

Differences in the quality of clinical primary care and targeted incentive payments: do incentives work?

Nicholas Steel,

Maisey S, Clark A, Marsh R, Gillam S, Fleetcroft R, Howe A.

RCGP Annual National Primary Care Conference

Edinburgh, 4th October 2007

Primary Care and the Quality & Outcomes Framework (QoF)

- General practice (GMS) contract rewards performance against quality indicators since 1 April 2004
- 10 conditions in QoF 2004/5; 11 in 2005/6
- High level of achievement on QoF indicators:
 - 96.3% in 2004/5
 - 99.1% in 2005/6
- Financial incentives can change behaviour

'Halo' effect or tunnel vision, and why?

1. Changes in quality of care from April 2003 to April 2005 for:

- 2 conditions in QOF**
 - asthma & hypertension**
- 2 conditions not in QOF**
 - osteoarthritis & depression**

2. How have practices changed to deliver QOF?

Summary of methods

Paper & electronic notes review

- 18 Norfolk & Waveney practices, stratified by deprivation, patient response 67%
- Recorded quality of care compared with pre-defined quality indicators
- Hierarchical regression analysis allows for
 - clustering within practices
 - differences in baseline scores between conditions

Interviews

- One doctor and one nurse from each of 12 of above practices

Quality indicator examples

Hypertension (QOF condition, QOF indicator)

- The percentage of patients with hypertension in whom the last blood pressure (measured in last 9 months) is 150/90 or less (QOF)

Asthma (QOF condition, non QOF indicator)

- The percentage of patients with asthma either on current medication or presenting with asthma, who have had their inhaler technique checked at least once every 5 years (QIGP)

Osteoarthritis (non-QOF condition)

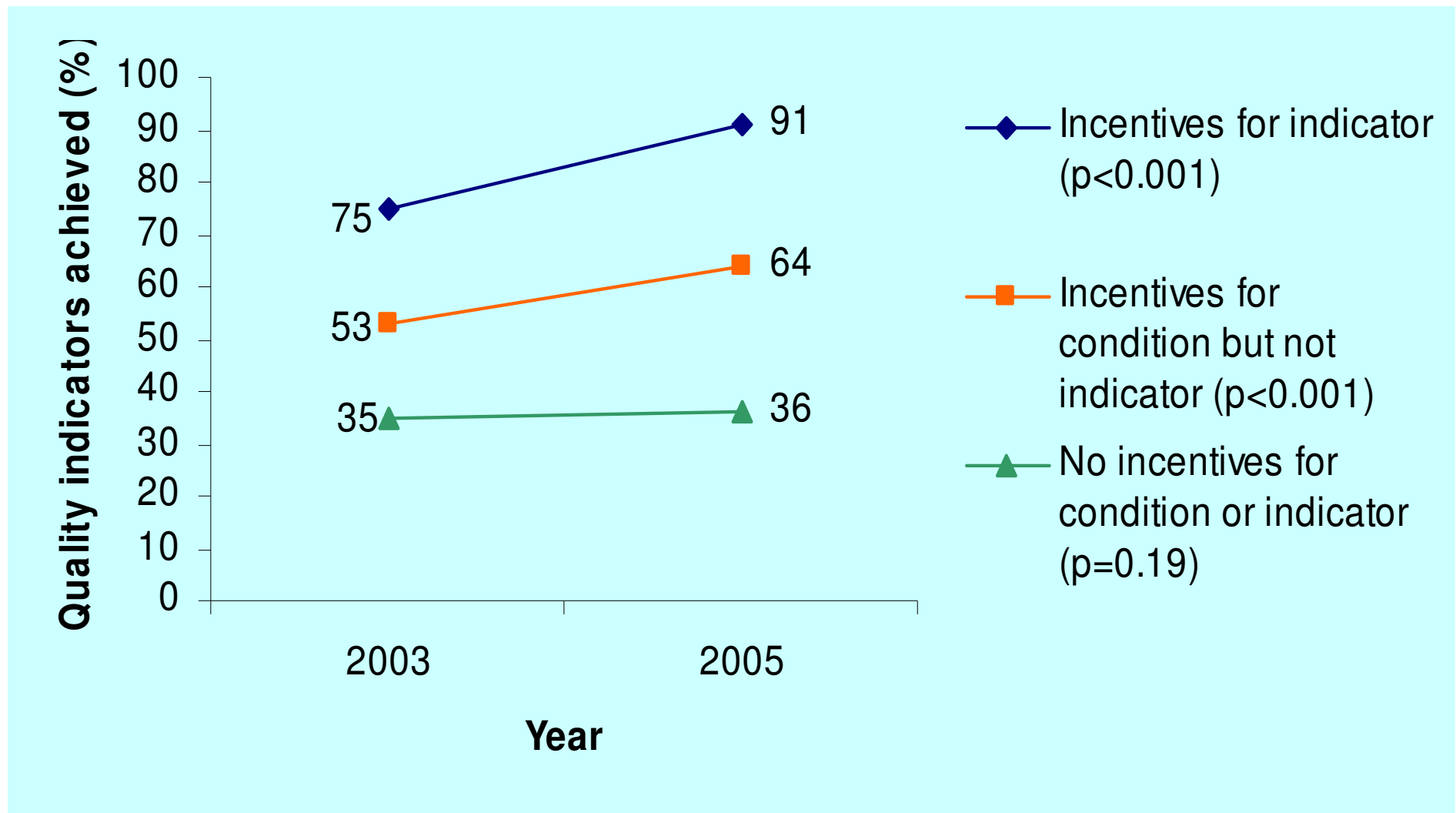
- The percentage of patients with osteoarthritis treated with a NSAID, whose notes contain a record that they have been advised of the gastrointestinal and renal risks associated with this drug (SCOPE)

