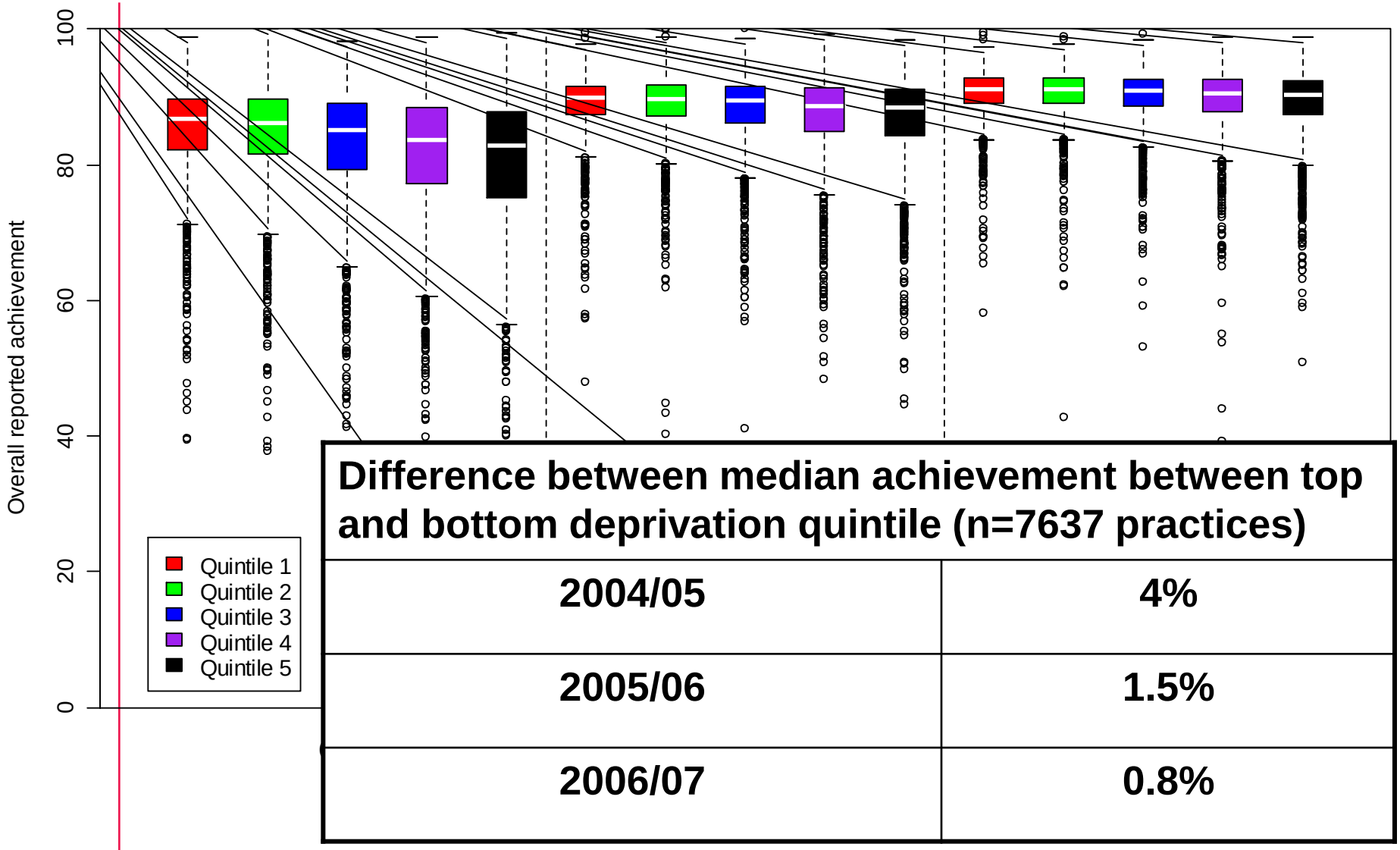


Difference between median achievement between top and bottom deprivation quintile (n=7637 practices)	
2004/05	4%
2005/06	1.5%
2006/07	0.8%

