

Should pay-for-performance be introduced in to Australian health care? Lessons from abroad

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Declaration of interests

- Co lead UK Quality and Outcomes Framework - NICE External contractor; with Professor Helen Lester
- Unrestricted research grant from NICE as the external contractor on QOF (2009-2013)
- Co-developed many of the indicators in the original QOF
- Not representing any organisation but my own views

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What I'm going to cover

- The P4P story in the UK: what is QOF? has it worked? (purpose?)
- Factors that underpin P4P:
 - Defining quality
 - Process v. outcome etc
 - Attributes of good indicators
 - “QOFability “
- Intended consequences of QOF (and data)
- Unintended consequences of QOF
- Changes to the way QOF is developed (NICE led)
- Examples of piloting
- Future challenges in developing P4P in the UK
- But first... would it (QOF and/or P4P) work in Australia?

Draft Primary Health Care Strategy

The Draft Primary Health Care Strategy recommended pay for performance as a key building block;

“...progressive introduction of pay-for-performance arrangements which are linked to improvement of patient health outcomes

Australian: Primary Health Care Strategy

The Primary Health Care Strategy 2010 recommends incentives as a key building block;

“Providing sustainable financing and system performance arrangements, including incentives for providing care in the most appropriate and efficient setting, is a key building block for primary health care reform”.

And

“Over time, the Australian Government will seek to strengthen the link between performance and funding”.

Building a 21st Century Primary Health Care System

The Strategy identifies **5 key building blocks** which are considered essential system-wide underpinnings for a responsive and integrated primary health care system for the 21st century:

- Regional integration
- Information and technology, including eHealth
- Skilled workforce
- Infrastructure
- Financing and system performance

Building a 21st Century Primary Health Care System

Drawing from these are **4 priority directions for change:**

- Key Priority Area 1: Improving access and reducing inequity
- Key Priority Area 2: Better management of chronic conditions
- Key Priority Area 3: Increasing the focus on prevention
- Key Priority Area 4: Improving quality, safety, performance and accountability

Policy window: Australian National Strategy

Building blocks

- Information and technology
- Skilled workforce
- Infrastructure

Priority area

- Better management of chronic conditions

Building up to:

- Financing and system performance
- Improving quality, safety, performance and accountability

That can accommodate P4P

Policy window



- Decisiveness and political will are important
- UK QOF introduced without piloting
- But, using the UK as an example, what needs to be in place in Australia before P4P can be introduced?

Policy window

- Kingdon's model (1995) examined how issues get onto the policy agenda and become translated into policy and identified three streams:
 - Problem: policy objectives
 - Policy: proposals, strategies
 - Politics: bargaining, compromise, negotiation and political will
- When all three streams flow together a policy window, (a short lived or temporary opportunity for pursuing significant policy change) exists
- “Appreciative setting” policy-makers show readiness to respond to an agenda item (Vickers 1995).
- **However, the subsequent agenda item must be seen as amenable to a policy intervention**

Implementing indicators

What needs to be in place to implement indicators/incentives?

- Exworthy and Powell (2004) suggested implementation is influenced by the three streams of:
 - **Policy**: goals and objectives
 - **Process**: technical and political feasibility
 - **Resources**: financial and human capacity

Policy window: Australia

Are the following in place?:

- Goals, policy objectives/proposals ✓?
- Technical feasibility / IT X
- Political feasibility / will ?
- Financial and human capacity X

UK Background: Improving quality in the 1990s

Motive:

- Recognition of care variation by the medical profession
- Recognition of care variation by Government

Means:

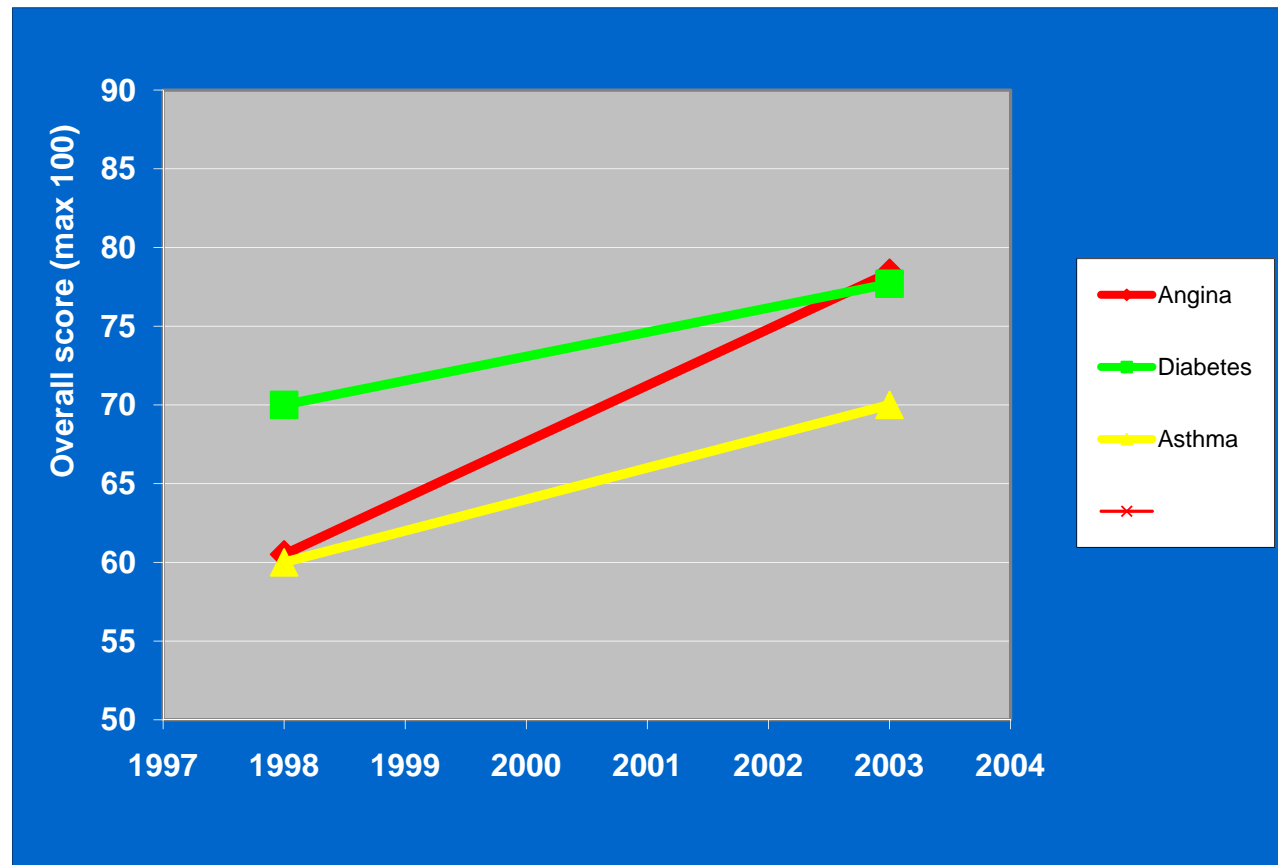
- **1980s: Quality can't be measured / There's no such thing as a bad doctor**
- **By 2000: Care is too variable / Quality can be measured / Care can be improved. BUT it's expensive to provide high quality care**
- **Rise of evidence based medicine**

Quality improvement initiatives:

