Improving health through the GP pocket? Assessing the development and impact of pay-for-performance on general practice in the UK

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Abstract

Financial incentives are being increasingly used to standardise and improve the quality of primary care, and enhance population health gain. In the UK, the Quality and Outcomes Framework (QOF), a component of the latest GP contract is a leading example of a large pay-for-performance (P4P) scheme in which GP's are paid according to their ability to manage certain patient conditions effectively. The QOF is a useful contemporary example of a negotiated performance management system which invites us to think about how professional groups – in this case GPs – negotiate and manage the increased surveillance of their working practice. It also enables us to examine how this system is negotiated by primary care commissioners and managers now responsible for managing this aspect of GP performance whilst addressing local population health needs. The QOF is now firmly embedded within general practice, however its exact function and ongoing re-negotiation has seen it imbued with a set of tensions which this paper will seek to unpack and examine. The paper will explore some of the literature around financially incentivised care in general and what insights those provide for our understanding of the QOF and its impact. The paper will present some early empirical findings drawn from ongoing research with primary care professionals to furnish this discussion.

Introduction

Pay for Performance (P4P) schemes have become an increasingly popular innovation for delivering primary healthcare. Typically, such schemes are designed to reward quality improvement by financially incentivising physicians to meet specified performance targets. They represent an economic response to the entrenched problem of variable and sub-optimal health care provision found across developed healthcare systems. P4P schemes have also been developed in response to what are perceived as disincentives for quality practice in capitation and standard P4P systems at the primary care level. In the UK, the P4P approach is embodied in the Quality and Outcomes Framework (QOF), a voluntary P4P element of the new General Medical Service (nGMS) contract for GPs introduced in April 2004. QOF financially rewards GPs for meeting prescribed levels of care and disease management, providing up to approximately 20% of practice income. The advent of the QOF has required GP practices to install computerised systems of record keeping and disease coding, providing information on disease prevalence and the organisation and quality of care provided by practices. As a result of the QOF, expanding areas of GP practice are subject to nationally negotiated, prescriptive clinical guidance as well as closer performance management by PCTs in exchange for what are generous and moderate quality improvement targets. GP practice has been drawn more firmly into the gaze of PCTs as they attempt to mobilise general practice (as well as other primary care practitioners) in meeting their broader strategic responsibilities to commission more effectively, tackle health inequalities and redirect the healthcare burden from secondary to primary or community care.

These new arrangements have been interpreted as an attempt to reconfigure general practice according to managerialist logic emphasising contractual relationships and performance indicators (Grant et al 2009). Furthermore, the codification of medical interventions through mechanisms like the QOF has been analysed as part of clinical governance regime in which professional practice is increasingly subject to guidelines, procedures and an ‘evidence base’ administered by a range of national agencies responsible for minimising risk, improving quality and ensuring cost-effectiveness (Harrison and Smith 2004). Therefore, the QOF is a useful example of the mapping and auditing of professional practice in which financial incentives have been used to try and align the goals of the state to manage performance and retrieve information, in the hope of also achieving some degree of patient health improvement, with the interests of

GPs as independent contractors. How this nexus of interests and relationships plays out allows us to better understand the possibilities of incentivised medical practice and the way in which professional groups negotiate and respond to these new modes of governance.

Policy Context

The 2004 Wanless Report prioritised public health in the UK as a mechanism for improving population health and identified the need for targeted incentives, local targets and performance management by Primary Care Trusts (PCTs) (Peckham and Hann 2008). The 2004 nGMS contract included a combination of capitation payments alongside targeted QOF payments to incentivise specific activities. In a broader sense, the nGMS contract forms one part of a government policy agenda that has sought to reform governance structures and identify levers and incentives that will facilitate improvements in service quality and help tackle health inequalities. This is an agenda combining both national performance frameworks and targets such as National Service Frameworks (NSF), which set out key interventions and time spans through which strategic health targets are addressed. National targets are also codified in Public Service Agreements (PSA), with the key PSA for health being delivery agreements 12 (*improving the health and wellbeing of children and young people*), 18 – (*promote better health and well being for all)* and 19 (*to ensure better care for all*). Each includes a range of indicators that should represent the strategic direction of healthcare policy and commissioning in these areas. Health inequalities have also been specifically targeted in *Tackling Health Inequalities: A Programme for Action* (DH, 2003) with two key goals:

