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Editorial

Research on the UK Quality and Outcomes Framework (QOF) and answering wider questions on the effectiveness of pay-for-performance (P4P) in health care

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To what extent can research on the UK Quality and Outcomes Framework (QOF) answer wider questions on pay-for-performance (P4P)? The answer to this is likely to be negative for the most part. I discuss why this is the case and propose future models that might answer wider questions on the effect of pay-for-performance on quality when new schemes are introduced.

The QOF is arguably the largest P4P system in the world in terms of scope and investment. Its scope includes coverage of the population of the United Kingdom (UK) across four nations and a wide geographical area. Investment includes target payments but also the resources required to maintain the infrastructure comprising information, communication, development and evaluation systems.[1]

It is also the most intensively researched P4P system in the world. A database search from its inception in April 2004 to the end of July 2011 limited to research publications in the English language retrieved 575 publications. Many of these studies try to answer questions on the impact of the QOF in terms of its effect on intermediate or true outcomes, processes of care, inequalities, cost-effectiveness and perceptions of staff and patients. Many of these papers, either in their title or abstract imply that they are seeking to answer questions on the effect of the P4P system and therefore directly or indirectly attempting to investigate P4P systems more generally.[2]

An important question for academics, policy experts and commissioners of services is therefore whether research efforts focused on the QOF will inform us about the more general impact of P4P systems. There are a number of reasons why research on the QOF will be limited in the information it can provide on whether, why, how and to what extent P4P will improve care. These reasons concern the nature of the QOF, how it was introduced and the degree to which it reflects P4P systems more generally.

First, the QOF is not simply a P4P system. It was introduced in the context of a wider contract for general practice, together with an infrastructure to support and achieve a wide system of indicators and targets, as well as incentives to achieve certain levels of performance. So, it is a multifaceted intervention consisting of computerised information systems with data templates, prompts, collection and feedback; P4P on staged achievement targets; benchmarking against other practices; and all based on a national system of development, piloting and approval of indicators and targets.

The QOF is therefore a complex (as opposed to a simple single) intervention system. One could argue that all P4P systems include some or all of these elements: nevertheless, it is important to differentiate the effects of the incentives from the wider system in which they are operating. For example, there are two key elements of payment in the system which may need to be separated: one element to resource the initial infrastructure and feedback of data and the other to provide a financial incentive.

Second, the context of the QOF is also important in terms of healthcare system, commissioner (payer) and provider characteristics. The QOF is a national voluntary system, in which individual independent contractor general practices and the partners in these practices are the direct beneficiaries. Because the level of incentives is so high, at around 25% of a practice's annual income, almost all practices participate in the scheme. The NHS in the UK is unusual in providing nationally agreed care which is free at the point of delivery without insurance-based payments.

Finally, the type of P4P system is also important. The QOF uses a pay for achievement (target) rather

than pay for improvement model, with fixed thresholds for structure, process and intermediate outcomes rather than an aim of continuous quality improvement with no threshold. Targets are often set at levels that enable most practices to achieve most of the targets that are set.[3]

In order to understand the additional effect of P4P over and above the effect of the system in which it is introduced, it is necessary to try to separate P4P from other aspects of the complex intervention required to make P4P systems work:

- The infrastructure to generate measurement, feedback and benchmarking of indicators should be introduced before the P4P element is introduced.
- Additional resources required to participate in the improvement system need to be differentiated from financial incentives intended to improve performance.
- Designers of such systems should consider how they are to improve rather than simply measure care within such a system.
- Financial incentives, if they are to be added, should be introduced under varying conditions of baseline performance (ceiling effects), different levels of payments or other incentive, and an improvement (getting better) versus achievement (reaching a target) system to evaluate the additional effects of such incentives.

Although this staged approach is not now possible with established schemes such the QOF, it should be considered for new performance measurement or improvement schemes. It is conceivable that the infrastructure and additional resources to measure, benchmark, improve and feed back performance may be sufficient to bring about improvement with minimal (or even without) additional financial incentives to providers, particularly given recent evidence that high rewards can lead to worse performance.[4]

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