

# Intended and Unintended Consequences in the UK's Pay-for-Performance Programme

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# A brief history of P4P in the UK

- 1986
  - “Good Practice Allowance” rejected by British Medical Association
- 1990
  - Financial incentives for high proportions of childhood immunisations and Pap smears
  - Remuneration for establishing health promotion clinics

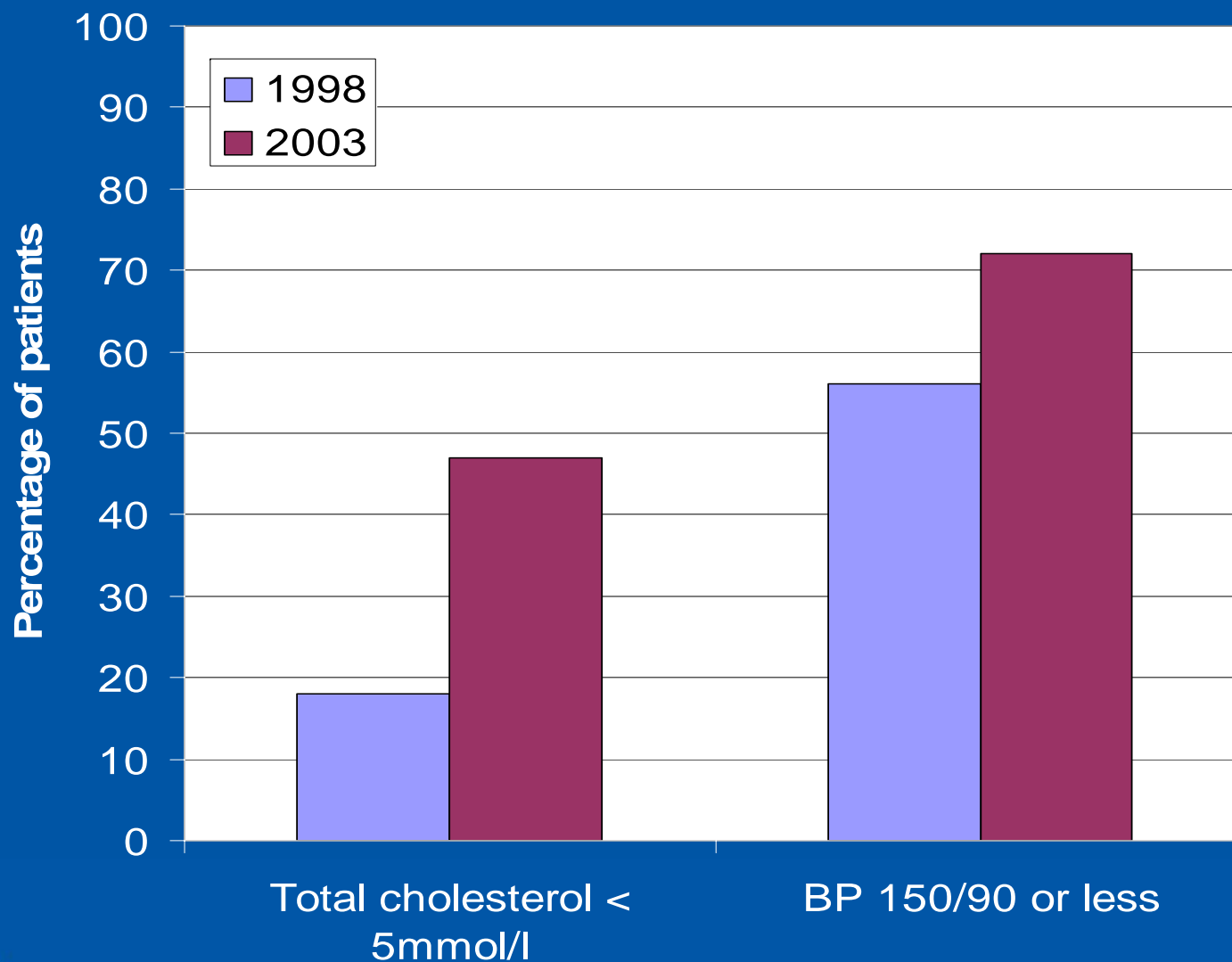


# Quality improvement in the UK

- Between 1997 and 2003:
  - National service frameworks
  - Clinical governance
  - Annual appraisal for clinicians
  - Public release of outcome data
  - National inspection programmes
- Evidence that quality of primary care improved over this period



# Changes in management of coronary heart disease 1998-2003



# The 2003 contract: pay-for-performance

- £1.8 billion (\$3.4 b) invested over 3 years
- GP income increased by up to 25%, dependent on performance
- 146 quality indicators
  - Clinical care for 10 chronic diseases
  - Organisation of care
  - Patient experience



# Quality indicators

- Each indicator worth between 1 and 56 points
- 1,050 points in total
- Each point earns \$145
- Maximum of
  - \$152,075 per practice
  - \$47,500 per GP



- **CHD 6.** The percentage of patients with coronary heart disease whose blood pressure is 150/90 mmHg or less
- Point score:
  - from 1 point (25%) to 19 points (70%)
- Income:
  - From \$0 to \$2,750

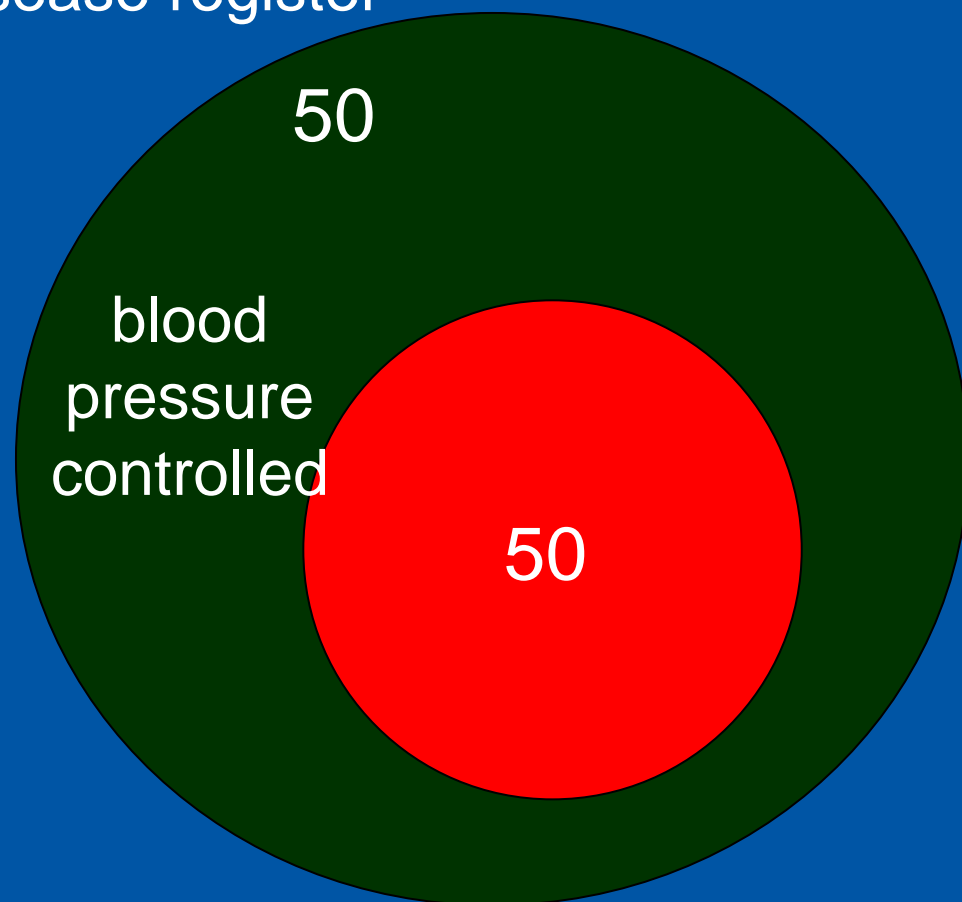


# Protecting patients

- Quality targets are not always appropriate
- Contract allows GPs to 'exception report' inappropriate patients, e.g. patients who:
  - Repeatedly fail to attend
  - Have terminal illness or are extremely frail
  - Can not tolerate medication
  - Do not agree to investigation or treatment