- *Reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth by 2010*
- *Reduce by at least 10% the gap between the areas with the worst health and deprivation indicators and the population as a whole*

At the local level, these national targets have been supported by (and are being increasingly replaced by) mechanisms such as Local Area Agreements (LAA), driven and implemented by Local Strategic Partnerships (LSP) – alliances formed between local authorities and other statutory agencies to develop long term visions for services at a local level. The delivery of national priorities set out by the Department of Health is organised within annual operating plans for PCTs, which is overseen by Strategic Health Authorities (SHA).

In terms of public health, in 2004 the DH published *Choosing health, making healthy choices easier* which reaffirmed the role of the NHS in delivering better public health outcomes. This commitment informed the development of Spearhead PCTs – the bottom fifth of local authority areas on various health and deprivation indicators – with the aim being to improve health outcomes in these areas at a faster rate than in non-spearhead PCTs and deliver on national health inequality targets by 2010. In order to meet these targets, it has been suggested that there will be a need for more intensive primary care intervention including more smoking cessation services and increased coverage of statins and antihypertensives to tackle cardiovascular disease. In terms of the role of the nGMS contract, there are a combination of capitation payments for GPs designed to encourage health promotion activities alongside targeted incentives for activities such as immunisation and statin prescribing.

In policy terms, the introduction and development of the QOF as part of the nGMS contract since 2004 has been subject to ongoing tensions and pressures. This is unsurprising given the historically powerful position held by general practitioners within the UK NHS (Moon and North 2000) and would appear to derive from conflict between the competing interests of the stakeholders involved in designing the QOF. The original QOF was negotiated by NHS Employers – representing NHS trusts - and the British Medical Association – the GP trade union. Latterly, as part of the NHS Next Stage Review (DH 2008) the National Institute for Clinical Excellence (NICE) has taken over responsibility for drawing up a menu of 'evidence based' QOF indicators from which NHS Employers and BMA will renegotiate the structure of the QOF for 2010/2011. The involvement of NICE was intended to make the development of indicators more transparent and subject to public consultation whilst, according to a DH policy adviser interviewed for our project, reducing political control over the selection of indicators.

According to this same stakeholder, who was involved in the early stages of QOF design and implementation conflict was inevitable as the government earmarked more investment in general practice (approximately £1.1 billion - a thirty per cent pay increase over three years for practices potentially) to improve working conditions and recruitment in exchange for more and better quality work, whereas the BMA perceived the increased incomes that could be generated by the

QOF as a *'thank you not a please – that the money they should have was for the past not the future, for having put up with crap for years…the BMA were very keen to show their members 'look what we have got for you for doing what you do every day, all you will have to do is record it better'. The DH…and NHS Employers…were very keen on saying 'it is a something for something contract', so there were different stories from the start'* (Adviser to DH).

The resulting QOF was a heavily incentivised scheme through which most GP practices received substantial pay increases via high QOF scoring. As a consequence of the QOF, up to 20% of the annual income of GP's is now related to the quality of care they provide (Roland et al., 2006). So far, the QOF has been associated with high performance levels (an average practice achievement of 95.5% of 1000 points available in 2006-7 compared with 96.2% of 1050 points then available in 2005-6 and 91.3% of 1050 in 2004-5 (NAO 2008)), although without an appropriate baseline of performance, it is difficult to attribute this achievement wholly to financial incentives (Doran, 2008). Nonetheless, GP practice partners have seen their incomes rise, on average, from £72,000 in 2002-3, to £113,000 in 2005-6 (National Audit Office, 2008).

