Quality improvement financial incentives for general practitioners

Executive Summary

Policy Context

Australia’s recently released National Primary Health Care Strategic Framework aims to improve access and reduce inequity in health care using a range of strategies including funding models and incentives as mechanisms to promote high quality care. Currently, the Australian health system relies on a mixed funding model with a focus on fee-for-service, which does not actively reward quality of care. Blended models, which include financial incentives such as pay for performance (P4P), have been proposed to encourage improvements in the quality and safety of health care provided, and the uptake and meaningful use of electronic health records (EHRs). Nevertheless, incentives are not sufficient to impact on care provision without both appropriate infrastructure and the engagement of general practice.

Key Findings

Quality improvement includes aspects of self-reflection and benchmarking, with continued evaluation to identify where additional improvements to practice can be made. Measures of the quality of care are typically structure (e.g. related to an organisation’s operations), process (e.g. clinical guidelines or care pathways) or outcomes-based (e.g. physiological indicators). Improvements can be measured in relative or absolute terms. The likelihood of engaging with incentives and the behavioural responses of health professionals are affected by the different characteristics of financial incentives, which may be directed at networks of practices, individual practices, or specific health care professionals. Payments may be offered as a bonus or addition to usual earnings, or may be withheld if practices do not achieve desired outcomes. Payments may be prospective or retrospective and may be linked to fixed thresholds or individual patients.

In Australia, sets of clinical indicators for quality improvement have been developed and are continually revised by the Royal Australian College of General Practitioners and the Australian Commission on Safety and Quality in Health Care. These standards assist general practices and practitioners to establish and implement processes to monitor and improve the quality of their services. Similarly, specific financial incentive schemes such as the Practice Incentives Program incorporate P4P (with sign on and service incentive payments) and practice-based capacity payments. It is not clear whether the incentives improve quality of care, as there is insufficient evidence to support or refute the use of financial incentives in the available literature base. P4P incentives have been shown to have some influence on diabetes care, but there is also evidence to suggest that while signing on to services may demonstrate high uptake, services are often provided, but not claimed through the incentive program.
The United Kingdom’s quality improvement approach relates to the Quality and Outcomes Framework (QOF) introduced in 2004. Coordinated by PHC organisations, this payment-for-quality scheme comprises 146 indicators, with related payments constituting up to one-third of a practice’s income. Absolute improvements have been demonstrated with a number of indicators including control of blood sugar levels among patients with diabetes, and provision of smoking cessation advice. Diabetes care is a particular focus of the QOF scheme, with ten per cent of the total indicators allocated to this condition. The QOF also includes a large investment in technology which is likely to have contributed to increases in recorded levels of care. Criticisms of the approach relate to the readily achievable levels of indicator targets, which provide little risk to practice incomes and little incentive for improvements over and above the specified levels. Enhanced Services are another significant financial incentive or lever in the UK quality improvement approach towards specific diseases. GPs affiliated with Local Enhanced Services had a higher probability of achieving QOF diabetes indicators than those without involvement of these community-based services.

In the United States, there is widespread use of P4P incentives. Clinical quality is most commonly incentivised, with over 60 per cent of programs offering bonus payments rather than withholding approaches, and the majority of programs providing one annual payment. In 2007, a pay-for-reporting model was introduced (the Physician Quality Reporting System) with physicians entitled to a lump sum payment if they met the criteria for submitting quality data based on a set of 74 indicators. The 2010 Affordable Care Act made public reporting of quality measures compulsory. There has been particular emphasis on EHRs with the Centers for Medicare and Medicaid Services delivering a successful EHR incentive program to encourage transition to, adoption of, and meaningful use of EHRs. Evaluated P4P programs have illustrated benefits for clinical outcomes such as depression severity, appropriate prescribing, blood pressure control and smoking cessation.

Canada has a predominantly fee-for-service system though the different regions have their own approaches to using financial incentives for quality improvement. The Health Council of Canada is responsible for monitoring progress in improving the quality of the health system, whereas local councils support initiatives operating at provincial and territorial levels. Canadian incentives for preventive services have enabled improvements in provision of influenza vaccinations, pap smears, mammograms and colorectal cancer screening. In some cases, the incentivised actions required additional infrastructure or equipment, hence uptake was limited among practices. In contrast, where incentives were linked to current standard practices, uptake occurred more readily.

In 2010, a Health Quality and Safety Commission was established to lead a national quality program in New Zealand; and the main focus was on hospitals. Currently, there is limited information about financial incentives in PHC in NZ, with a proposed shift towards non-financial incentives as drivers for improvements in quality. Capitation funding is widespread in NZ though additional funds are available for primary health organisations working to address chronic disease management, health promotion and improving access. In 2006, the Primary Health Organisation Performance Management Programme was developed and included P4P against performance indicators as a core component. However, despite positive preliminary results and the availability of performance scores, no formal evaluation data are available.

Across all literature in this review, there was a lack of explicit acknowledgement of whether the outcomes measured were absolute or relative improvement.
Policy considerations
Based on the findings of this report, the following points may be considered.

Who gets paid?
- Information is lacking about distribution of payments
- There is a range of different systems with some incentives directed at groups or organisations and others directed at individuals
- Future incentive programs should acknowledge that team-based care is central to PHC

How much is enough?
- Strength of financial incentives is often not well reported
- Low incentives are unlikely to motivate behaviour change and/or the administrative burden related to claiming a minimal reward may not be worthwhile
- High incentives raise overall health system costs and perverse incentives may prevail
- A series of tiered or differentiating targets based on baseline performance and/or a piece-rate payment approach may be used for each appropriately managed patient

What are the consequences?
- Crowding in/out, exception rates, and gaming
- Coercive behaviour by GPs towards patients considered as non-compliant
- Conflict within workplaces by directing incentives at GPs
- The administrative burden of making claims for funds may be a disincentive especially in regions lacking resources or infrastructure (i.e., rural and remote)

Absolute versus relative improvement
- Absolute improvement is defined as the change in performance from baseline to follow-up; relative improvement is defined as the absolute improvement divided by the difference between the baseline performance and perfect performance (100%)
- Absolute targets are likely to be more effective than relative targets because they are transparent and create less uncertainty regarding the efforts to be eligible for payment
- Relative targets may reduce collaboration and dissemination of best practices because they encourage competition

Lack of quality data
- Challenges of publicly reported data, large datasets and limited enrolled populations
- Inconsistent units of analysis across evaluations of incentive effectiveness

Other influencers
- Processes and workforce availability
- Complexity of billing, administrative burden
- Accreditation processes, practice population composition and marketing of incentives affect practices’ willingness and ability to engage with incentives
- The use of financial incentives alongside a range of non-financial incentives and other quality improvement strategies (i.e. performance tables, professional standards).

Methods
A thorough (non-systematic) review of literature (Australia, UK, US, Canada and NZ) was undertaken. Materials were published between 2011 and 2014, collected from academic and grey sources including but not limited to PubMed, Trove, Google Scholar, Cochrane Database of Systematic Reviews, and Government websites. Key search terms included: “quality improvement”, “financial incentive”, and “pay for performance”.

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