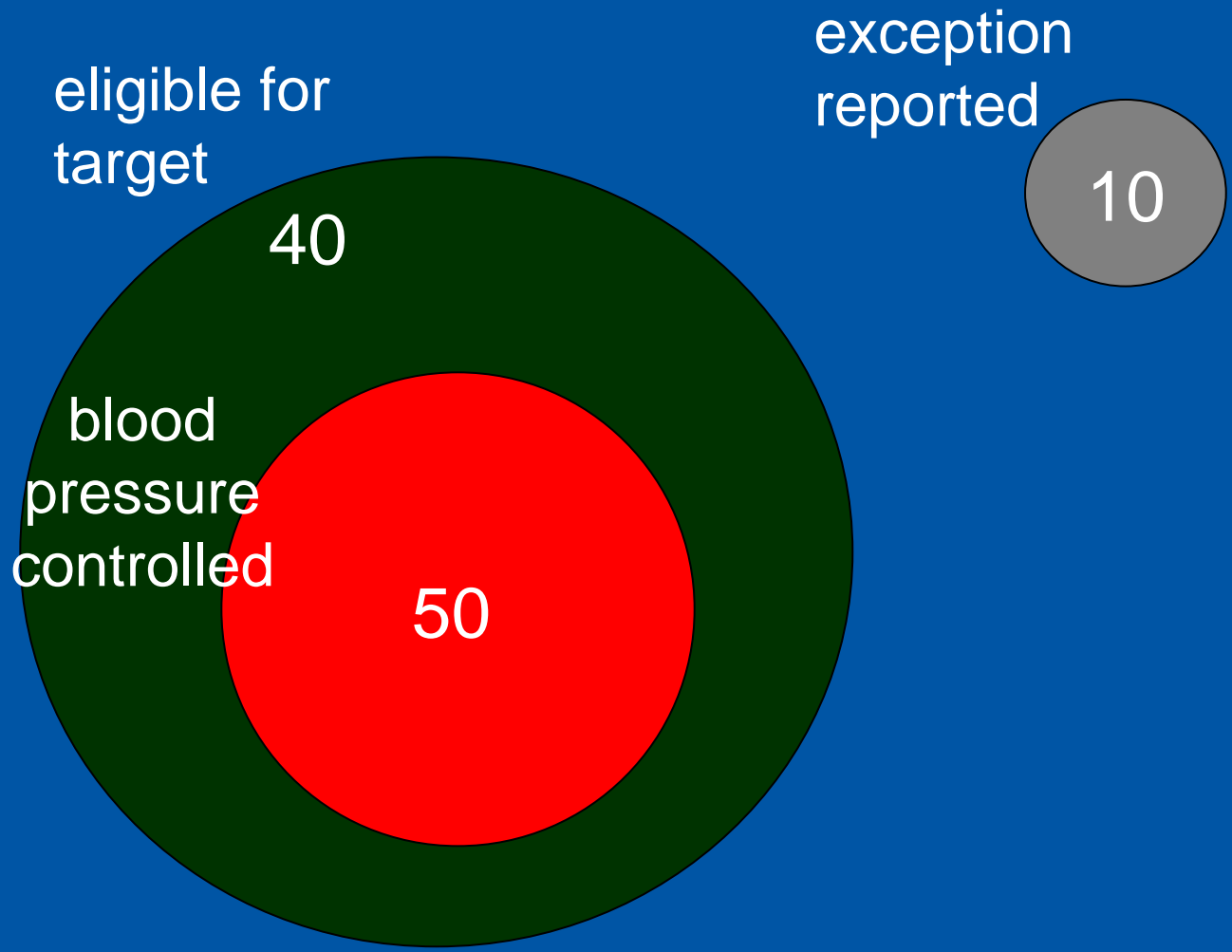


coronary heart  
disease register



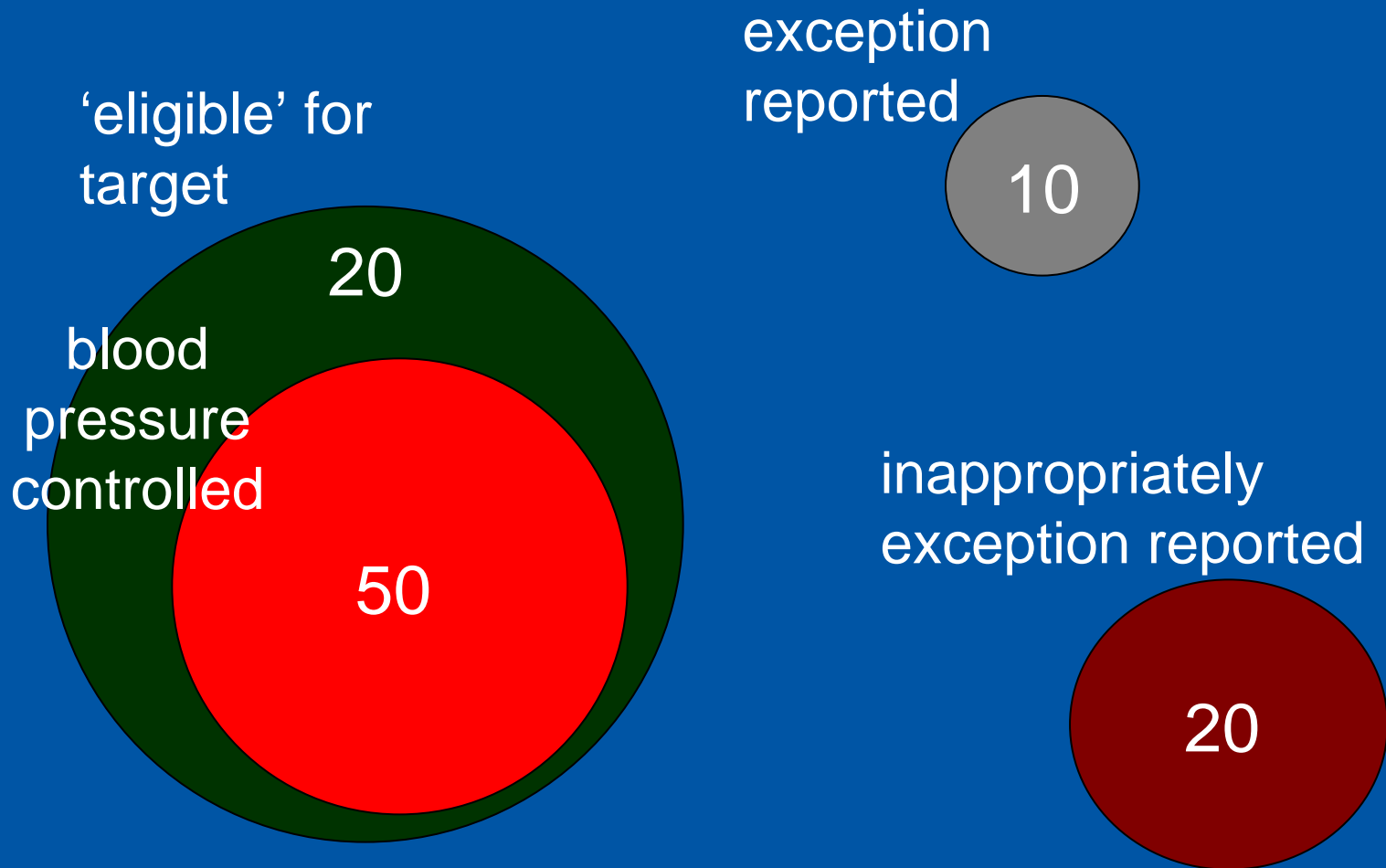
Achievement =  $50/100 = 50\%$  (\$1,530)





Achievement =  $50/90 = 56\%$  (\$1,870)





Achievement =  $50/70 = 71\%$  (\$2,750)



# Investigating consequences

- Intended:
  - Was there a high level of performance on the clinical indicators?
- Unintended:
  - What use did practices make of exception reporting?
  - Was there evidence of gaming?