To earn points and claim payment for management of illnesses such as Coronary Heart Disease (CHD), practices must report the number of patients on their list who have CHD (the denominator) along with the proportion of patients whose treatment meets targeted levels (the numerator). This provides PCTs with information regarding both disease prevalence and quality of care. The indicators usually have both a clinical process element (the percentage of patients whose blood pressure is recorded) and an outcome (the percentage of patients whose blood pressure is below specified levels). The ten clinical areas covered by the QOF are: coronary heart disease, stroke, hypertension, diabetes, COPD, epilepsy, hypothyroidism, cancer, mental health and asthma. Indicators are evidence based and designed to improve and make consistent service quality, reduce secondary care referrals and ultimately tackle health inequalities through case finding and population health gain. Typically, points are awarded to reflect workload and consist of both a minimum performance threshold (payments beginning once 40% of eligible practice population have been treated) and a maximum threshold (90% of those eligible) with graduated payments in between. The QOF also allows GPs to 'exception report' to ensure that they are not penalised by patients who do not attend reviews of their medication or where patients are unable

to tolerate medication, possibly due to side effects. Exception reporting is supposed to ensure that GP performance is only measured against a viable practice population, however it is possible for reporting to be 'gamed' to exclude high-risk patients or those for whom GPs have missed targets, thereby decreasing the patient pool and maximising QOF scoring (Gravelle et al., 2008). QMAS – a national IT system - is used to collect and analyse the QOF data that is self-reported by each practice. This data is publicly accessible and allows for feedback to patients about practice performance whilst being a useful epidemiological tool and generating comparable data about the effectiveness of incentives. Primary Care Trusts (PCTs) are responsible for monitoring and auditing practice self-reported performance through expert monitoring teams. At the local level, the QOF has recalibrated the relationship between general practice and PCTs due to their responsibility to assess and monitor QOF scores. From 2010/2011 this may change further with the advent of 'local' QOFs whereby PCTs will have the option of selecting additional quality targets for GPs to meet the demands of their local population. The QOF will continue to be nationally negotiated and there will continue to be national crosscutting QOF targets, but it will become potentially differentiated across different localities as PCTs interpret and implement the scheme in different ways.

The literature on P4P

It is apparent from the literature that available evidence on the impact and effectiveness of P4P schemes is changing rapidly (Roland, 2008). Furthermore, it is important to note that the characteristics and structure of the schemes vary (Chaix-Couturier et al., 2000) and can have varying levels of effectiveness, even when an apparently similar intervention is used (Doran, 2008). Additionally, when attempting to evaluate incentives schemes it is vital to recognise the context of the scheme and the difficulties in disentangling and measuring one impinging influence on GP and practice behaviour (Roland, 2008).

Impact on quality and quantity of care

Despite some scepticism about the evidence base of the effectiveness of P4P schemes in improving quality (Rosenthal & Frank, 2006), other systematic reviews (Chaix-Couturier et al., 2000) and (Gosden et al., 2001) have concluded that P4P contracts do affect physician behaviour and increase the number of primary care services provided although often in complex ways. For

example, Chaix-Couturier et al (2000) found that incentives had a different impact on behaviour depending on the age and sex of physicians, previous experience of incentives, continuing education, payment methods, the type and severity of the condition being incentivised, the volume of activity and the location and type of practice. Nonetheless, they found that introducing P4P in areas such as night calls and elective gynaecological surgery produced an increase in physician output. Another area of concern regarding the QOF has been the effect of payment thresholds on GPs motivation to case-find. Some studies suggest that the existence of such targets act as a disincentive to exceed the target, by discouraging GPs from going the 'extra mile' for their patients (Marshall & Harrison, 2005). Indeed, a recent Audit Commission (2008) report noted that QOF is unlikely to encourage practices to try and include the most 'hard to reach' since no further points are received once 90% coverage had been achieved. However, there is conflicting evidence that claims GPs have exhibited altruistic behaviour whereby practices could have reduced their number of patients treated by 11.8% without reducing their revenue from QOF (Gravelle et al., 2008)