- National Service Frameworks for major chronic diseases
- Audit

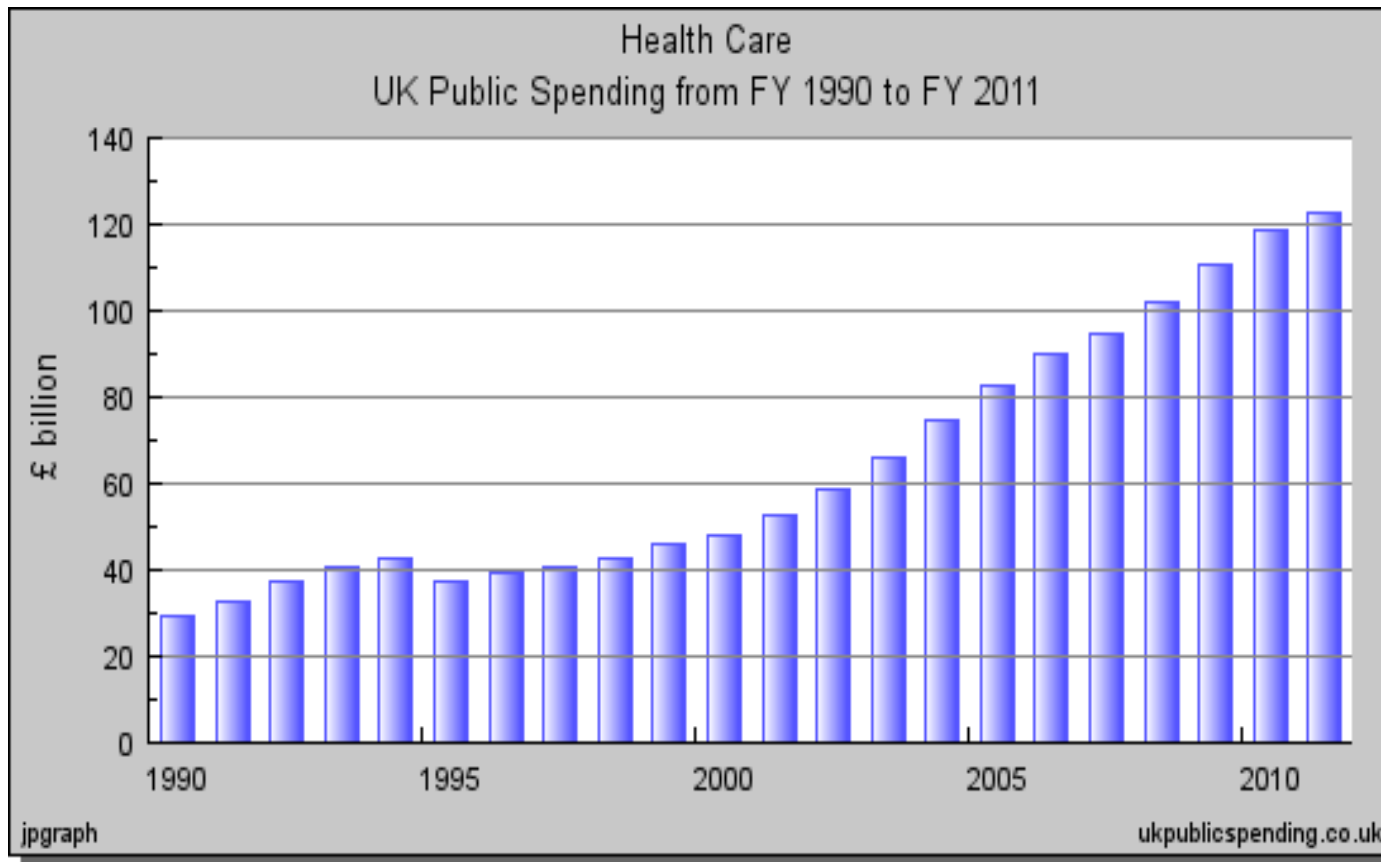
Quality of care in the UK improved between 1998 and 2003

- Quality was improving already
- So evidence of improvement pre-P4P.



Campbell et al. BMJ 2005; 331: 1121-1123

UK expenditure on health care since 1990



Political will to invest in the NHS underpinned by sustained economic growth

Defining quality

Quality of care for individual patients

Access - can patients access the health care they need?

Safety

Effectiveness - is it effective when they get there?

- clinical or technical effectiveness
- effectiveness of interpersonal care

Additional domains of quality for populations

Equity

Efficiency

→ Leading to desired **health outcomes**

Defining quality

- A clear definition is the foundation upon which everything else is built.
“We cannot assess quality until we have decided with what meanings to invest the concept”
(Donabedian 1985 p. 450) for each indicator
- Quality measures must relate to specifically defined aspects of care (Campbell et al 2002)
→ particularly if money is attached or summative

Attributes of good indicators

- **Clarity:** clearly defined aspect of quality of care
- **Acceptability:** is acceptable to both those being assessed and those undertaking the assessment.
- **Attributable:** achievement of the aspect of care defined by an indicator should be 100% under the control of those being assessed.
- **Evidence base:** underpinned by guidelines etc
- **Feasibility:** valid and reliable consistent data are available and collectable.
- **Reliability:** minimal measurement error, reproducible findings when administered by different raters (inter-rater reliability).
- **Sensitivity to change:** has the capacity to detect changes in quality of care, to discriminate between and within subject.
- **Predictive value:** has the capacity to predict quality of care outcomes.
- **Relevance:** be in an area where there's a recognized gap between actual and potential performance

Context



County Champions of England at
cricket 8 times...!

**County Champions: 1881,
1897, 1904, 1926, 1927, 1928,
1930, 1934**

Knowledge transfer

- Can't transfer indicators between countries without testing for “attributes” in a health system context (Sheldon 2004; Marshal et al 2002)
- Difficulty developing preventive indicators
- Difficulty linking structure and outcome
- Difficulty attributing process to outcome

Purpose! What is it?

- Summative or formative?
- Quality improvement or quality assessment?
- Reward: learning and/or payment?
- Practice level, team or individual staff?

Purpose of QOF?!

- Intended consequences of the new contractual arrangements were to **reward quality of care** rather than numbers of registered patients, **improve data capture** and care processes, and to **improve patient outcomes and doctor working conditions**
- Central dilemma? Is it a payment mechanism or a quality improvement scheme?

USA: P4P

- In a national survey in USA, 52% of HMOs (covering 81% of enrollees) report using pay for performance (Rosenthal 2006)
- Average of 5 performance measures per scheme. (UK QOF 86 clinical indicators!!)
- Rewards for reaching fixed threshold dominate; only 23% reward improvement
- 5-7% of physician pay (UK QOF: ~25%!!)

Why measure quality?

- As a basis for **quality improvement**: comparisons can stimulate and motivate change
- As part of **pay for performance** schemes (e.g. QOF)
- As part of **regulation** (e.g. of minimum standards)
- To assist **purchasing** (e.g. contracts which include minimum quality standards)
- To identify areas of need for **future investment**
- To inform service **users**

Summative and formative

Summative: judgmental test of whether minimal standards are achieved on a given day.
Pass or fail a standard



Formative: non-judgmental educational systems using optimum standards that foster quality improvement by focusing on education, self-development, improved performance



So not just pass or fail but also 'working towards'

Formative assessment



“QOFable”

To be an ideal QOF indicator, the clinical issue in question should be:

- Common: high prevalence (heart disease not ear infections)
- Diagnostic certainty (not clinical judgement i.e. osteoarthritis)
- Evidence-based: leads to better outcomes
- Have a significant morbidity and/or mortality
- Recognised gap between actual and potential performance
- Logical /internally consistent indicators: extractable from QMAS
- Directly under control of every general practice (BP control not death from cvs) & every PCT can do it (i.e. scans)
- Free of obvious unintended consequences
- Can't solve different life expectancies across the UK



P4P: The Quality and Outcomes Framework

- Introduced in April 2004 for all practices in the UK
- Family practitioner income dependent on performance against 146 quality indicators
- Most are process measures rather than outcomes
- Each indicator allocated between 0.5 & 56 points (1,050 in total)
- Each point earns an average practice £76 (84 Euro)
- Maximum of:
 - ❖ £79,800 (88,052 Euro) per practice
 - ❖ £25,000 (27,586 Euro) per physician
 - ❖ Achievement scores are publicly reported:
www.qof.ic.nhs.uk
 - ❖ 25% of practice income = P4P

Transaction costs

- Year 1 (04-05) £76 per point
£624,132,687
- Year 2 (05-06) £125 per point
£1,063,583,954
- Year 3 (06-07) £125 per point
£1,268,175,404



Domains and points in 2009

Domain	No. of Indicators	Pts	% of total
Clinical	86	697	70%
Organisational	36	167.5	17%
Patient Experience	3	91.5	9%
Additional Services	9	44	4%
TOTAL		1000	100%

Protecting patients against inappropriate treatment: Exception reporting

- Physicians may exclude ('exception report') patients for whom targets are inappropriate
- Discretionary exception reporting:
 - ❖ treatment not tolerated
 - ❖ patient terminally ill, exceptionally frail or has supervening condition
- Non-discretionary exception reporting:
 - ❖ patient refuses intervention or repeatedly refuses to attend
 - ❖ patient newly registered or diagnosed
 - ❖ service not available to practice

Intended Consequences

- Increased computerization
- Better organized care
- Greater job satisfaction/more money...
- Improved care