Impact of the Quality and Outcomes Framework

1. On practice organisation
2. On the quality of clinical care
3. On health inequalities
4. Unintended consequences

Gaming (cheating/fraud)

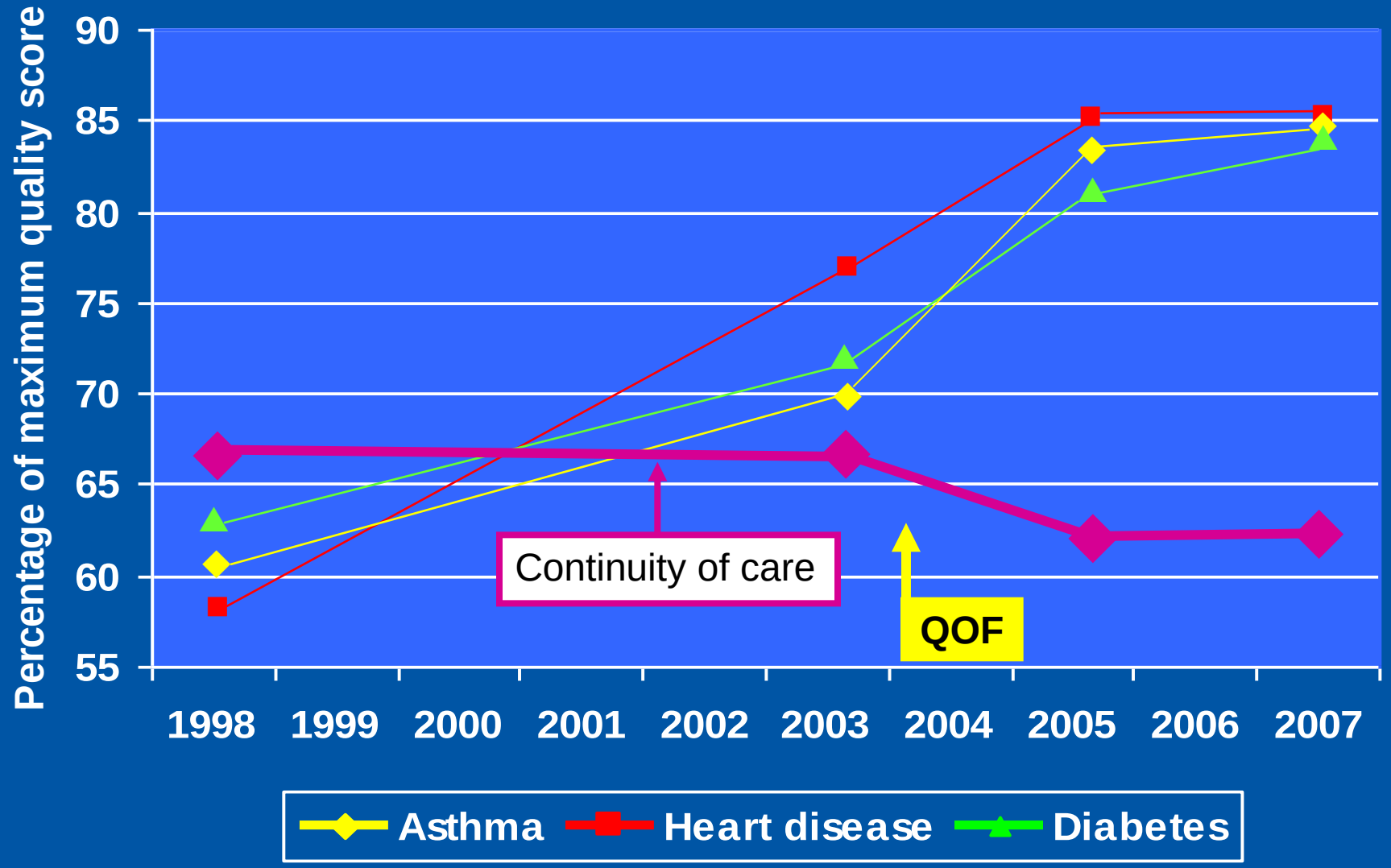
Exception reporting rates

	2004/05	2005/06	2006/07	2007/08	2008/09
Overall median (%)	**5.4**	**5.3**	**5.5**	**5.3**	**4.9**