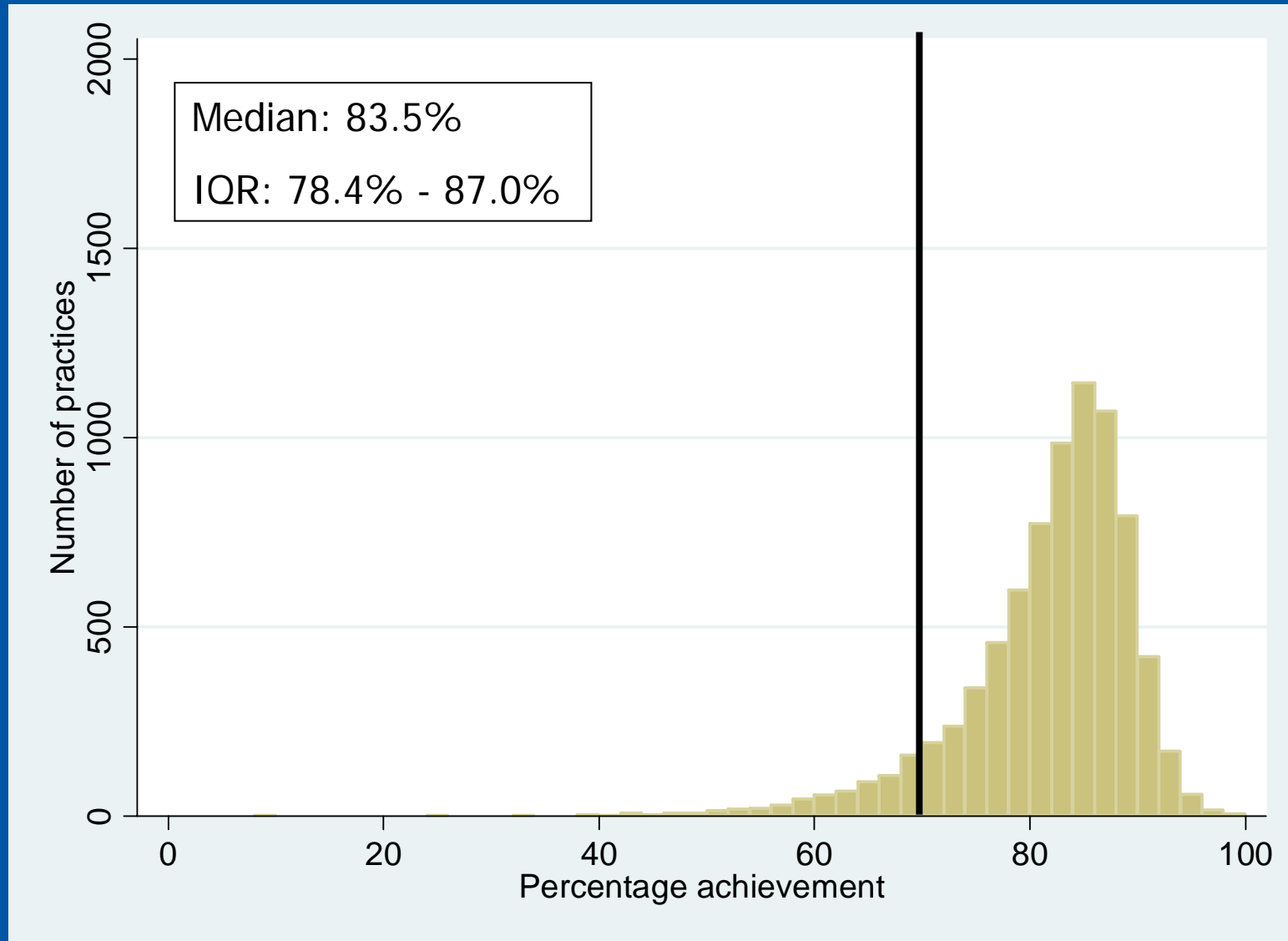


# Points scored in Year 1

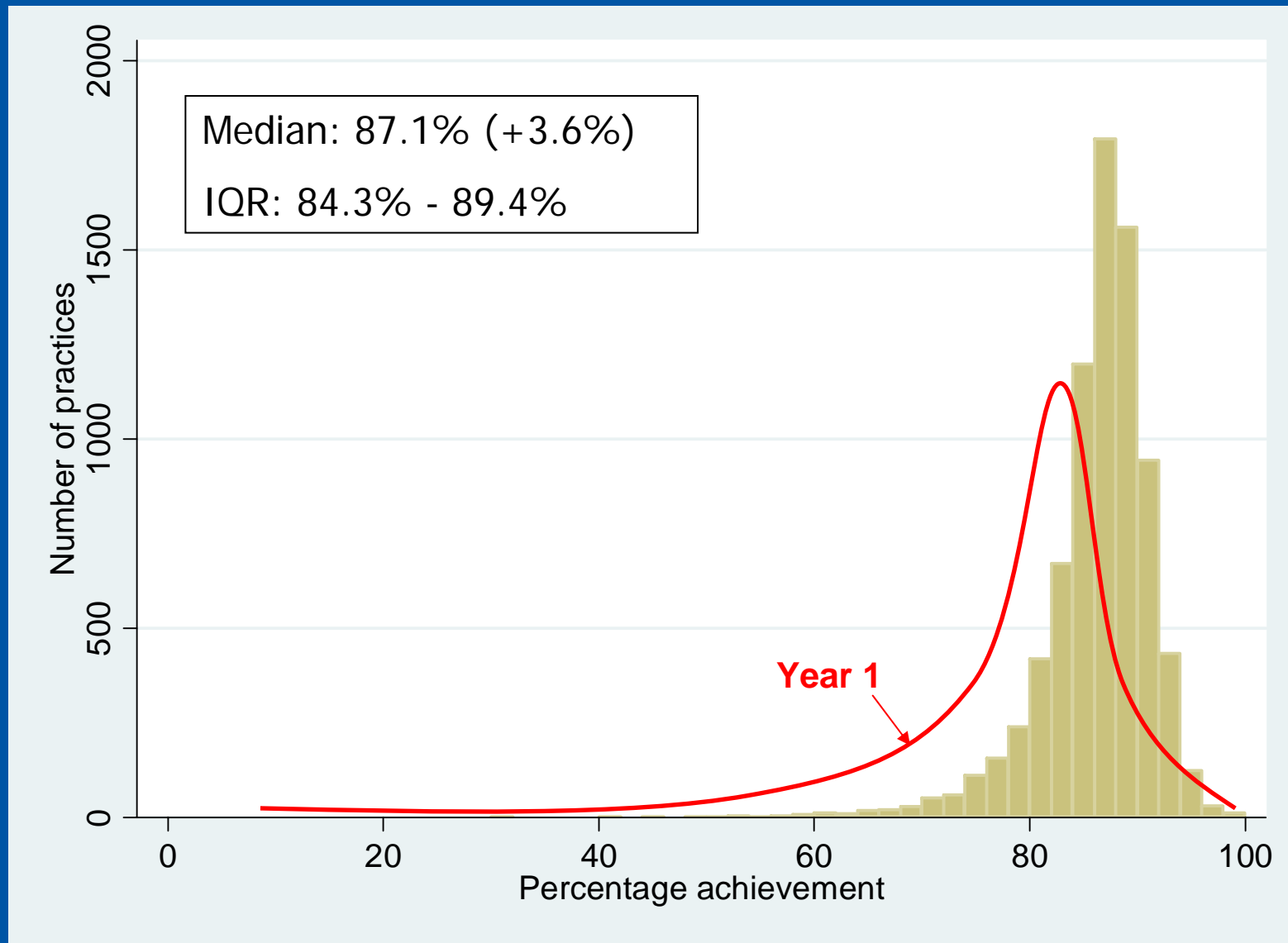
- Overall
  - Mean 959 points scored (91.3% of total)
  - GPs earned mean \$43,455
  - 222 practices (2.6%) scored max 1,050
- Clinical domain
  - Mean 530 points scored (96.3% of total)
  - 564 practices (6.6%) scored max 550