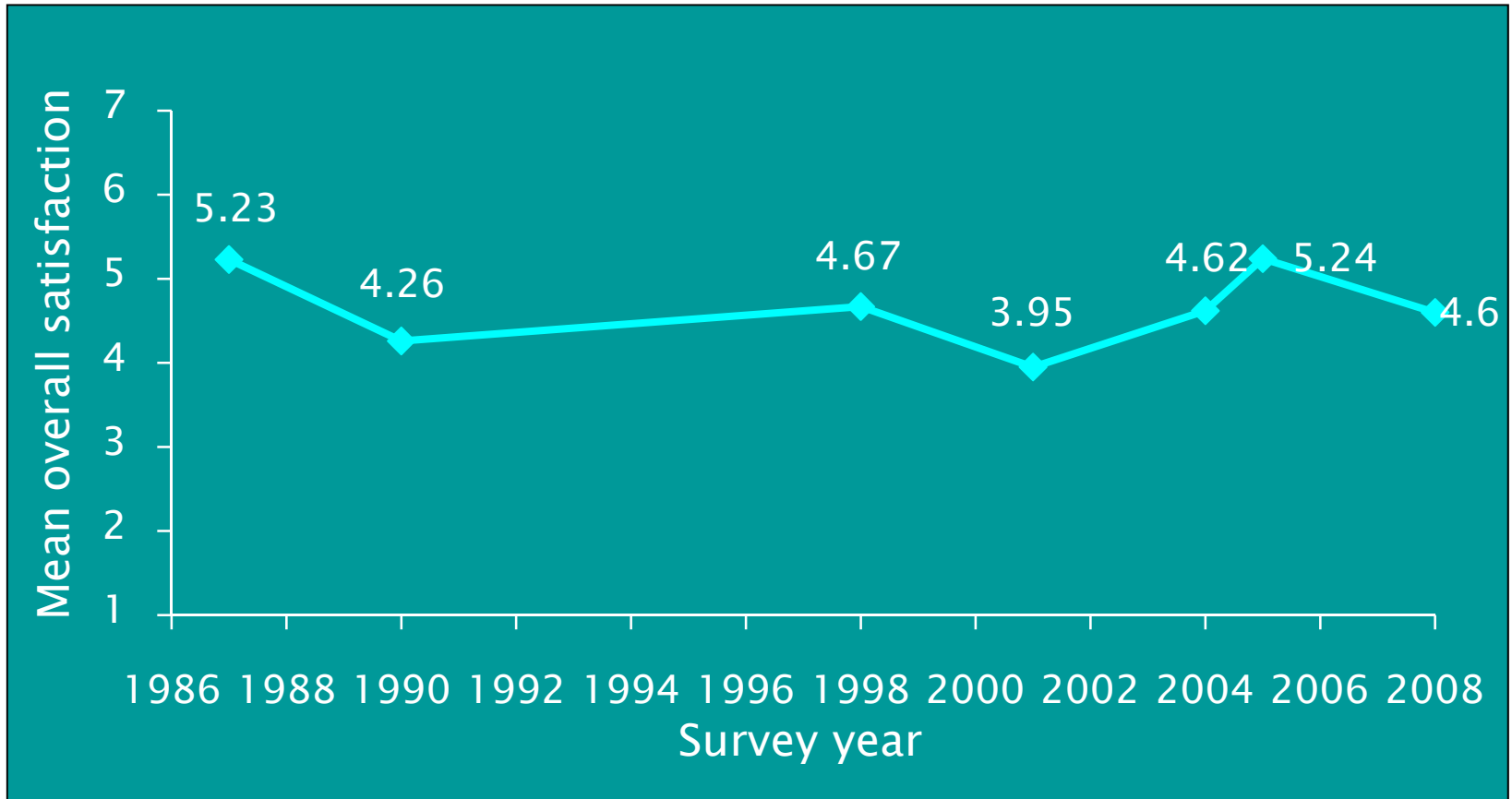
Improved organisation of care

- More systematic protocol driven care
- Greater use of templates improves recording and outcomes of care
- Recall means better follow up
- Role of nurses may be changing
McDonald, Lester and Campbell, Soc Sci Med 2009; 68(7);1206-1212
- Practices with more nurses achieve better QOF scores/intermediate outcomes
Griffiths et al BJGP 2010;6034-9

Intended Consequences

- Increased computerization
- Better organized care
- Greater job satisfaction/more money...
- Improved care

Trends in Job Satisfaction



Intended Consequences

- Increased computerization
- Better organized care
- Greater job satisfaction/more money...
- **Improved care**

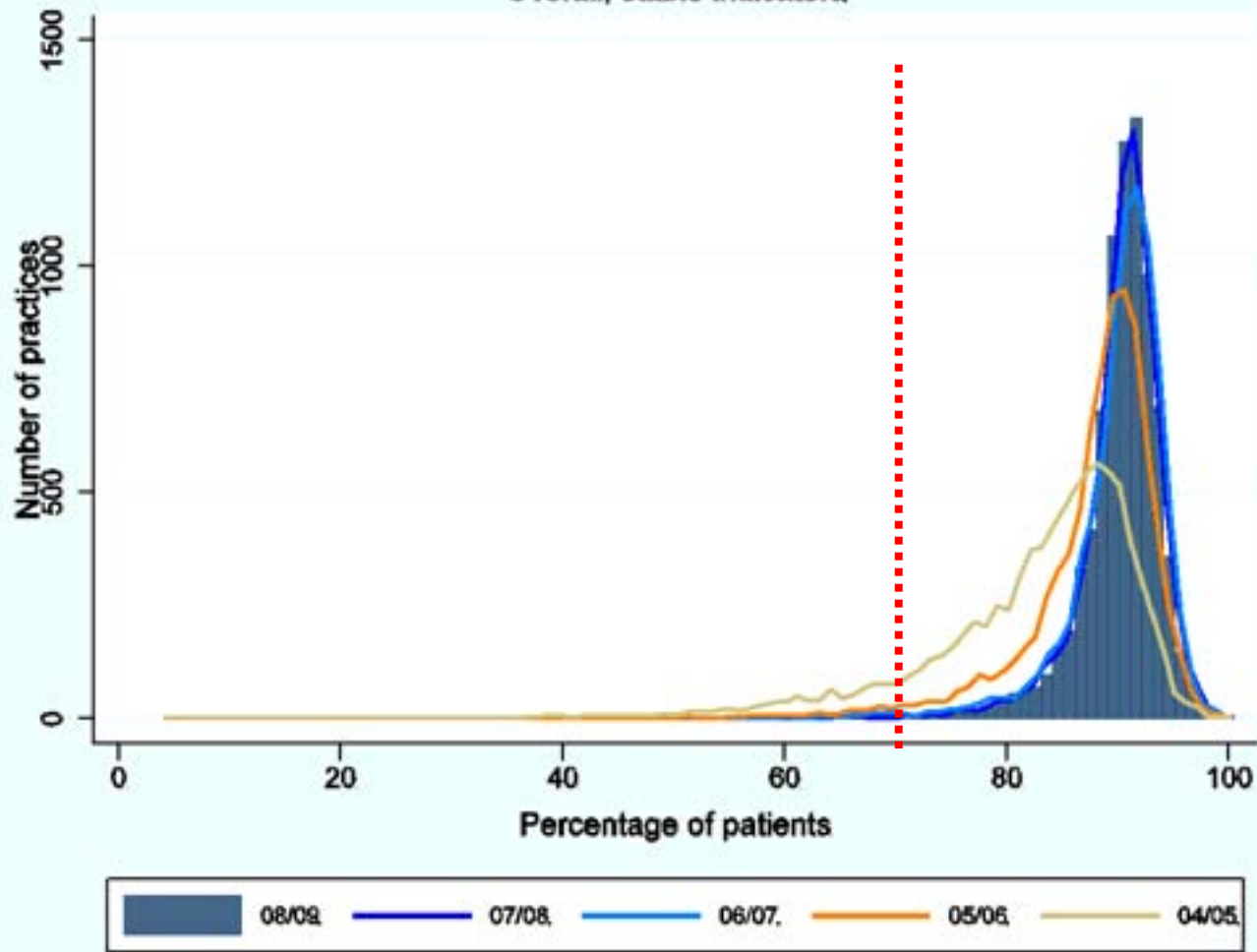
Things aren't always as they seem



- Know the baseline
- Setting thresholds for achievement/payment requires knowledge of the starting point