Motivation and Values

In developed health systems, the need for greater accountability, efficiency, consistency and confidence in public sector performance has led to a shift from a relationship of trust between service funders and professionals to one of increased surveillance and management of professional practice (Harrison & Smith 2004). Consequently, the motivation and behaviour of GPs is increasingly assumed to require external structures of reward and regulation in order that performance is efficient and accountable in pursuit of broader financial and healthcare targets. This is in spite of some evidence that financial incentives represent only one facet of GPs' motivation to improve service quality alongside personal motivation to improve patient care, professional autonomy and pride and peer pressure (Spooner et al. 2001). Nonetheless, when comparing P4P with salary payments, Chaix-Couturier et al. (2000) found that evidence shows salaried physicians refer their patients less frequently and had a lower level of activities than P4P physicians. Similarly, Gosden et al. (2001) found that doctors under P4P schemes undertake more visits and conduct more investigations than those under capitation systems. In their discussion of the 1990 GP contract in UK in which GPs were remunerated via capitation payments as well as some P4P payments, Moon and North (2000) cite evidence that P4P might

be a more controllable source of income for practices rather than the less predictable demand for consultations, home visits and out-of-hours visits generated by larger, capitated, list sizes.

A key concern that recurs in the literature is whether financial incentives generate dysfunctional physician behaviour (Gravelle, Sutton and Ma, 2008) or negatively affect their motivation (McDonald et al. 2007), particularly in light of well-established inverse care patterns (McLean, Sutton and Guthrie, 2006). Some commentators have argued that the use of incentives attached to fixed performance targets risks neglecting resources of emotion, morality and trust which are said to be a key part of a physician's professional repertoire (Harrison & Smith 2004). Others have been more strident, declaring that *'state-driven clinical priorities'* risk the loss of GP's *'professional identity and reputation'* (Mangin & Toop, 2007). Studies suggest that GPs can be anxious that 'biomedical' QOF targets might undermine holistic, continuity of care of the 'whole person' and might militate against developing relationships with patients as treatment is increasingly divided up by a larger team of health practitioners (Roland et al. 2006). One qualitative study which looked at the effect of financial incentives on doctors in California found that some physicians felt pressurised by bonuses based on limiting referrals to secondary care and enhanced productivity. These types of payments increased 'performance anxiety' on the part of doctors. This was in contrast to payments that were based more on quality of care and patient satisfaction which were judged more conducive to a *'satisfying practice environment'* (Grumbach 1998). However, recent qualitative work (Whalley et al., 2008) done with GPs after 18 months of the QOF suggests they feel that professional autonomy has decreased and workload increased but job satisfaction continues to improve and job pressure decrease under the QOF. GPs also report that they feel the QOF has improved quality of care beyond what they thought.

Nonetheless, some disquiet has been generated by the possibility that external incentives may 'crowd out' professional self-esteem and a sense of self-determination. Conversely, there is the potential for a 'crowding in' effect if GPs feel like they have some ownership of incentives (Marshall & Harrison, 2005). McDonald et al (2007) found that QOF as an externally imposed system of incentive did not damage the internal motivation of GPs. They attributed this to the fact that the indicators within the QOF aligned with what GPs themselves considered good clinical care objectives. Furthermore, Chaix-Couturier et al., (2000) found that acceptance of

financial incentives by GP's was promoted by trust, accuracy of data, appropriate stimulus for change and supportive medical leadership. Roland et al (2006) note that the performance indicators in the current QOF were negotiated with representatives of the profession itself, which ensured a degree of alignment of objectives and may reduce the potential for decreased internal motivation. This also reduces the possibility of professional backlash against the clinical priorities enshrined in P4P schemes (Duckett et al., 2008). Nonetheless, they did find that GPs were anxious about the impact on professional (internal) motivation. However, the authors note that there is scope for external incentives to enhance internal motivation by providing positive feedback on professional competence (the 'attributional effect' (Deci et al., 1999). They suggest a more likely outcome is a complex combination of both 'crowding in' and 'crowding out' of internal motivation by external incentives.

