Early Experience with Pay-for-Performance in the United Kingdom


Study Overview

Objective. To report first-year experience with a large-scale pay-for-performance initiative in the United Kingdom.

Design. Cross-sectional analysis of data from clinical computing systems.

Setting and participants. Data were extracted from 8105 family practices from April 2004 to March 2005. Analyses were restricted to 76 clinical quality indicators in 10 chronic disease domains.

Main outcome measures. The main outcome was reported achievement of the quality indicators (the proportion of patients deemed eligible for an indicator from each practice who met the indicator). For 30 quality indicators, exception reporting (ie, the number of patients who were excluded from the indicator) was determined by comparing the number of patients deemed eligible for an indicator with the number reported on a disease-specific registry. Factors associated with achievement on the quality indicators were assessed using regression models.

Main results. The median reported achievement for all clinical indicators was 83.4% (interquartile range, 78.2%–87%). In multivariable models, achievement was lower in practices with a high proportion of patients who were living in a single-parent household, had low income, or were aged ≥65 years. Achievement was also lower in larger practices, practices with a higher proportion of family practitioners who received medical education outside the United Kingdom, practices with a higher proportion of practitioners aged >50 years, and practices in areas with low practitioner-to-patient ratios. The median rate of exception reporting was 6% (range, 0%–85.6%). The frequency of exception reporting had the single greatest effect on reported achievement. A 1% increase in the proportion of excluded patients was associated with a 0.31% increase in reported achievement. In total, variables included in the model explained only 20% of the variation among practices.

Conclusion. Performance in the first year of the new pay-for-performance initiative was high. Patients’ socioeconomic and demographic factors and practice characteristics were significantly associated with performance in some cases. Some practices appeared to have achieved high performance by excluding a large number of patients by exception reporting.

Commentary

Although it has received some attention from commercial and government payors, pay-for-performance initiatives for outpatient care have been implemented on only a small scale in a few markets in the United States. Meanwhile, the National Health Service (NHS) of the United Kingdom has embarked on a major policy change that greatly increased payments to family practitioners based on performance with respect to 146 quality indicators related to chronic disease care, organization of care, and patients’ experience. This study by Doran et al begins to assess the impact of this policy change. Their assessment of 76 quality indicators showed that practices were able to reach these quality goals at relatively high rates. Because there were no baseline measurements, it is unclear how much of an impact the program had. Still, the results are impressive and suggest that a true emphasis on quality improvement was occurring in many practices. Because practices could receive full payment even if only a portion of eligible patients received a service or reached a goal (eg, full credit was given if 70% of patients with coronary heart disease from a practice had a last measured blood pressure ≤150/90 mm Hg), the NHS may choose to increase the requirements in the future in an attempt to boost quality of care even further.

The significant association between patient socioeconomic factors (eg, single-parent household, lower income) and lower quality scores may raise concern that providers who care for the neediest populations will be unable to meet or maintain quality goals. However, the variation in quality due to these factors was relatively small, and policymakers could choose to adjust for these differences.

Information on the impact of patient exclusion will be of particular importance to providers working in settings with public quality reporting. It is reassuring that the rates of exception reporting were low and the median (6%) does not...
seem clinically inappropriate. However, tracking legitimate reasons for exclusion may be financially worthwhile for practices, as this was the factor most commonly associated with measured achievement. Doran et al also raised the concern that exception reporting will be exploited by some practice, calling attention to the need for overseeing frequency of and reasons for excluding patients from publicly reported quality indicators.

What can physicians practicing in the United States learn from the U.K. experience? There are several major differences between primary care in the United Kingdom and the United States that need to be considered. In the United States, there are many payors, particularly in the case of working-aged adults, whereas in the United Kingdom, the NHS provides the vast majority of income to primary care physicians [1]. Therefore, no one payor in the United States will have the leverage that the NHS has. The United Kingdom was in the political position to increase the overall pot of money paid to primary care. It is unclear if pay-for-performance schemes that use smaller amounts of money or that reduce payment to low performers in order to pay more to high performers would have similar impact on achieved performance in the United States. Lastly, information technology is much more established in primary care practices in the United Kingdom, whereas only a minority of practices have clinical computing systems in the United States. The NHS supports the purchase of electronic health record systems by practices, but currently there is no government support for purchasing these systems in the United States. Implementing quality measurement on this scale without an established information technology infrastructure would be a costly and daunting task.

Applications for Clinical Practice
The U.K. experience suggests that pay-for-performance can positively influence clinical practice in the outpatient setting. The size of the financial incentive required to produce noticeable improvements in quality outside the United Kingdom is yet to be determined. Appropriately capturing allowable exclusions can improve providers’ measured performance, but payors and regulators will have to be alert to the possibility that some providers will abuse the reporting of exclusions.

—Review by Stephen D. Persell, MD, MPH

Reference