Achievement for 50 'stable' clinical indicators

Reported achievement
Overall, stable indicators



**Median
reported
achievement:**

2004/5 84.9%

2005/6 89.2%

2006/7 91.0%

2007/8 90.9%

2008/9 90.8%

**Stable
indicator:**
continuously
incentivised
under the
QOF since
2004-5.

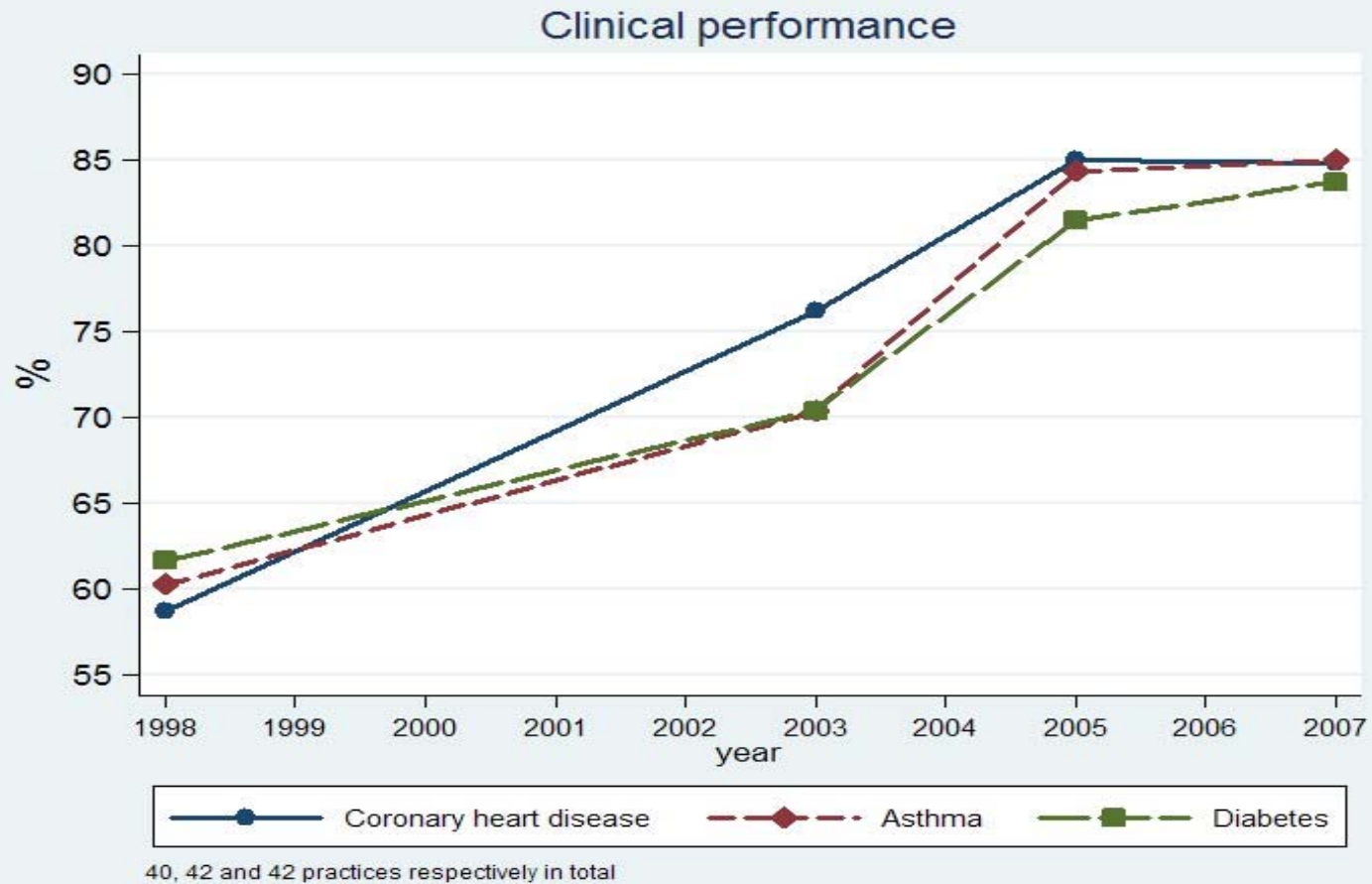
QuIP 1998-2007: Aims

- **Aim:** Evaluate the impact of the 2004 GMS contract and Quality and Outcomes Framework on the quality of care provided in general practice
- **Nationally representative sample of 42 practices**
- **Clinical quality:** Medical audit of angina, asthma and diabetes care using validated clinical review criteria.

Campbell et al NEJM 2007; 357: 181-190

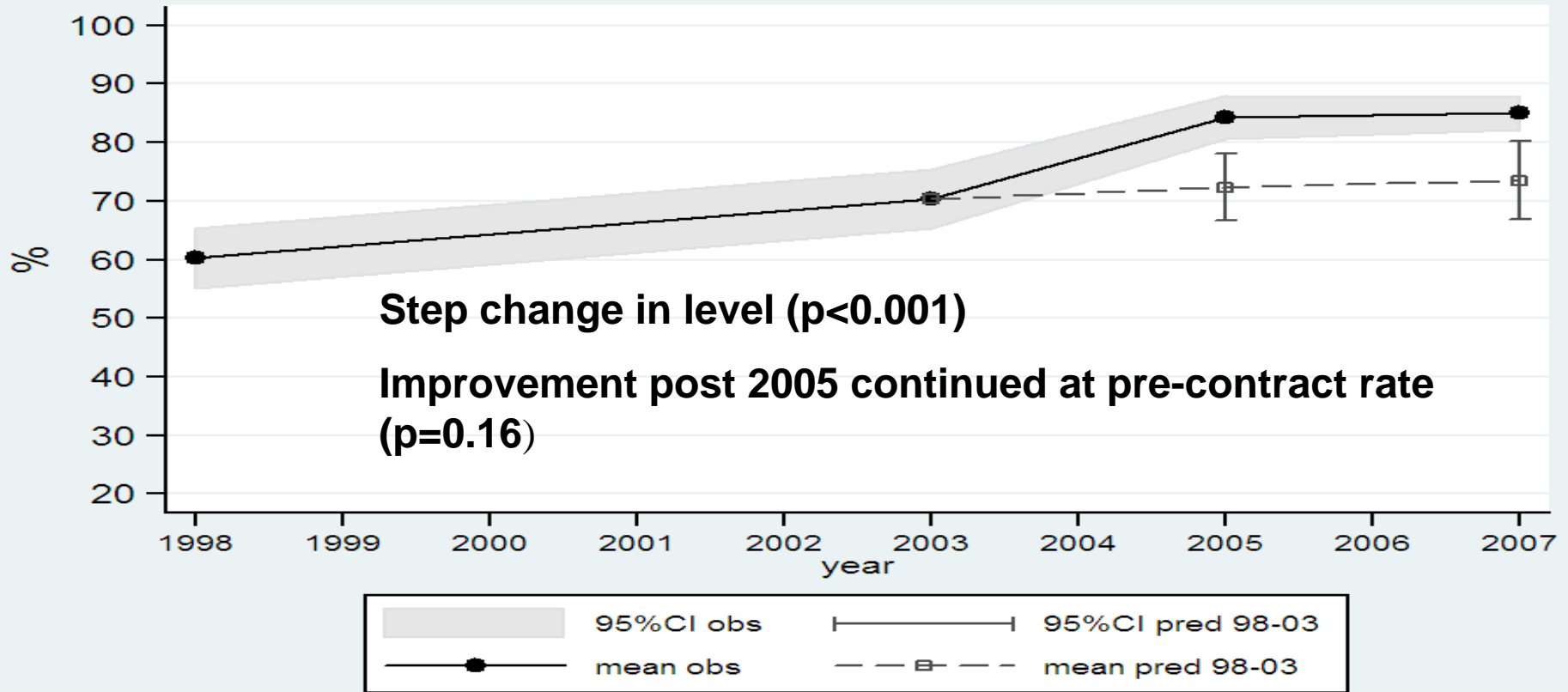
Campbell et al NEJM 2009; 361: 368-378

Data from QuIP: 1998-2007



Asthma

Asthma overall



prediction based on logit model - 42 practices in total

displaying CIs of untransformed mean scores (decisions based on CIs of mean difference of transformed scores)

Unintended consequences



- Change in professional values
- Changes to practice nurse and salaried doctor roles
- Less holistic approach
- Changes to continuity of care
- Changes to non incentivised areas
- Equitable health intervention

Changes to professionalism

“We developed this zero tolerance of blood pressure. No-one is allowed to say ‘It’s a little bit up, leave it’ it’s not acceptable.”

Senior GP

Roland M, Campbell S et al. *Primary Health Care Research and Development* 2006; 7: 70-78

Unintended consequences

- Change in professional values
- Changes to practice nurse and salaried doctor roles
- Less holistic approach
- Changes to continuity of care
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Changes to nurses' roles

“They (the GPs) forget we're actually nurses. You've not stopped all day because you have had ill patients. And then they come in and tell you that you are 1% down on a target.”

“All the three nurses, we agree that we're doing a lot more of their work for them (the doctors), and not much in the way of money recognition.”
(practice nurse)

McDonald, Lester and Campbell, Soc Sci Med 2009; 68(7);1206-1212

Changes to salaried doctor roles

“They are feathering their own nests essentially and I do think that it, the other aspect of it is I think they are abusing the younger generation of doctors.” (salaried GP)

Lester, Campbell, McDonald. *British Journal of General Practice* 2009;59:908-915

Unintended consequences

- Change in professional values
- Changes to practice nurse and salaried doctor roles
- **Less holistic approach**
- Changes to continuity of care
- Changes to non incentivised areas
- Equitable health intervention

Less holistic approach?

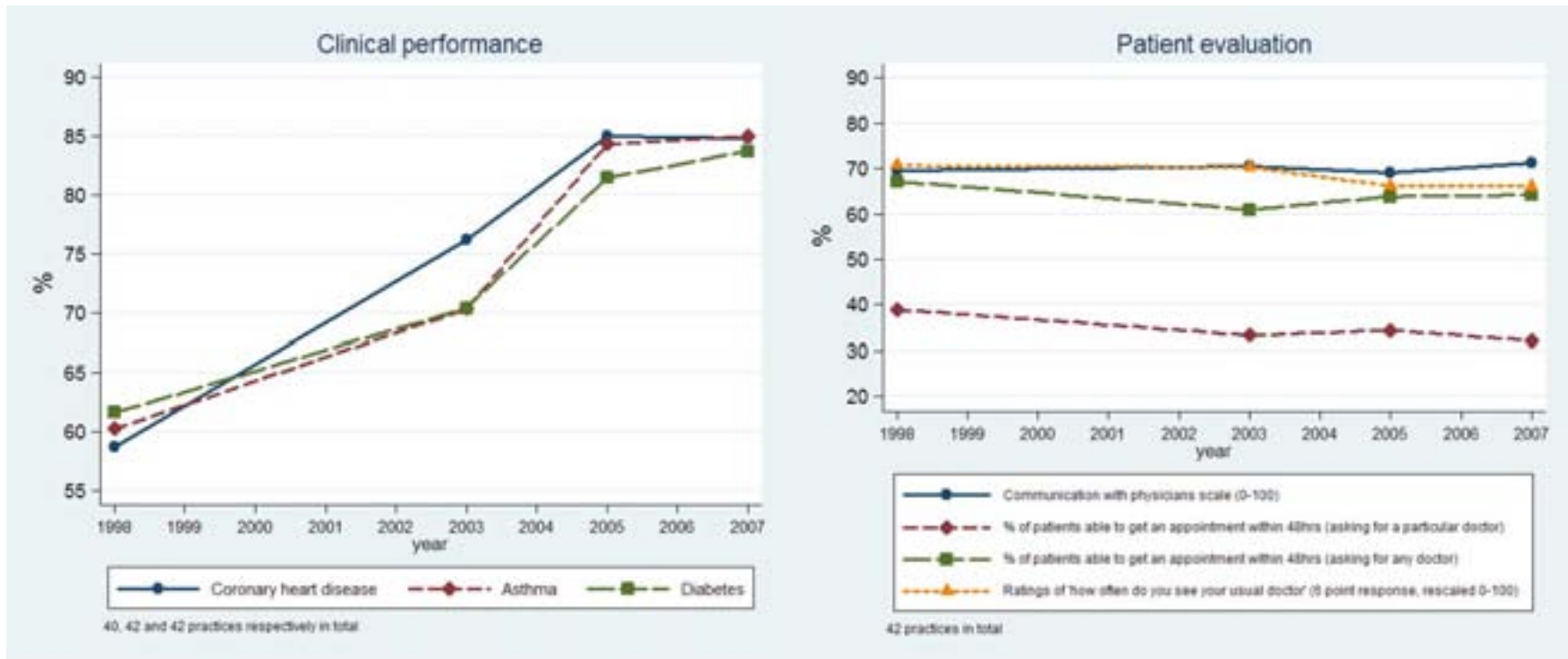
“The profession has essentially been bribed to implement a population based disease management program that often conflicts with the individual patient centered ethos of general practice...it comes dangerously close to medicine by numbers and threatens the basis of general practice.”