A potential problem created by an external incentive scheme like the QOF is that it could lead to the neglect of those non-incentivised areas of care which will continue to rely on the professionalism or moral motivation of GPs (Roland et al., 2006; Steel et al., 2007) – what Rosenthal et al. (2004) call the problem of 'multitasking'. Roland et al (2006) found evidence of concern amongst GPs that un-incentivized areas like acute care, preventive care, care for specific groups like children or older people, patients with multiple co-morbidities would suffer as GPs chased targets. Indeed a recent study found that whilst quality of care for QOF-incentivised conditions improved substantially between 2003 and 2005, there was little or no improvement in non-incentivised quality indicators (Steel et al., 2007). Although Roland (2007) argues that this could be interpreted as a positive in that GPs appear to be maintaining standards of care in these areas in spite of the lack of incentives and the time required to focus on QOF targets. However, a study of performance-based contracting in the USA found that the attachment of incentives to improved performance was creating 'adverse selection' whereby patients in the most severely ill group were less likely to be admitted to a substance abuse programme (Shen, 2003). There is a further problem identified by Rosenthal et al. (2004) who argue that incentives may lead to a focus on individual measures for care management where a more integrated approach might be appropriate, particularly in areas of co-morbidity.

Findings

Since September 2008, our research team has been interviewing GP practice staff and PCT staff across four PCTs to try and gain insights into how the QOF has impacted upon their work and practice and to examine some of the issues raised by the literature on P4P schemes. At the PCT level, we have conducted 3-4 interviews with primary care managers, commissioners and directors of public health. Within each PCT area we have visited two practices to date, interviewing 4-5 staff including GPs, practice managers and practice nurses. In our PCT interviews we have explored how the QOF fits within their broader commissioning remit and how PCTs have managed the QOF and their relationship with practices. In our practice interviews we have examined how the QOF has impacted upon the clinical and organisational aspects of GP practice and how they have responded to the scrutiny of their performance against QOF indicators.

General Practice

Impact on Care

Overall, most GPs interviewed were reluctant to admit that the QOF had significantly improved the coverage or effectiveness of their care, often downplaying the impact of financial incentives with few admitting or recognising that their practice had been improved. This may be because they believe that the QOF was both '*too easy'* and '*pitched too low'* (GP Partner, NW England PCT) to have an impact. Nonetheless, as noted above with the BMA, some GPs believed QOF's main function was merely recompensing them for the work they were already doing:

To be honest with you it hasn't changed because we were providing these services anyway…but what happened was the services we were providing got permission and the seal of approval from government really more than anything else (GP Partner 1, London PCT A).

Although one did admit that he felt QOF had enabled a more intensive care of patients, for example:

I think the value of QOF is that it has allowed us to focus on things that we would never have focused on. Probably the biggest thing for me in QOF would be something like CKD (chronic kidney disease) for example, when did I last do an EJFR on somebody before QOF came along?

Never did really…I think it has made you focus on some of the issues…It has allowed you to focus in on the detail that we should have been doing several years ago (GP Partner 2, London PCT A).

One thing most respondents did agree upon was that the QOF has helped to standardise and structure the organisation of care, enforcing the maintenance of disease registers, the implementation of call/recall policies and in some cases improving the skill mix of practice staff. In some practices, nurses and administrative staff have been able to access training in specialist areas such diabetes or mental health and taking on greater responsibility for routine QOF tasks such as immunisation and screening. In one practice we visited, administrative staff were being trained in checking blood pressure checks as well being involved in the record management and case-finding aspects of the QOF. Some practices has also developed QOF systems with designated QOF leads who managed the updating and reporting of QOF scores and providing intelligence for QOF teams. In high-scoring practices it appears common to divide practices up into QOF teams whereby each GP works with a nurse and an administrator to maintain control of QOF performance on a particular set of disease indicators such as CHD. Furthermore, according to one DPH we interviewed it is often practice managers who have responsibility for QOF because it is a relatively easy thing for GPs to measure their practice manager's performance against. In spite of this division and delegation of labour however, few practices visited so far mentioned specific QOF pay bonuses for salaried staff.

GP Motivation

Despite some disquiet about the increased organisational demands and QOF being in tension with the needs of some patients in deprived areas, there has been little evidence so far of GPs admitting their 'intrinsic' motivation might be compromised by an external reward scheme like the QOF. This GP felt that the QOF was well aligned with her professional goals and practice:

I think a lot of the incentive is just because that's what you do because you're a professional, trying to do a good job and that's a part of your job. And, you know, professionals should have intrinsic motivation to do these things otherwise you shouldn't be doing that job, anyway…I think it complements, personally I think it complements it, I don't mind doing QOF, it gives you

some things to hang people's diagnosis diseases on, it helps to remind you what should be done, I think it's got lots of benefits to it, so I don't mind at all doing QOF, doesn't bother me in the slightest, but I just see it as part of what we should be doing anyway, and that fact that it makes you record it and do it is fine by me, I think that probably lots of young GPs probably feel like that. Personally, because we've kind of grown up with it, it's nothing different to what we expect… (Salaried GP, London PCT A).