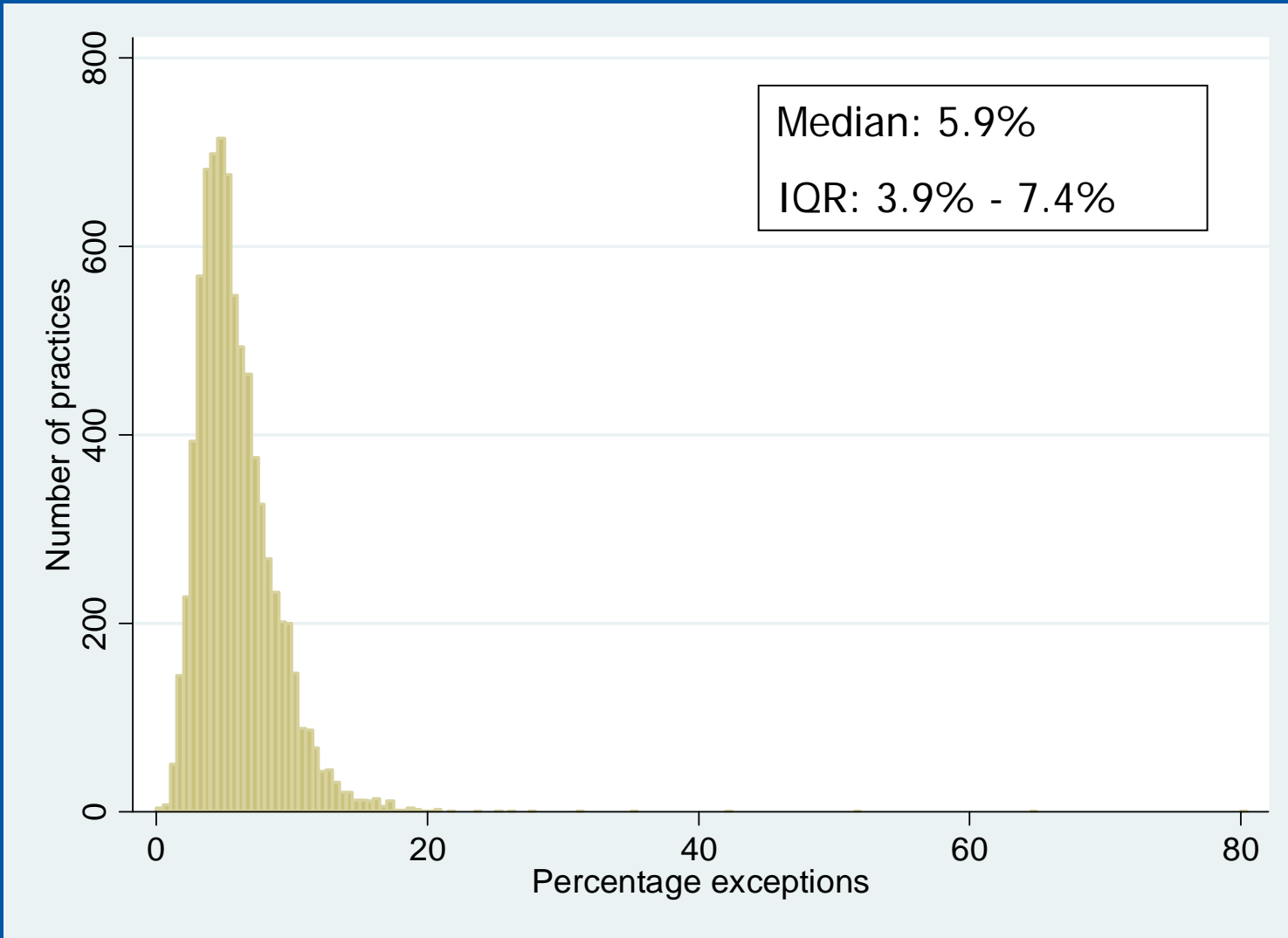
# Reported achievement, Year 1



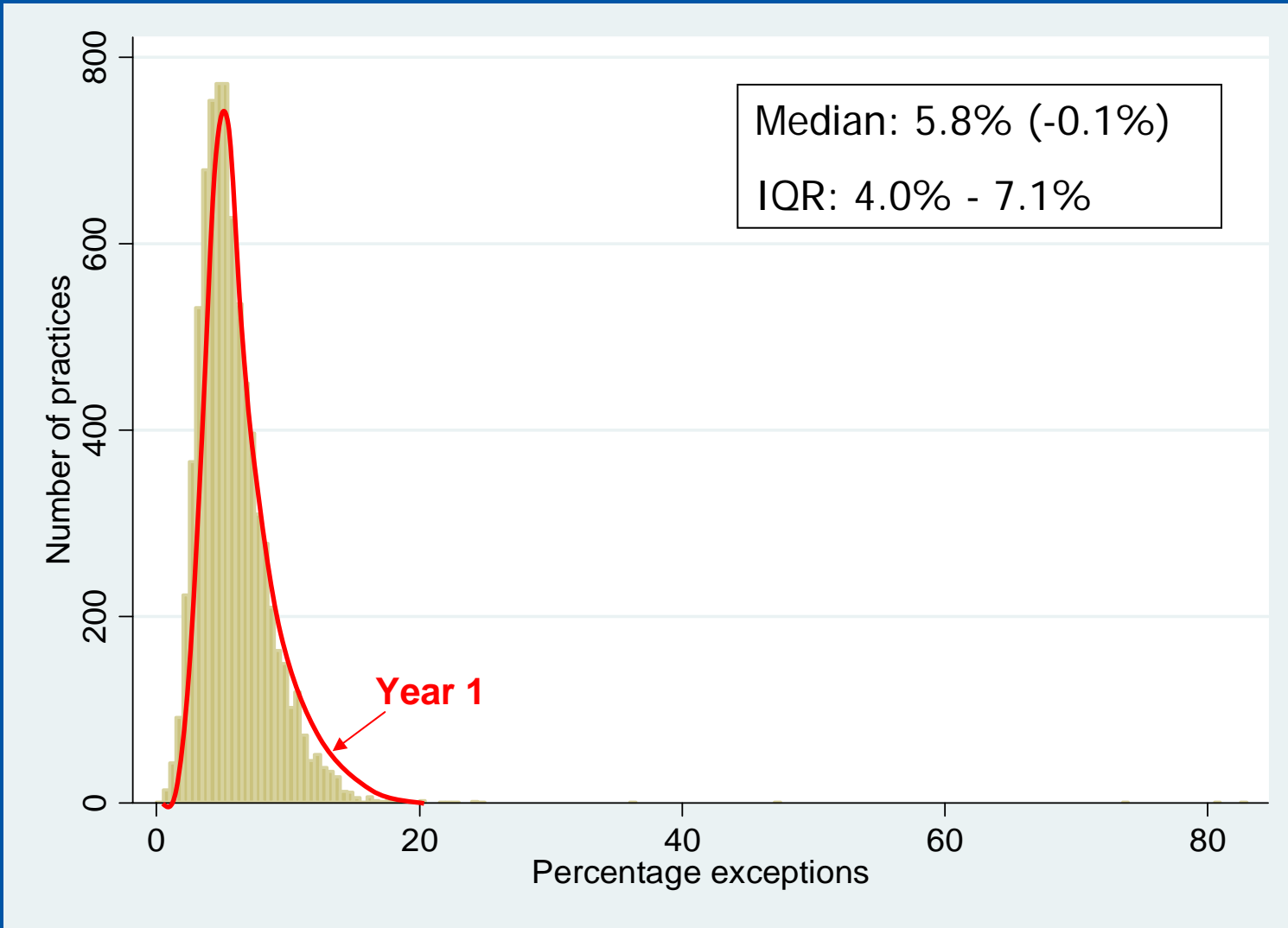
# Reported achievement, Year 2

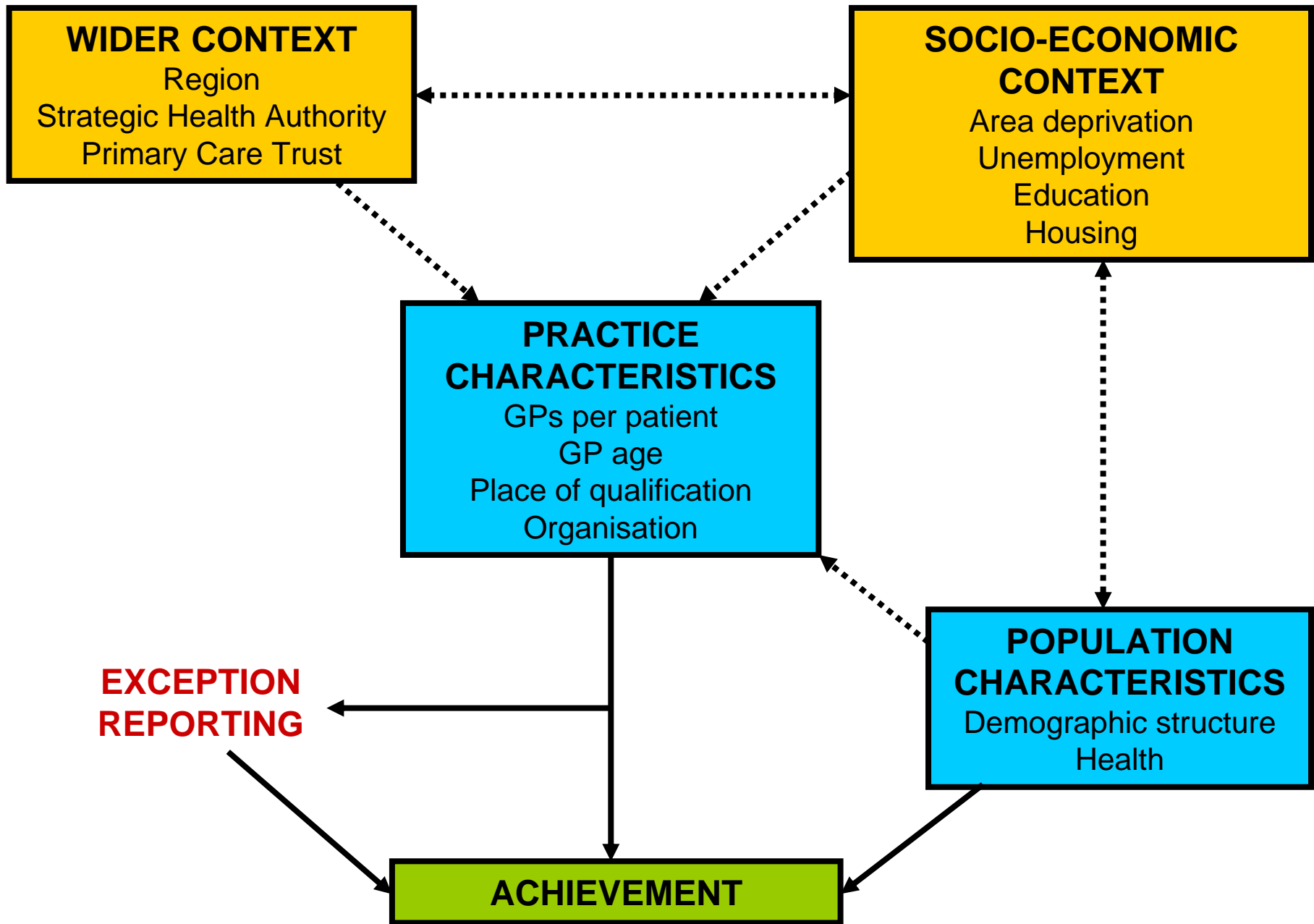


# Exception reporting, Year 1

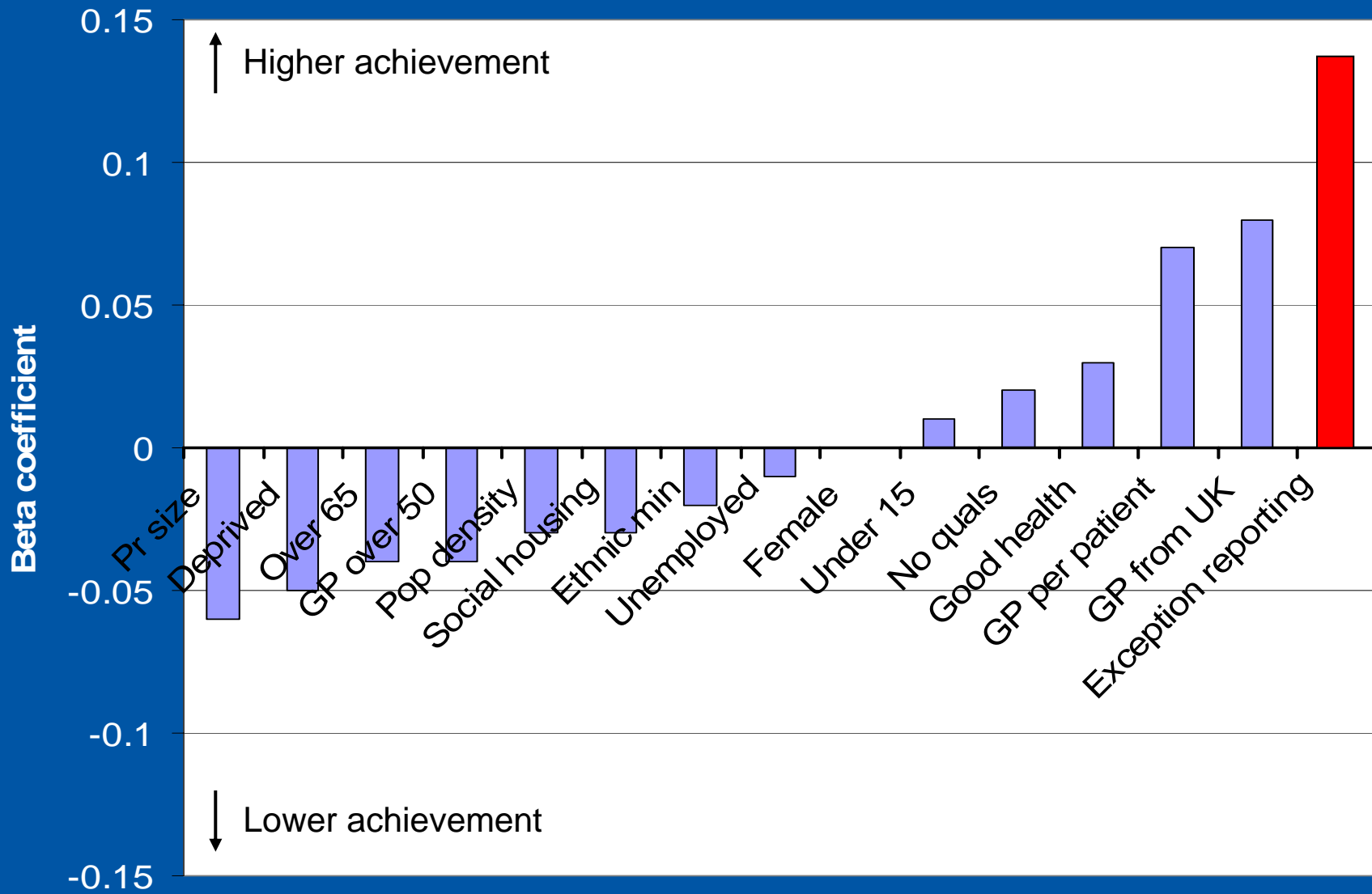


# Exception reporting, Year 2





# Reported achievement



# Exception reporting

- 1% increase in exception reporting → 0.31% increase in achievement
- Practices better at identifying and treating patients with chronic conditions also better at identifying patients for whom the targets are inappropriate
- Practices exploited exception reporting in order to game the new system



# Gaming?

- Generally low levels for exception reporting would suggest that wide-spread, large scale gaming was uncommon
- Small minority of practices exception reported a much larger proportion of their patients: 91 (1.1%) excluded over 15% of their patients