Lipman T. *Br J Gen Pract* 2005; 55: 396.

Unintended consequences

- Change in professional values
- Changes to practice nurse and salaried doctor roles
- Less holistic approach
- **Changes to continuity of care**
- Changes to non incentivised areas
- Equitable health intervention

Clinical performance – patient evaluation



(a)

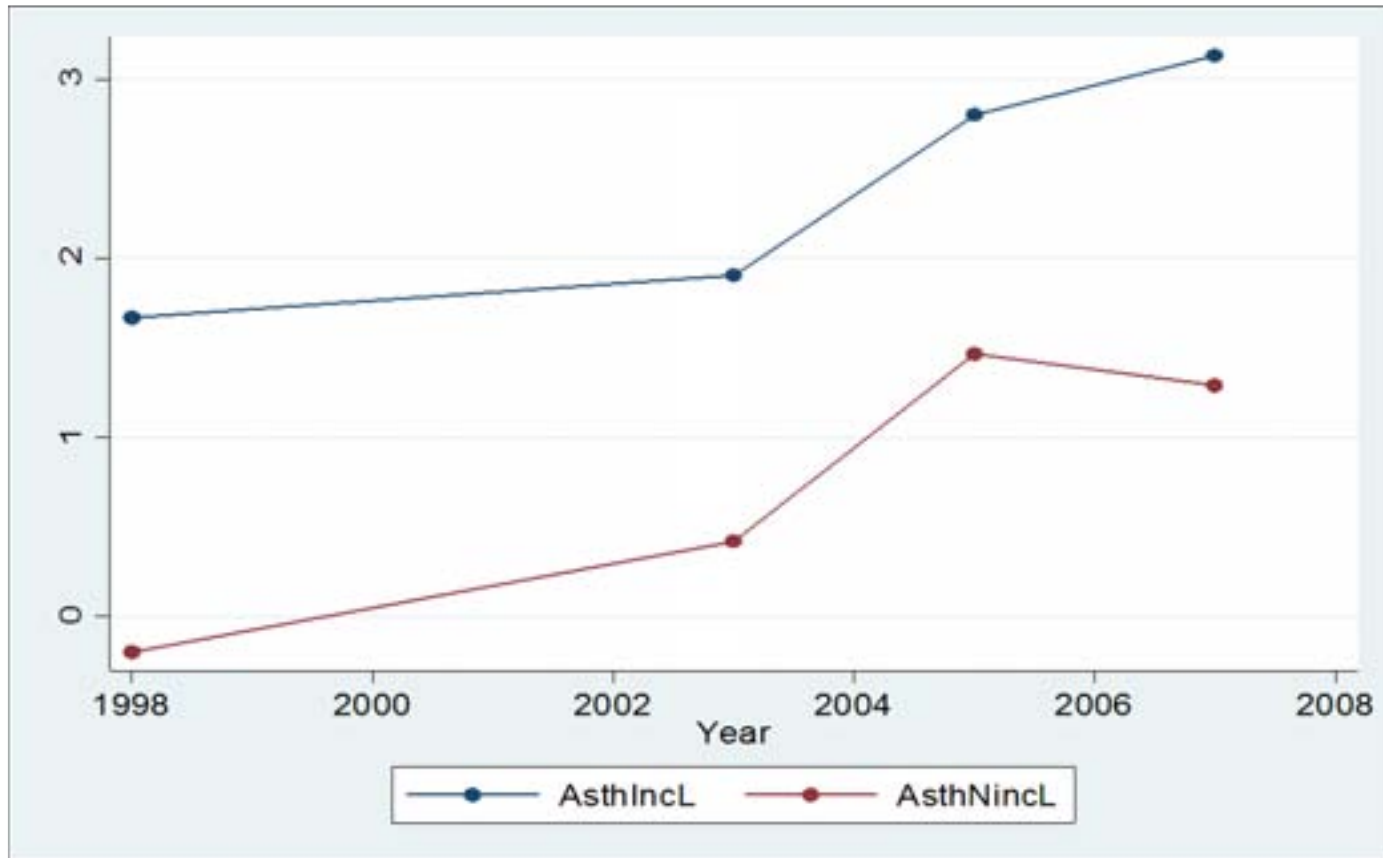
(b)

Figure 1: Mean Scores for (a) Clinical Quality at the Practice Level for Coronary Heart Disease, Asthma, and Type 2 Diabetes, 1998 to 2007 and (b) for patient evaluations of communication with their physician, access to care and continuity of care, 1998 to 2007

Unintended consequences

- Change in professional values
- Changes to practice nurse and salaried doctor roles
- Less holistic approach
- Changes to continuity of care
- **Changes to non incentivised areas**
- Equitable health intervention

Asthma: incentivised V non incentivised indicators

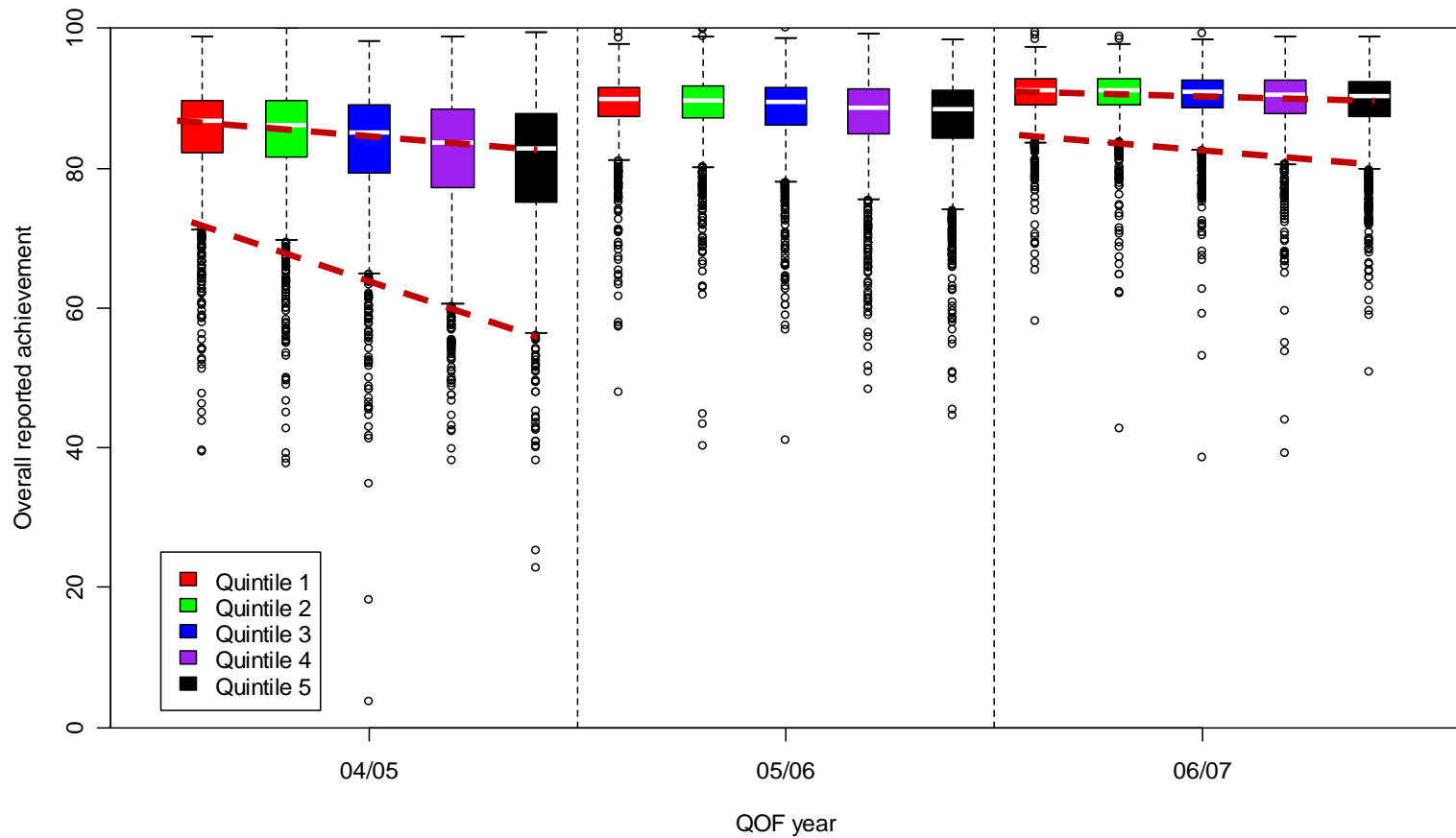


Campbell et al NEJM 2009; 361: 368-378

Unintended consequences

- Change in professional values
- Changes to practice nurse and salaried doctor roles
- Less holistic approach
- Changes to continuity of care
- Changes to non incentivised areas
- Equitable health intervention: can be positive!!