A Director of Public Health observed a similar response along generational lines:

…there is a slight cultural thing I think. The older GPs, some of whom are coming up for retirement, when they became GPs, medicine was regarded as an art and the objective of the day was to make a really clever diagnosis etc and I think training changed in the 70s and 80s to saying 'how do you actually do the best for your patients' so the GPs now have been trained to know that for example if all your patients who have had a myocardial infarction are on statins, then that will reduce their risk. Actually it is really boring but it has been internalised because it is part of their training to do so (Director of Public Health, NW England PCT).

This raises intriguing questions about the nature and appeal of general practice in the future as medicine is increasingly codified, incentivised and governed according to rationalised forms of knowledge and management systems of the kind typified by the QOF. Any resistance that exists to P4P schemes like the QOF may wither as new generations of doctors (and managers) are trained in this way. However, there is little substantive resistance in evidence from our study at the moment anyway. Indeed, one GP refuted the notion that QOF encouraged non-holistic care:

I don't know if it does. I think it probably, if you think about holistic medicine as saying 'ok let's look at all your illnesses and how they interact with each other', so diabetes, heart disease, hypertension and all of that, then it probably has made you focus on the fact that this person control of A will help B whereas previously you might have thought let's just control his hypertension without any consideration of his cholesterol level of what his arteries might be doing and his risk of dying of a heart attack and things like that (GP Partner 2, London PCT A).

Some GPs appear aware of the tradeoffs that QOF embodies and the dangers associated with target chasing and the potential for a loss of holistic, relational care with patients. The health gain associated with QOF was also questioned:

I think the negative side has been the preoccupation with the targets, achieving the targets that people have set you and I question whether the targets or the achievements are real and therefore the analysis of mortality, morbidity all of that will probably not support QOF results that have been coming out over the last few years (GP Partner 2, London PCT A).

However, they also appear to believe themselves to be a group who can compensate and negotiate these tradeoffs successfully without damaging patient care. This tended to be expressed as deriving from a personal professional motivation, but when discussing other GPs was more about the size of the external rewards on offer:

Just because it was no longer incentivsed in QOF, I would still do it, but I suspect I am somewhere out here, not like some of my colleagues. But if it is around recognised, it is evidence based, cost-effective, I would still go with the flow…but I can't say that would be echoed by some of my colleagues who are a bit more dinosaur-like in their approach (GP Partner, NW England PCT).

Primary Care Trusts

In the view of some PCT managers, QOF has incentivised improvements in quality of care in some clinical areas:

It does seem to have been a reasonable incentive to get practices to actually do things a lot better. For example, the percentage of people getting their blood pressure measured over time has increased. The percentage of people getting a diagnosis for various things has increased and I don't believe for one moment it is because the instance in the population has increased, although it may well be the case for some, I think it is because practices have become more assiduous in how they do that and I am presuming although I don't have concrete evidence of

this, that it is to do with the financial incentive in the QOF process because they have consistently improved over time (Director of Public Health, London PCT B).

Similarly, another DPH suggested that the QOF has been internalised by practices anxious to maximise their 'points':

Yeah, we have had very high returns. Most of GP do very well on the QOF. I don't have any doubt that the QOF has improved healthcare. They do it well. It is interesting because they are competitive…because they have a number of points, some get very upset if they can't score the full 1000 points. It is interesting – as well as money, they also seem to feel that their score reflects the nature of their practice and they don't like to be seen to be low. That is helpful. I am not too sure how we got there but I think that is a general thing…I think because there was a lot of negotiation, most GPs accept that practically all of the QOF is sensible (Director of Public Health, NW England PCT).

