Removal of GP incentives associated with decline in quality of care

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Credit: University of Dundee

The removal of financial incentives for doctors working in primary care is associated with a decline in performance on quality measures, according to new findings by researchers from the Universities of Dundee and Cambridge, and staff from the National Institute for Health and Care Excellence (NICE).

Researchers said the decline in performance measures may be partly accounted for by changes to documentation after incentives were removed. But they added that declines in measures involving laboratory testing suggested the removal of incentives had changed the actual care delivered to patients.

Professor Bruce Guthrie, Professor of Primary Care Medicine at the University of Dundee, said, "Our research shows that removal of financial incentives is associated with an immediate decline in performance on twelve quality measures studied.

"Although some of that decline may just be that clinicians have changed how they document the care that they give, declines in measures involving laboratory testing suggest that the removal of incentives did change the actual care delivered to patients.

"A key implication of this study is that reductions in quality are likely after incentives are removed, although the size of the reduction will depend on the context and the nature of the indicator."

Results of the study are published in the *New England Journal of Medicine*.

The issue of financial incentives and pay-for-performance schemes in health care has been hotly debated even as they have been introduced in many countries, including the United Kingdom, the United States, Canada, Germany, Australia and New Zealand.

In 2004, the UK's National Health Service (NHS) implemented the Quality and Outcomes Framework (QOF) in UK family practice. QOF was the world's largest pay-for-performance health care scheme, but the number of quality-of-care indicators and the proportion of income dependent on pay for performance have been reduced over time.

Scotland abolished the QOF altogether in 2016, while in England there has just been a major review of QOF.

The researchers said the benefits of pay-for-performance schemes in improving the quality of care remain uncertain, but there is even less information on the effect of removing incentives from existing pay-for-performance schemes.

They analysed electronic medical record (EMR) data from almost 3000 English primary care practices, with more than 20 million registered patients, from 2010 to 2017. They looked at twelve quality-of-care indicators in the Quality and Outcomes Framework for which financial incentives were removed in 2014 and six indicators for which incentives were maintained.

Compared to previous years, there were immediate reductions in the documented quality of care for all twelve indicators where financial incentives were removed. Reductions ranged from 5.8 percent for documentation of smoking status to 62.3 percent for documentation of lifestyle counseling for patients with hypertension.

Three years after removal of the incentives, there were still significant reductions in documented quality for all 12 indicators, with the largest reductions in two of the three health-advice indicators (−71.6 percent for lifestyle counseling for patients with hypertension and −65.9 percent for preconception advice for patients with epilepsy) and in one of the intermediate-outcome measures (−53.6 percent for documentation of seizure-free status for patients with epilepsy).

Reductions in clinical-process measures were generally smaller, ranging from a reduction of 9.2 percent for thyroid-function testing in patients with hypothyroidism, to a reduction of 37.5 percent for glycated hemoglobin testing in patients with serious mental illness, with similar

reductions for other intermediate clinical outcomes, ranging from a reduction of 10.1 percent for cholesterol control in patients with CHD to a reduction of 16.8 percent for cholesterol control in patients with stroke or TIA.

In contrast, analysis of the six indicators for which incentives were maintained showed no clinically important changes in documented quality three years after 2013–2014 for four indicators (blood-pressure measurement in patients with serious mental illness, documentation of alcohol consumption in patients with serious mental illness, cholesterol control in patients with diabetes, documentation of smoking cessation advice for patients with chronic illness, and blood-pressure control in patients with CHD and in patients with stroke.

Professor Martin Roland, Emeritus Professor of Health Services Research at the University of Cambridge, said, "Despite widespread implementation, questions persist about the ability of these schemes to improve the quality of care or patient outcomes, and there is ongoing debate about the sustainability of performance once financial incentives are removed.

"Our overall interpretation is that the observed smaller reductions in quality for core clinical care (e.g., blood-pressure management, retinopathy screening, and laboratory measurements for processes and outcomes) do reflect changes in clinical practice but that the much larger reductions in documentation of clinical advice and seizure-free status of patients with epilepsy should be more cautiously interpreted."

Mark Minchin, Associate Director at NICE, said, "This study suggests that, at a minimum, payers planning to remove financial incentives should monitor the quality of care after removal. In doing so, they face the same conundrum involved in introducing incentives: the uncertainty about whether changes in documented quality represent true changes in

patient care."

More information: Mark Minchin et al. Quality of Care in the United Kingdom after Removal of Financial Incentives, *New England Journal of Medicine* (2018). DOI: 10.1056/NEJMsa1801495

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