Inequality in quality of care Achievement by area deprivation quintile



Doran et al. Lancet 2008; 372: 728-736.

How big is the cake?



If the cake can't get any bigger, need to:

- Allocate fewer points to existing indicators/incentives
- or
- retire indicators

Why retire indicators?

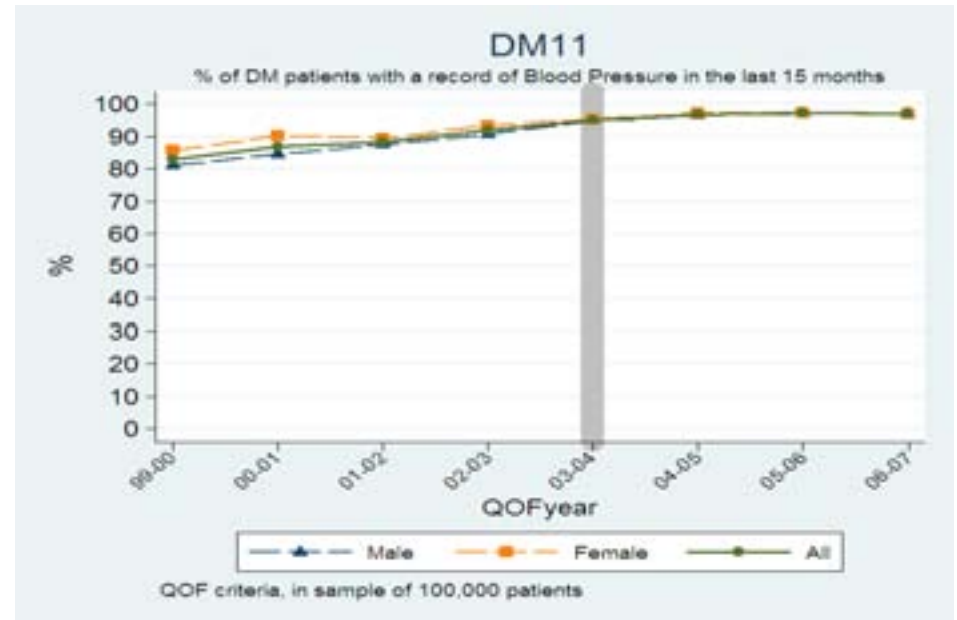
- Indicator not effective
 - evidence against the activity
 - unintended consequences of the activity
 - indicator not practical
 - duplicates other indicators
 - Activity results in significant harm or unintended consequences
 - Limited potential for further improvement on the indicator for the substantial majority of practices (achievement ceiling trend)
- Monitor any indicators/incentives that are retired

Criteria for retiring indicators

Criterion	
Reported achievement	
<i>Average rate</i>	High
<i>Variation</i>	Low
<i>Historical trends</i>	Plateauing
Exception reporting	
<i>Average rate</i>	Low
<i>Variation</i>	Low

Historical trends DM11

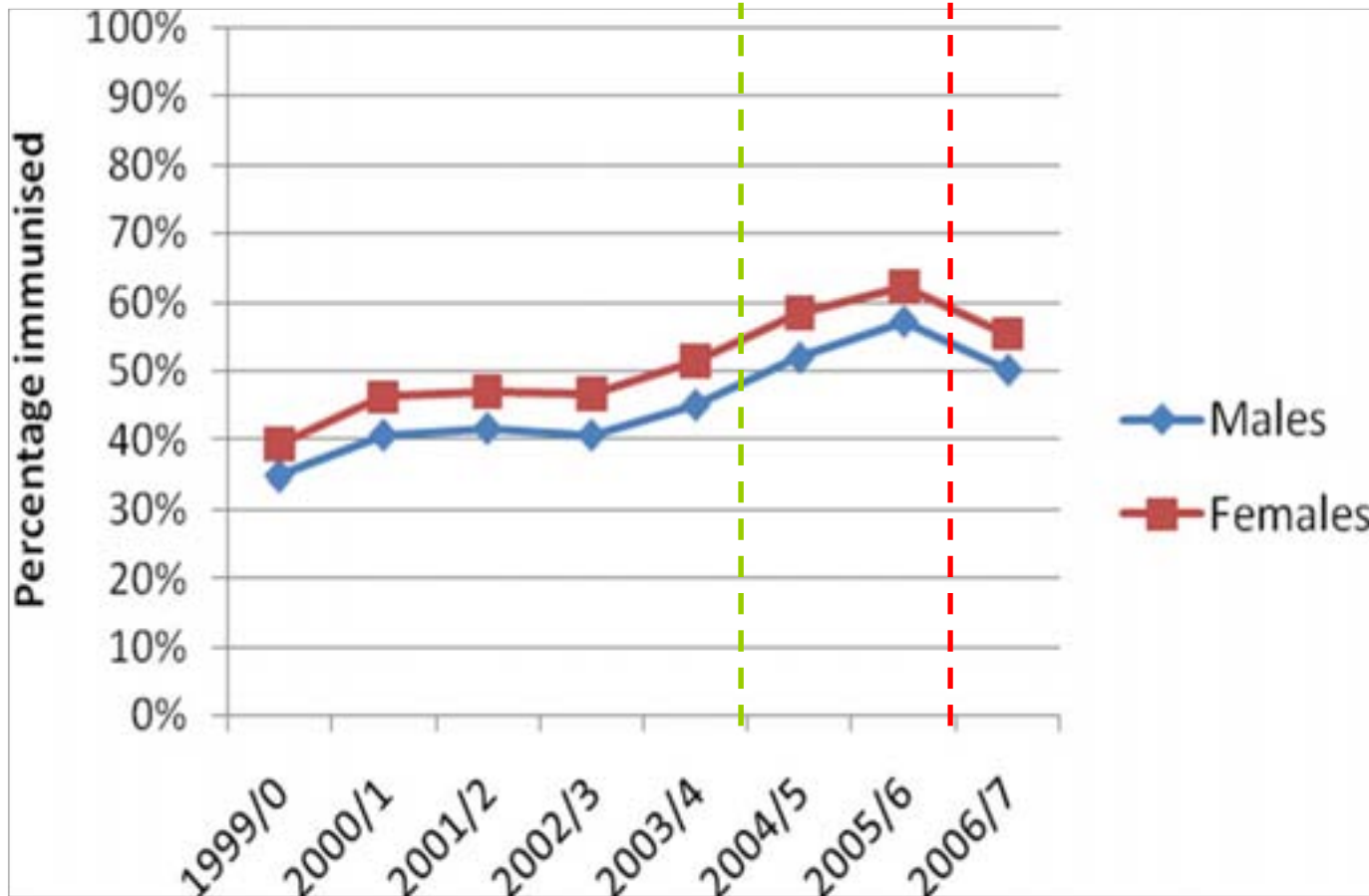
In Year 4 (2007-08):	
Mean points scored	2.996
No. of practices scoring maximum points	8228 (99.2%)
Mean reported achievement	98.4%
No. of practices with 100% achievement	1733 (20.9%)
Mean exception reporting rate	1.0%
Remuneration for 'average' practice	~£374. 50
Cost to NHS	~£3.1m



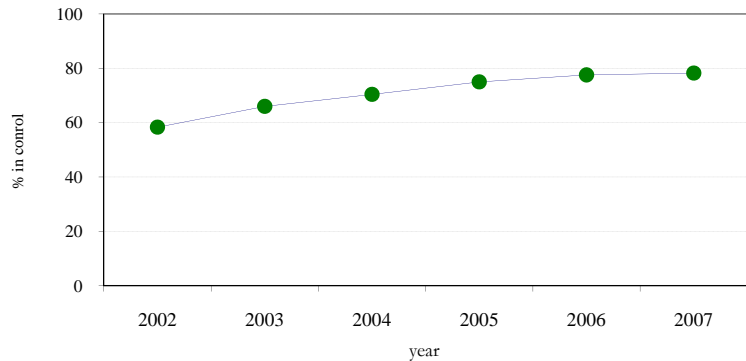
And what happens next...?