# Findings from the UK

- The new financial incentives were associated with generally high levels of achievement in 2004/05
- Achievement increased in 2005/06 (when incentives increased by 64%)
- Population and practice characteristics had small but (in some cases) significant effects on achievement
- Large-scale gaming was not widespread



# Some lessons from the UK

- P4P can be very expensive
- Incentives should be aligned with FPs' professional values
- Integrated IT systems are required to monitor the programme
- A clear baseline is needed to avoid paying for improvements that have already occurred
- Introducing pay-for-performance incrementally reduces risks for providers and payers
- Payers should allow for the possibility of higher-than-expected achievement
- The risk of inappropriate treatment can be decreased through exception reporting, but monitoring is required to prevent abuse



# More details...

Our research:

[www.npcrdc.ac.uk](http://www.npcrdc.ac.uk)

[tim.doran@man.ac.uk](mailto:tim.doran@man.ac.uk)

Details of indicators:

<http://www.ic.nhs.uk/services/qof>



# Additional results...



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# Views of practice staff

“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.”

[GP16]

Roland M, Campbell S, Bailey N, Whalley D, Sibbald B. Primary Health Care Research and Development 2006; 7: 70-78



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“I enjoy being given the autonomy to manage the different diseases.... because we are actually meeting targets, patient care has definitely improved.”

[Nurse 12]



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“Why is the NHS paying me so much?”

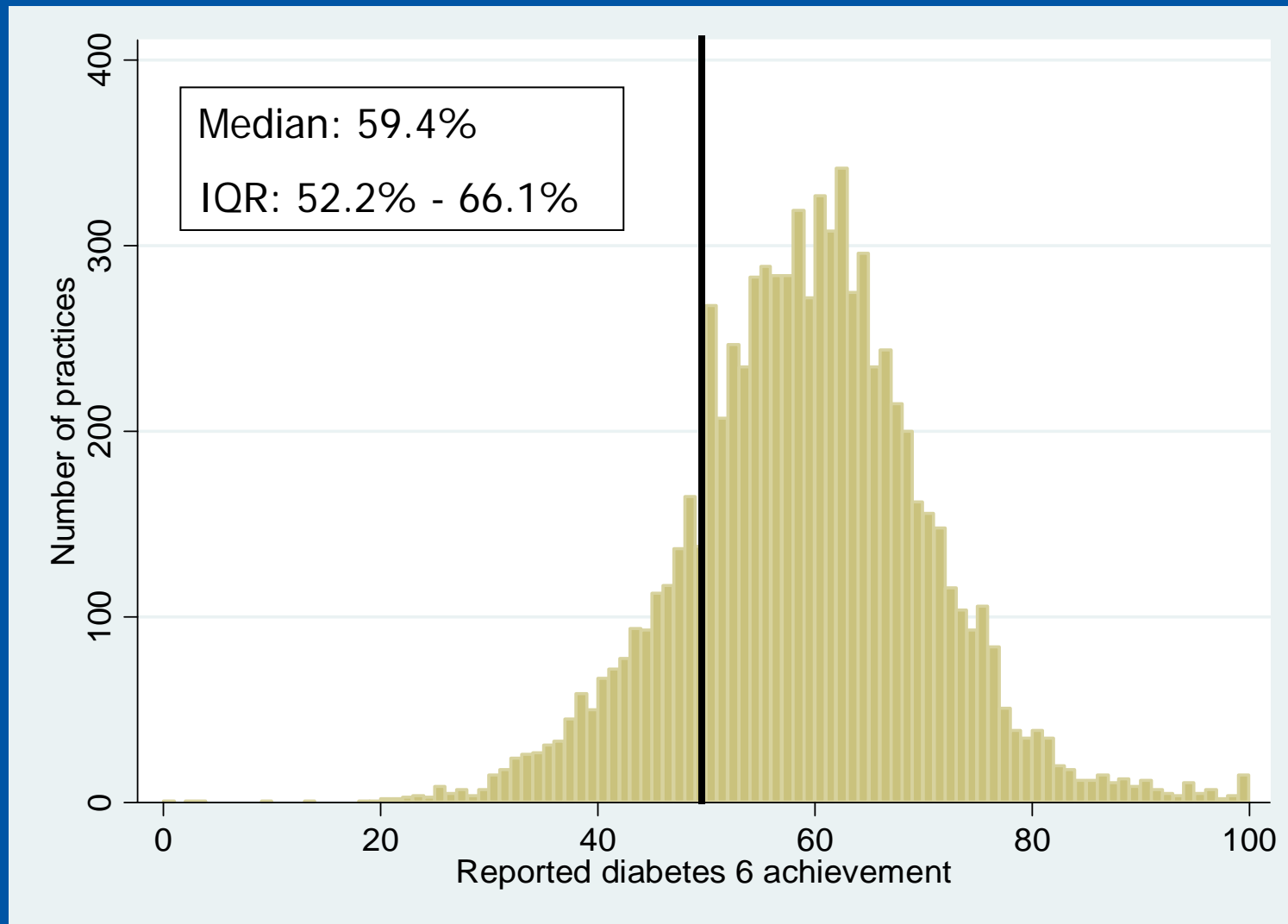
[GP18]