Range (%)	**0 - 86**	**0 - 28**	**0 - 26**	**0 - 22**	**0 - 19**

Unexpected side-effects - access

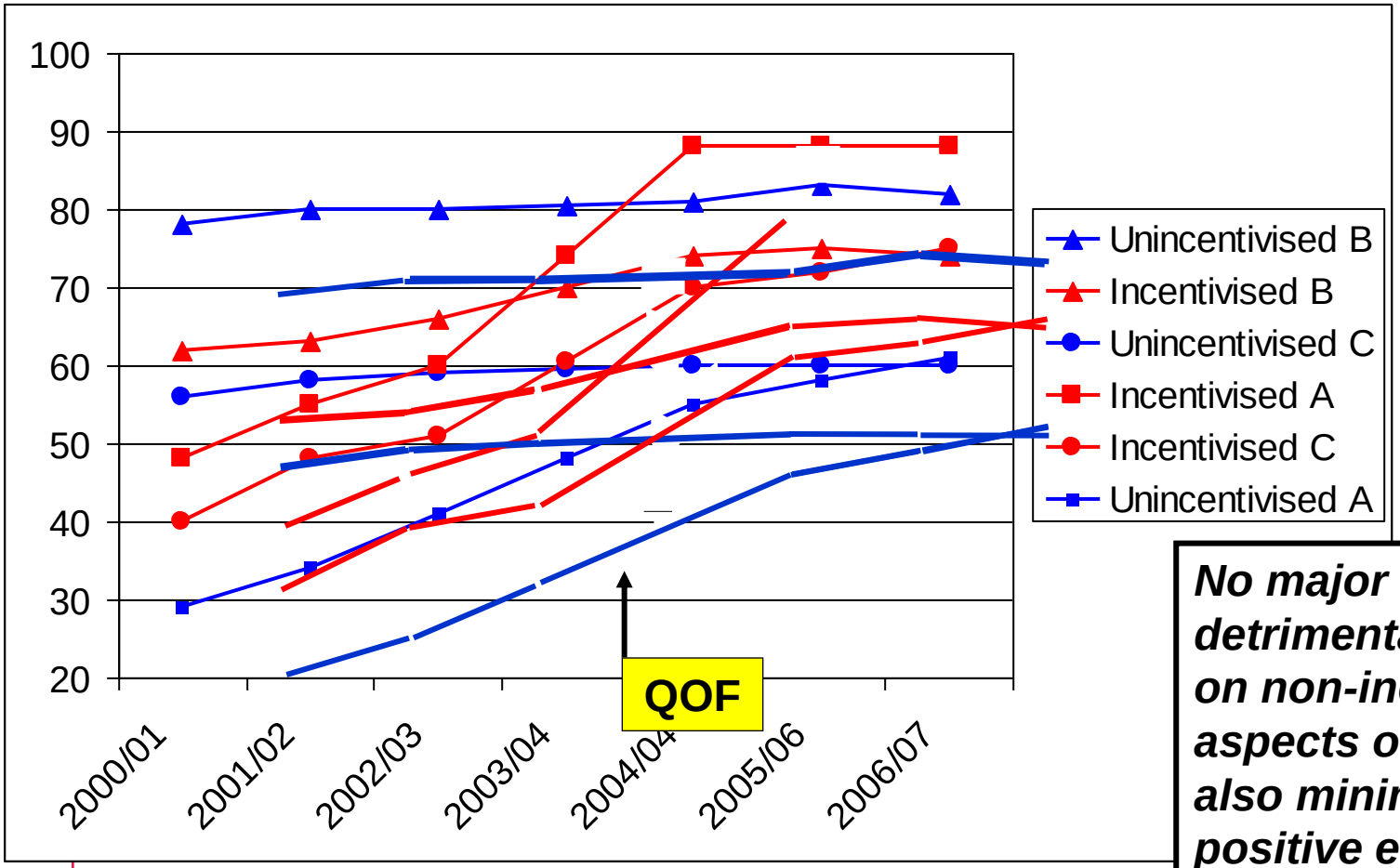
Indicator:	Patients should be able to make an appointment to see a doctor within 48 hours
Response:	Advanced Access – offer unlimited appointments ‘on the day’
Consequence:	Patients are unable to book ahead, and can only book on the day