- Expectation that work in removed areas will continue since 'embedded' in primary care?
- Very limited UK evidence base
- Helen Lester worked with Kaiser Permanente in California – up to 8 years of data including 4 'shared' indicators with QOF

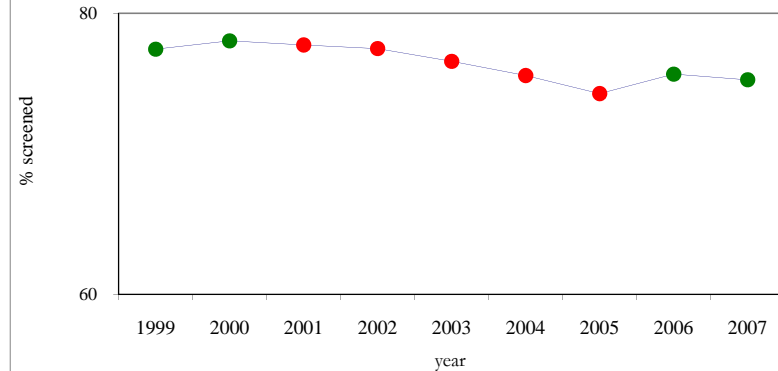
Consequences of retiring indicators: Asthmatics receiving influenza vaccination



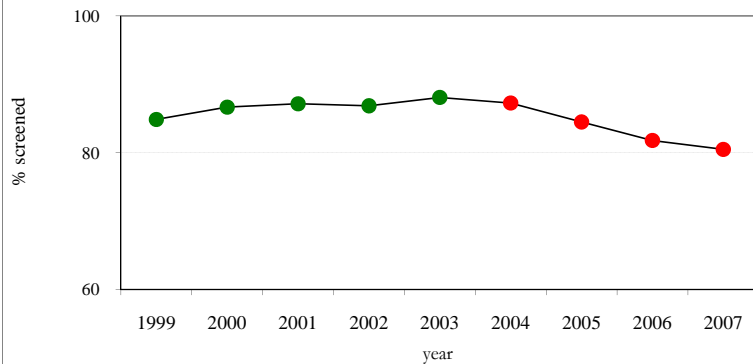
Red dot: incentive off, **Green** dot: incentive on



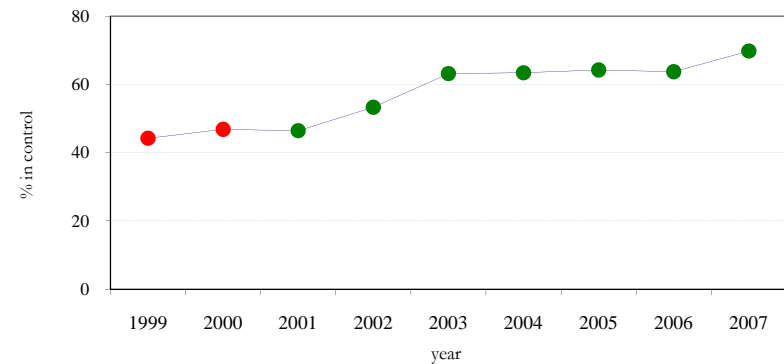
**Hypertension Control
(systolic < 140), ages 20 and up**



Cervical Cancer ages 21-64



**Diabetic Retinopathy
Screening, ages 31 and up**

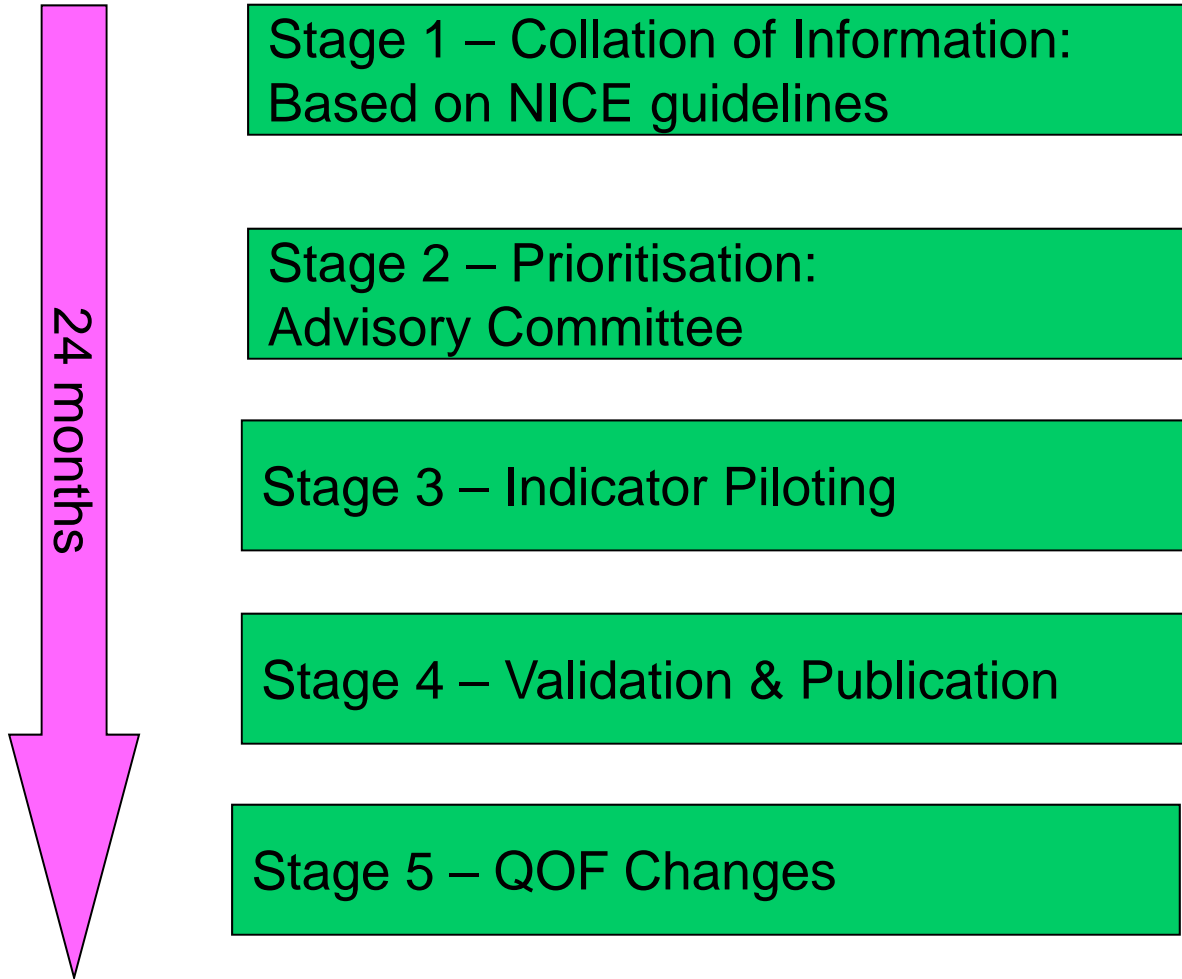


**Diabetes Glycemic Control (< 8%),
ages 18-75**

New ways of working

- NICE led process since April 2009
- External contractor:
 - University of Manchester/YHEC/RCGP
- Co-leads: Stephen Campbell, Helen Lester

New development process



UK QOF Piloting

Pilot cohorts

- 4 separate cohorts
- Each cohort:
 - 30 practices in England: nationally representative
 - 2 practices each in Northern Ireland, Scotland and Wales
- Pilot handbook
- NEC and NHSIC data
- Initial visit one month after start of pilot
- Final visit: in the 4-6 weeks after pilot finishes: qualitative interviews

Pilot 1: October 2009- March 2010

- Pilot 1: October 2009 – March 2010
- 6 clinical areas / 13 indicators

<u>Condition</u>	<u>Number of indicators piloted</u>
• Asthma	1
• Dementia	1
• Diabetes	2
• MI	2
• SMI	6
• Palliative care	1

13 indicators

- **ASTHMA:** The percentage of patients with asthma who have had an asthma review in the previous 15 months that includes an assessment of asthma control using the 3 RCP questions.
- **DEMENTIA:** The percentage of patients with a new diagnosis of dementia to have FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register.
- **DIABETES 1:** The percentage of patients with diabetes with a record of testing of foot sensation using a 10 g monofilament or vibration (using biothesiometer or calibrated tuning fork), within the preceding 15 months.
- **DIABETES 2:** The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or 4) ulcerated foot within the preceding 15 months.
- **MYOCARDIAL INFARCTION 1:** The percentage of patients with a history of myocardial infarction (from 1 April 2011 {from 1 October 2009 for the purposes of piloting} currently treated with an ACE inhibitor, aspirin or an alternative anti-platelet therapy , beta-blocker and statin (unless a contraindication or side effects are recorded)
- **MYOCARDIAL INFARCTION 2:** The percentage of patients with a history of myocardial infarction who have a record of intolerance or allergy to an ACE inhibitor who are currently treated with an ARB (unless a contraindication or side effects are recorded)
- **MENTAL HEALTH:** The % of patients with schizophrenia, bipolar affective disorder & other psychoses, record of :
 - 1: alcohol consumption in the preceding 15 months.
 - 2: BMI in the preceding 15 months.
 - 3: blood pressure in the preceding 15 months.
 - 4: total cholesterol: hdl ratio level in the preceding 15 months.
 - 5: blood glucose level or HBA1c in the preceding 15 months.
 - 6: cervical screening within the last 5 years.
- **PALLIATIVE CARE:** The percentage of patients on the palliative care register who have a preferred place to receive end-of-life care documented in the records.