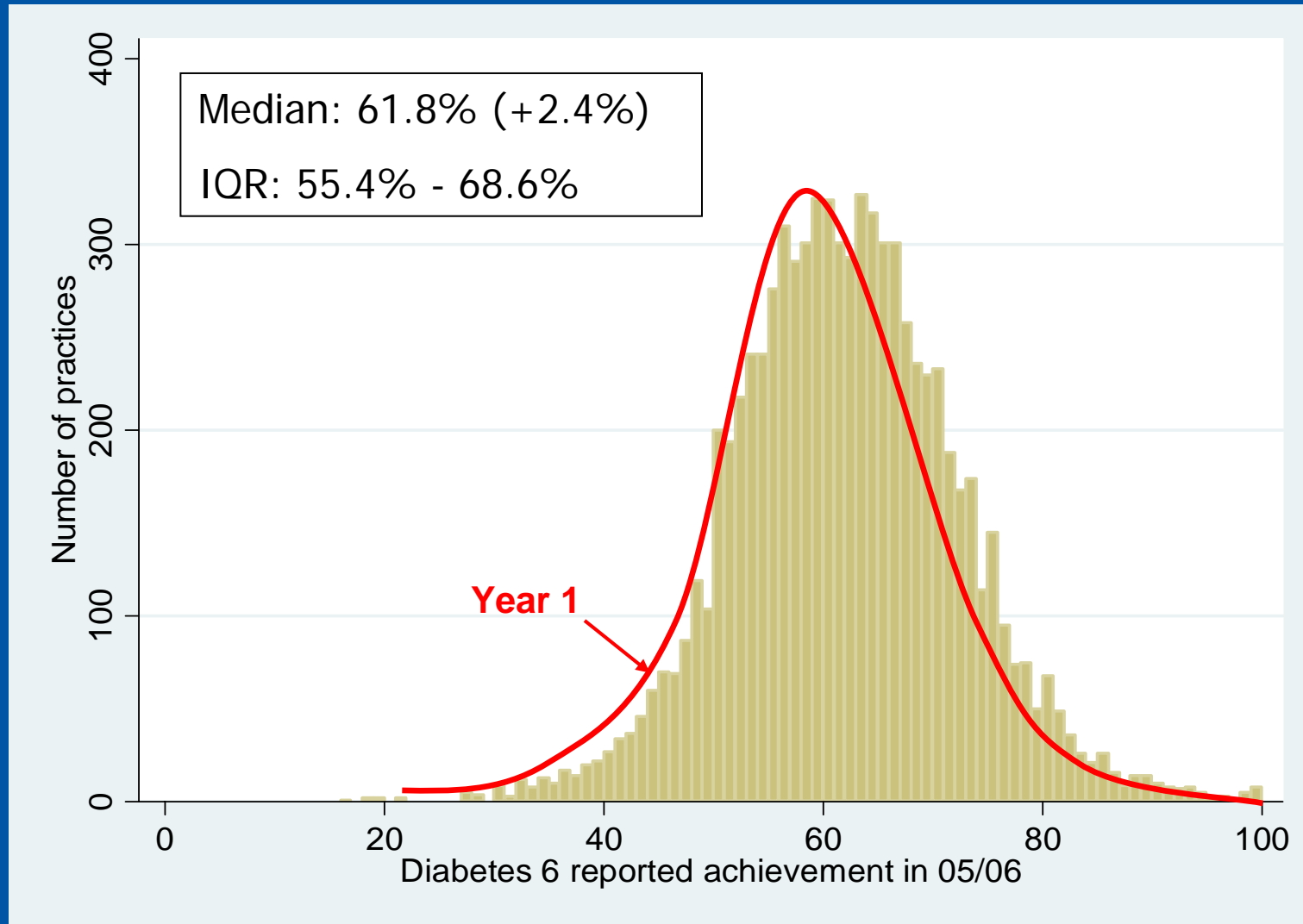
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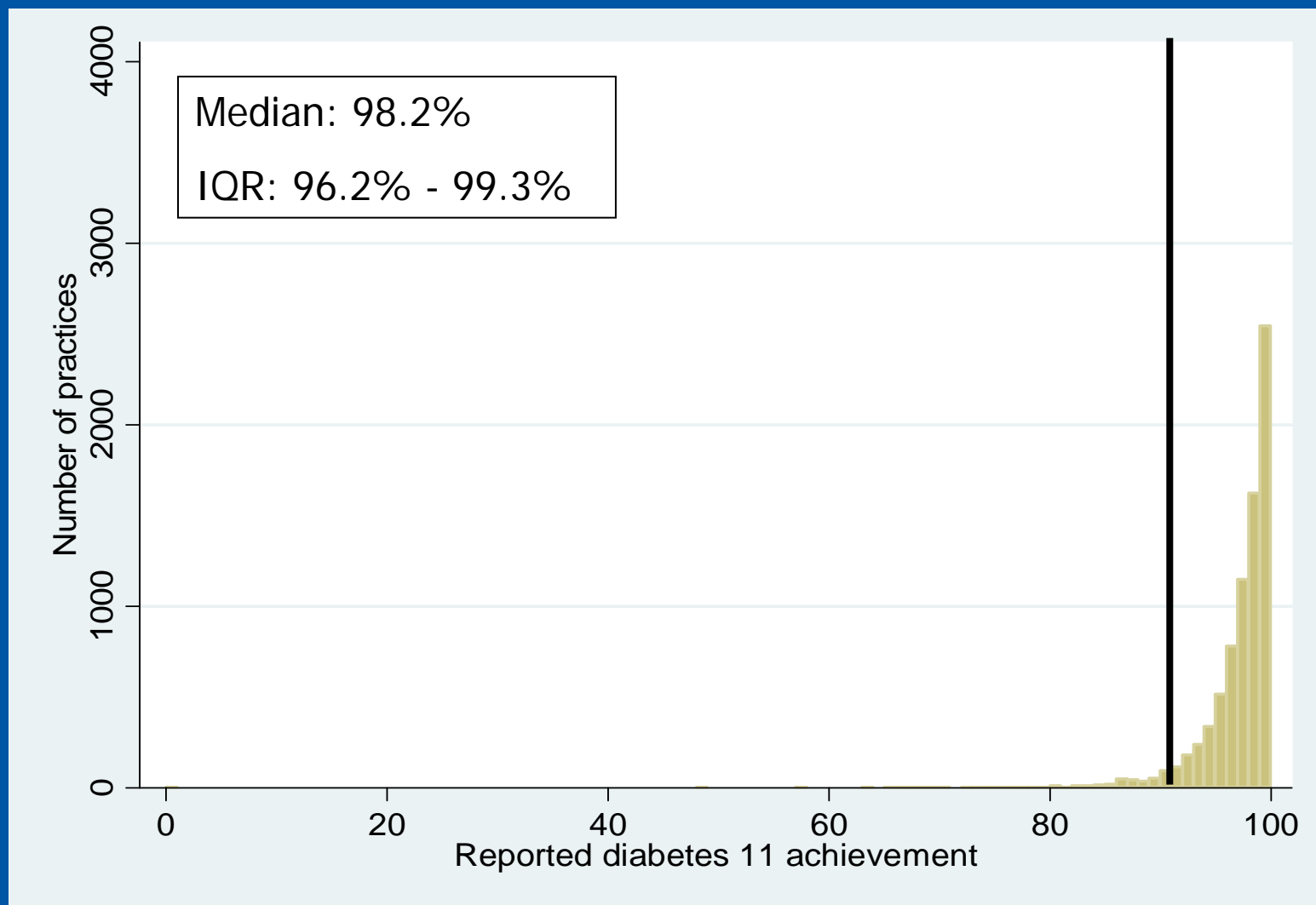
# Reported achievement for HbA<sub>1c</sub> <7.4%