Unexpected side-effects – continuity of care



(Campbell S et al NEJM 2009)

Unexpected side-effects – un-incentised conditions



No major detrimental effects on non-incentivised aspects of care but also minimal positive effect

Changes in quality of care for 28 incentivised and 20 un-incentivised conditions.
Data from random sample of 4500 patients from 150 practices on GPRD database
A = Measurement, B = Treatment, C = Intermediate outcome

Unexpected side-effects – impact on professionalism

"It will not provide the care for the whole person. It doesn't allow that I have sat in this chair for over twenty years and I know my patients really well. It doesn't allow for that. You can't count that…and you can't count the caring element" (FP) *Roland et al. Primary Healthcare R&D 2006*

"I think because it largely focuses on things which we should be doing anyway, it's just an additional motivation to make sure that we are practising good practice" (FP) *McDonald et al, BMJ 2007*

Unexpected side-effects – impact on professionalism

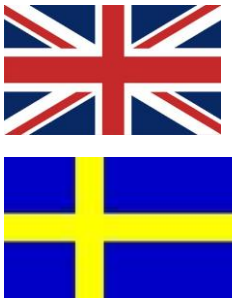
"When we're not meeting a target, I will go in and speak to them privately. I did do one area of naming and shaming … that did work quite well …they don't want to be seen as the GP who's falling down." (FP)

McDonald et al BMJ 2007

"Percentages are for wimps. I don't accept that once you've hit 90% or 70% that's OK. It's not OK. It means that 10% haven't been caught ……. We developed this zero tolerance to blood pressures a while ago. No one is allowed to say 'It's a little bit up leave it'. It's not acceptable. If you're not doing something about it, you need to be able to justify why you're not" (FP)

McDonald et al. BMJ 2007

Learning from the UK's experience (1)

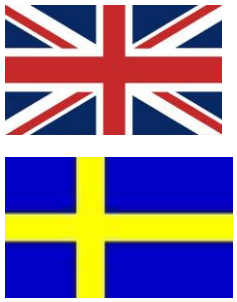


1. High quality primary care should be the foundation for high value health systems
2. When reforming primary care, focus on the deficiencies and preserve what is good
3. Multiple approaches at all levels of the system and over prolonged periods of time are required to improve quality
4. It is important to balance external and internal drivers for change and recognise the complex dynamic between the two
5. Financial incentives are a high profile intervention which are probably little more effective or less effective than other interventions

How doctors are paid

	Description	Implications in absence of professionalism
Salary	Pay independent of workload or quality	Do as little as possible for a few people as possible
Capitation	Pay according to number of people on doctor's list	Do as little as possible for as many people as possible
Fee for service	Pay for individual items of care	Do as much as possible, whether or not it helps the patient
Quality	Pay for meeting quality targets	Carry out a limited range of highly commendable tasks but do little else

Learning from the UK's experience (2)



6. Like all interventions, they have intended consequences which can be largely predicted and managed. The unintended consequences are greater when the incentive is larger
7. There is now a growing evidence base to influence the design and implementation of incentives. Academic input is important

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