Depression (non-QOF condition)

- The percentage of patients receiving a diagnosis of a new depression episode, for whom presence or absence of thoughts about suicide is recorded at initial assessment (SCOPE/QIGP)

Sources: QoF, NICE, QIGP, RAND/SCOPE

Quality indicators achieved in 2003 and 2005 by incentive category



Quality indicators achieved in 2003 and 2005 by condition

Condition	No of indicators	No of patients		Mean indicators achieved			P-value* for change		
		2003	2005	2003 %	2005 %	Change (95% CI) 2003-5 %	2003-5	Rel to osteoarthritis	Improvement (% of max possible)
Asthma	7	130	123	59	73	14 (8-20)	<0.001	0.004	34
Hypertension	14	149	155	58	70	12 (8-16)	<0.001	0.001	29
Depression	6	145	134	37	38	2 (-1-4)	0.22	0.92	3
Osteoarthritis	9	162	158	36	38	2 (-3-6)	0.43	-	3

*From linear regression using patient level data, adjusting for clustering within practices

Better quality of care only where incentivised

- Standardisation of care
 - *‘The care is a lot more standardised, the guidelines are taken into account....previously it was very much more individualistic, depending on which doctor they first pitched up with as to how their care pathway would go, ...some might be ignored completely’ (nurse)*
- No improvement in care for non-incentivised conditions
 - *‘I think you're really lucky in some ways if you've got one of the contract problems,...they are getting more attention. I think that some of the other conditions are less seen now ... I don't think it's worse, I just think that they don't get the extra focus’ (nurse)*

Teamwork and box-ticking

- Nurses: more job satisfaction & teamwork
 - *‘There was a cohesion developing that we were suddenly having all these meetings and having to put our heads together about how we did things as a team rather than things being a bit fragmented as they were previously’*
- Doctors: less freedom, more box-ticking
 - *‘when you have a team of 4 or 5 people to supervise every day there will be a stream of queries coming back to you that have to be solved. And the work is actually different, it's more complex, it's more time-consuming and there's no relief from it actually’*
 - *‘As a professional person, if I think something's worth doing I'll do it, I don't want to be told to do it’*
 - *‘I do the work, but you are not very keen on ticking the boxes’*

Summary

- **Payment for performance has had positive effects:**
 - Big improvement for conditions in QOF
 - Chronic disease management
 - Nurses satisfaction, autonomy, teamwork

- **But these benefits came at a cost:**
 - Non-incentivised conditions lower priority, but no decline
 - Doctors were ambivalent about ‘tickbox’ medicine
 - Data manipulation

The challenge for primary care

- How can broad generalist high quality primary care be maintained?
 - How can quality be improved for non-incentivised care?
 - How can doctor's professionalism and generalist skills be harnessed alongside standardised protocol-driven care?
 - How can patients' concerns be incorporated?

- *'to respond to this proposal in a way that improves the technical aspects of quality while maintaining the values that have characterised general practice in Britain for generations'* Paul Shekelle BMJ 2003

Acknowledgements

- Thanks to all practices and staff
- NS was funded by a National Primary Care Researcher Development Award from the National Co-ordinating Centre for Research Capacity Development, RM was funded by SuNet (Suffolk and Norfolk Research Network), Norwich Primary Care Trust Research Office funded practice expenses for this project
- Steel N, Maisey S, Clark A, Fleetcroft R, Howe A. Quality of clinical primary care and targeted incentive payments: an observational study. *British Journal of General Practice* 2007; 57:449-454.
- Maisey S, Steel N, Marsh R, Gillam S, Fleetcroft R, Howe A. Effects of payment for performance in primary care: qualitative interview study. *Submitted Aug 2007*
- Correspondence to n.steel@uea.ac.uk