Criteria for assessing a pilot indicator

Attribute	Summary / recommendation
Clarity	<ul style="list-style-type: none"> • RAND Appropriateness Method
Acceptability	<ul style="list-style-type: none"> • Risks, issues, relative impact and uncertainties
Feasibility	<ul style="list-style-type: none"> • ‘Technically feasible’ in current GP systems and supported by current methods of data extraction for QOF,
Reliability	<ul style="list-style-type: none"> • Reproducible in test pack
Implementation	<ul style="list-style-type: none"> • Baseline and potential change in baseline (evidence of sensitivity to change); • Exception reporting / gaming; • Changes in practice organisation; potential barriers; • Unintended consequences
Changes existing QOF indicators	<ul style="list-style-type: none"> • Summary of any suggested changes
Changes in wording	<ul style="list-style-type: none"> • Summary of any suggested changes
Cost effectiveness	<ul style="list-style-type: none"> • Summary of evidence of cost effectiveness
Overall NEC recommendation	<ul style="list-style-type: none"> • 1) no major barriers/risks/issues/ uncertainties • 2) some barriers/risks/issues/uncertainties but okay • 3) major barriers/risks/issues/uncertainties preclude it

RAND Appropriateness Method (RAM)

Example of AC recommendation

- Classify foot risk as: at low current risk of foot ulcers (normal sensation, palpable pulses), at increased risk (neuropathy or absent pulses or other risk factor), at high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or ulcerated foot.

Examples of indicator

- The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or 4) ulcerated foot within the preceding 15 months

RAND Appropriateness Method (RAM)

Systematically combine:

- evidence (NICE briefing paper and additional guidance)
- collective judgement of experts
- By deriving a consensus opinion from a group with individual opinions aggregated into refined aggregated

RAM rating

**Indicators rated 7-9 necessity to do and record
feasible**

**≥80% of ratings of panellists in the same 3 point
region of a 1-9 integer scale**

**Outputs: indicators that are necessary with
agreement**

Data extraction: involve IT experts!

Business rules/data extraction specification written by NHSIC/Primis+

- *Feasibility*: including 'technically feasibility' in current GP systems and supported by current methods of data extraction for QOF
- *Reliability*: including Extraction Software Provider (e.g. PRIMIS+) producing a Test Report
- *Implementation*: including baseline and final extraction / sensitivity to change
- These assessments are made in conjunction with comments received from the NHSIC.
- Data from: baseline and final (trend)

Qualitative: ask staff!

Qualitative interviews with practice staff in April – May 2010

- Acceptability
- Implementation

- Based on interviews with 66 members of staff in 27 Practices:
- 24 GPs
- 19 PMs
- 13 nurses
- 8 others
- All interviews digitally recorded

Acceptability - implementation

Diabetic foot risk assessment

Indicator as piloted:

- The percentage of patients with diabetes with a record of testing of foot sensation using a 10 g monofilament or vibration (using biothesiometer or calibrated tuning fork), within the preceding 15 months.

Acceptability - implementation

Diabetes foot risk assessment

- The procedure is performed routinely in a majority of practices by nurses. However, assessment is not always made using a formal classification system nor routinely recorded. The assessment is also often performed outside the practice by a podiatrist or chiropodist.
- Changes required to GPSS diabetes review templates where not already included
- Education or training of nurses in some practices.
- Workload implications for practice staff

“We were doing the assessment, we weren’t recording what they were”. (PM,mile)

Acceptability - implementation

Palliative care

Indicator as piloted:

- The percentage of patients on the palliative care register who have a preferred place to receive end-of-life care documented in the records

Acceptability - implementation

Palliative care

- Anxiety over the rigidity of the stipulated timeframes which are too prescriptive
- Perceived potential harm to patients
- Changes to timing of which patients are put on the PC register: the palliative care register is perceived to often be quite subjective and the timing of raising preferred place of death is an issue
- The indicator does not pro-actively encourage GPs to keep the preferred place for end of care up to date
- Undue focus on one isolated question from a multifaceted and complex issue

Acceptability - implementation

Palliative care

“To make sense of this you’d have to ask this at a standard time before death, and that’s unpredictable. I can understand why this is very attractive to healthcare planners, but actually in the real world I think it’s a very difficult one”.(dr,gp,night)

“So I think if this is going to become a tick box exercise it might be that the question will be pushed at an inappropriate time, the wrong moment for the sake of obtaining some points” (sb,gp,new).

Conclusions: Policy window

- Whether the idea of P4P gains enough legitimacy in Australia will depend on whether this open policy window creates actual policy change.
- But the window should remain closed until....



Evidence and decisions needed on...

- Current baselines?: most UK practices were already achieving above maximum thresholds before 2004 .
- How data will be entered, extracted and utilised for any P4P scheme? → put infrastructure in place & involve IT experts!
- Focus for assessment: general practice/primary care, community services
- Should patients register with only one practice? Attribution issues if not
- Focus of incentives: single conditions or multi-morbidities?

Evidence and decisions needed on...

- Recipients of the incentives: doctors only or all practice staff?
- How many indicators/incentives? Limited size, focus on clinical indicators with a cycle of piloting and removal
- What level (%) of practitioner income should to be attributed to P4P? → PIP accounted for 9% in 2003
- Who will pay? Single funder?
- Purpose: payment mechanism or quality improvement?

P4P: is it “AUSable” – is the window open?

Pay for performance in Australia should evolve NOT be imposed.

- Can't transplant QOF to Australia - no IT infrastructure.
- Australia does have P4P within the PIP, embodied in Service Incentive Payments (SIP) for diabetes, asthma, cervical screening, and outcome (threshold) payments for diabetes, cervical screening and indigenous health.
- Australia has practice-level data collection and reporting system - in the Australian Primary Care Collaboratives.
- These schemes could be built on and developed, whilst taking into account the key lessons from overseas.

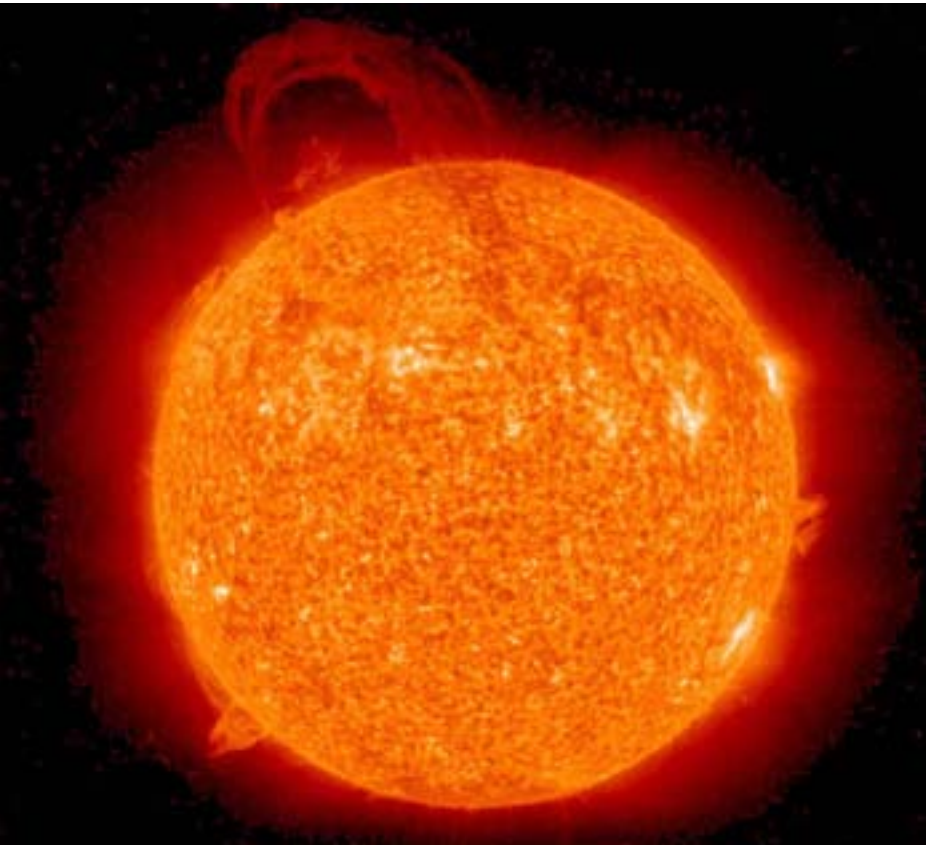
Wider context

- Pay-for-performance : only as one part of a multiple systems based strategy for quality improvement – not a panacea.
- Clear purpose for P4P : as a payment mechanism for health care staff, to maintain levels of quality or to improve quality (the intended consequences).
- Unintended consequences
- Mix of organisational/clinical/patient experience indicators
- Mix of financial and professional incentives

Wider context

- Pilot all indicators!
- Monitor achievement in areas where indicators are removed!

Don't just focus on P4P – wider context



- Unintended consequence of focusing only on P4P
- There is no “magic bullet” for quality improvement (Oxon 2005)
- Fingers burned....

Future challenges: UK

- Value for money is a BIG issue:
- Improving quality at no extra cost
- Cost effectiveness and value for money
- Greater focus on outcomes and public health measures
- Government expectation that indicators will be removed from QOF on a regular basis and replaced by new piloted indicators

Thank you very much for listening!

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