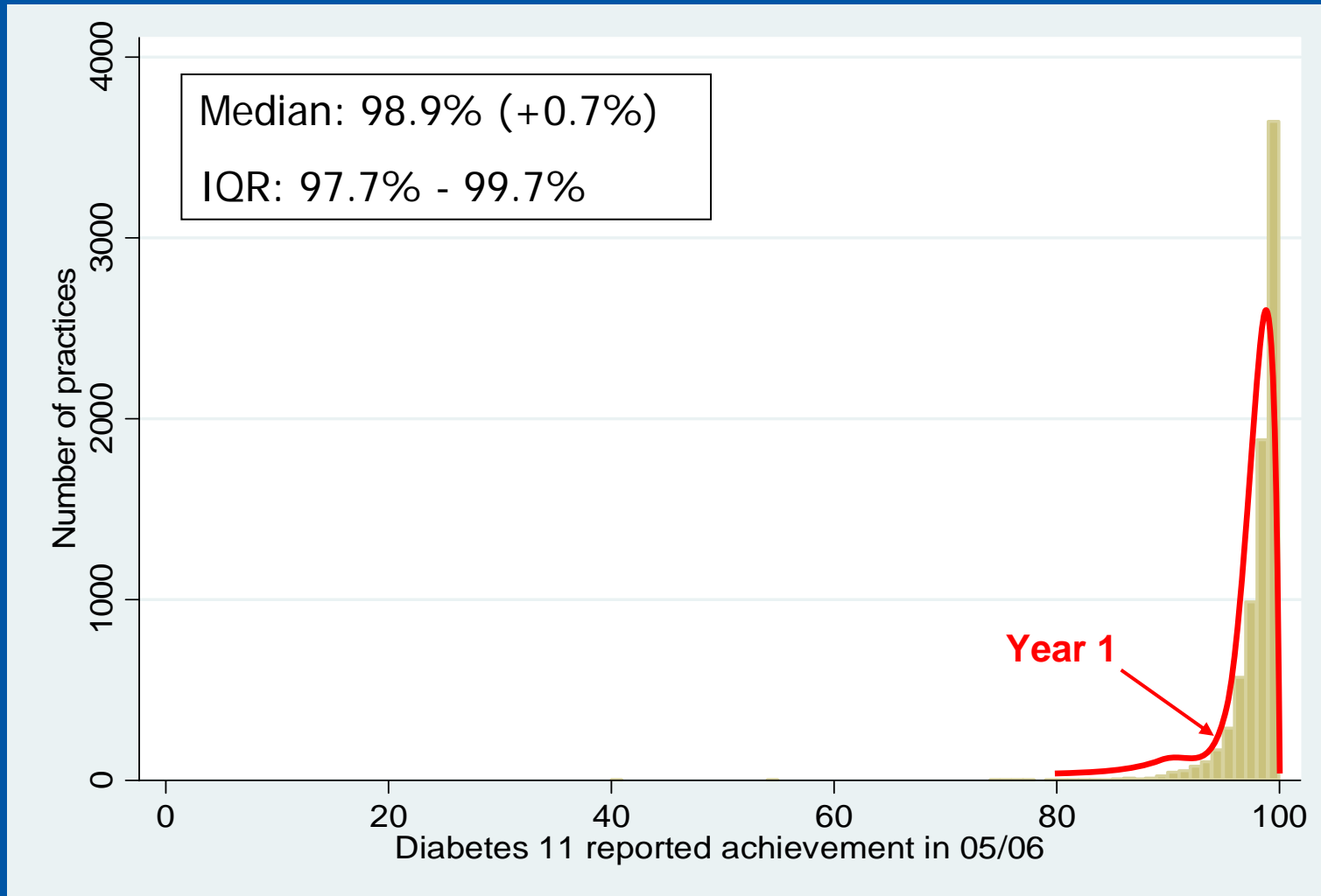
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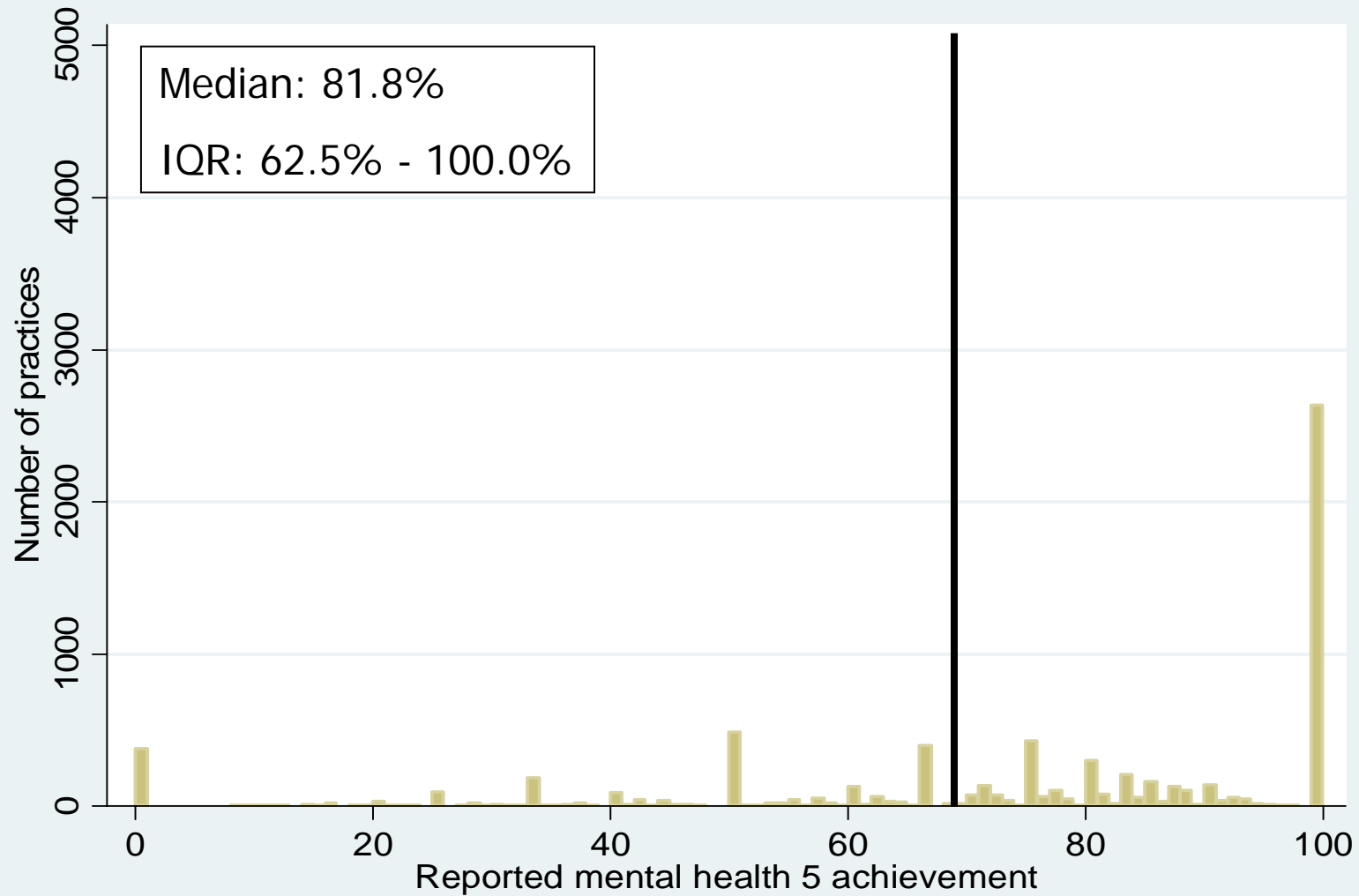
# Reported achievement for diabetics with BP recorded



# Reported achievement for diabetics with BP recorded



# Reported achievement for lithium levels within therapeutic range



# Reported achievement for lithium levels within therapeutic range

