Do points mean prizes?

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Background

The link between the quality of health care and incentive systems is much debated, and the 2004 General Medical Services Contract in the UK offers a key test of that connection. The contract linked 25% of practice income to performance on 147 publicly-reported indicators that made up the Quality and Outcomes Framework (QOF see Figure 1). Contrary to expectations, most GP practices achieved over 90% of their QOF targets (pushing costs over the level budgeted for by approximately £1.5 billion in 2005*), but what is unknown is how this effect was achieved.

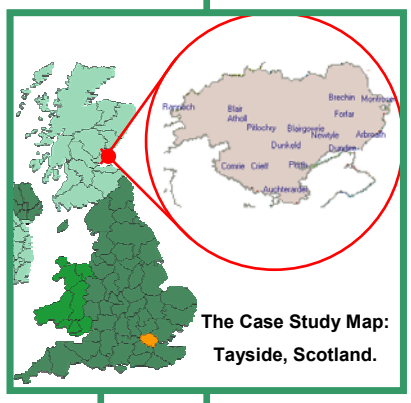
* As reported by the Technical Steering Committee in the British Medical Journal, March 2006

The QOF: Points = Prizes

Clinical Domain Area	Number of Indicators	Points Available	2004/05 Pounds per point*	Unadjusted Total for 2004/05	2005/06 Pounds per point*	Unadjusted Total for 2005/06
Diabetes Mellitus	18	99	£75	£7,425	£125	£12,375
Chronic Obstructive Pulmonary Disease	8	45	£75	£3,375	£125	£5,625
Coronary Heart Disease	15	121	£75	£9,075	£125	£15,125
Asthma	7	72	£75	£5,400	£125	£9,000

* Within the Clinical domain, the baseline payment per point is adjusted up or down for each practice according to the prevalence of each clinical condition for that practice's patients

Figure 1



The Case Study Map: Tayside, Scotland.

Figure 2

What We Did

» We examined quantitative reported data on workload and activity to produce a before-and-after analysis of clinical quality and determine whether non-incentivised conditions (such as mental health) were being crowded out in favour of incentivised ones (such as cardiovascular disease).

» We studied attitudes and perceptions by a staged process of qualitative analysis in three Scottish health boards with GPs, practice nurses and practice managers (Figure 3), then conducting in-depth fieldwork in two different GP practices in Tayside (Figure2) to explore changes taking place at the front line.

Aims

Against that unexpected outcome, we aimed to discover how the 2004 contract affected the day-to-day operation of GP practices in Scotland.

» Did the QOF lead to improved organisation of care, in the form of registration and recall systems and protocols?

» Did it change the division of labour within practices (to more specialized GPs, nurse-led care, a bigger role for practice managers)?

» What was the biggest motivation in adhering to the QOF (financial advantage, better treatment practice, fear of adverse media comment)?

Views about the new contract system and its effects

Practice managers interviewed: 5

"I think that the new contract has forced practices to become more business-oriented and to structure their administrative systems much better."

Doctors interviewed: 23

"My worry is that practices will be come so focussed on incentivised care that they start to ignore the areas where there is no financial incentive to do the work"

Nurses interviewed: 11

"I think care is much better. You're highlighting things every time patients come in…you probably did one of these when they came before but now you automatically do them all."

Figure 3

Provisional Findings

» When we put together data on behaviour with data on attitudes we found attitudes varied more than behaviour.

» The public reporting of QOF activity had the unintended effect of making GP practices benchmark their financial performance against their peers.

» Disease registers, recall systems and nurse-led, protocol-driven care were perceived to have led to higher quality care for incentivised conditions, but to have led to other conditions (like depression) being crowded out, and this is supported by our early quantitative evidence.

Find out more…

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