Certainly, some motivated practices appeared to have internalised the logic of the QOF and appeared to enjoy the challenge provided by maximising their points and in this instance were keen for QOF to be made more difficult:

We are quite driven, we are quite motivated and we want to achieve. It you give me some targets I will do my absolute utmost and work my backside off to achieve them…if you give a load of motivated self-employed business people…If you give me targets to achieve, I will do my damndest to do it and I think…to achieve real improvements the standards have got to be cranked up which is great, I like a challenge (GP Partner, NW England PCT).

Some PCT staff expressed unease about the tendency to rely on financial incentives for general practice, this tends to mean GPs are contracted through a Local Enhanced Service (LES) to carry out particular health activities not covered by the QOF. This respondent suggested this was often a pre-emptive response to the power of Local Medical Council's (LMC) and rooted in the PCTs own statutory obligations to commission particular services and collate data for the Strategic Health Authority:

I think that is why we jump into the LES as the way forward rather than step back and look more strategically at about other ways which we could do it and I think we have got to be a bit smarter in the ways that we look at that because there is a temptation – and it works – to say 'uh, we have got this problem now, well we have got to do this, we are going to have do a LES' because GPs in the LMC will say 'we are not going to do it if you don't pay us for it'…I think some people, overhearing discussions like that, would be quite shocked at hearing how the GPs come over – you know that they won't do anything unless they are paid for it...quite frankly I think some of the comments are quite appalling…you just think 'where is the patient in all of this?' and sometimes we do end up paying because it is the only way and we are monitored – we have to report on that and we get a red mark if we don't do it...(Director of Primary Care Commissioning, London PCT B).

This sense of unease was repeated by several PCT staff, some arguing that GPs should not be paid for work that they should be doing anyway:

…we would expect some of this to be going on anyway, so I mean I recognise that even for the good of the patients you need to be remunerated but you are a professional and provided we are being fair and reasonable, it is not about trying to get the last spot of blood out of the budget. So I do recognise what they say, but I don't think they are just a business and they should be deciding on each one whether it is worthwhile for the business, they should be saying 'is it something that improves the care of our patients and are we being treated fairly financially?' Not the other way around and I am very strong about that (Director of Public Health, NW England PCT).

Unsurprisingly, as noted above few GPs or practice staff feel that the advent of financial incentives – particularly the QOF – has increased their coverage or activity levels, arguing that the key change is that they are now better rewarded for their work and have an incentive to be better organised as a practice. It has been commonplace to hear GPs argue that they were already doing most of the work found in QOF and locating that within a professionalism which has always informed their work and transcends any set of financial inducements.

PCTs and General Practice

An interesting development related to the new contractual and commissioning arrangements for PCTs is the need to performance manage general practice and generate ways of incentivising practices to pursue a range of primary health interventions and management of chronic diseases. Theoretically, this gives PCTs leverage to influence and scrutinise the activities of practices:

QOF is voluntary, but if you are doing QOF and then you are not doing it properly that to me is a way you could then flag onto that 'you are not managing your patients well in terms of chronic disease'. But you have to have very strong evidence to do it. So that is one issue but there is a way of, contractually, when you have got patients who are at risk of harm, you have the levers to do it…We will find ways of not commissioning from you if you aren't going to be delivering to these standards ((Director of primary care commissioning, London PCT A).

However, there are barriers to making use of that leverage. Given the historically powerful role of GPs, it has clearly proven difficult to change GP behaviour in some areas.

You probably need dedicated people who can go out, I mean I don't have the time to do it and we have got lots of other things to do, but you probably just have to do a lot of charming, hassling of people…you know training, we will show you how to do it, you can even have somebody with you when you do the first one or two. So, one of the things is GPs say 'why should we do it, it is a lot of extra work, it is a lot of paperwork' and I say 'because it improves the health of your patients'. Not sure it wins any friends (Director of Public Health, NW England PCT).

This is even more pronounced by a lack of capacity in some PCTs to scrutinise performance and support practices effectively:

The bit where I am doubtful about the capability / capacity is our internal ones of actually being able to do it because I don't…it is difficult to recruit people into commissioning is difficult anyway. To recruit people into Primary Care is harder than doing acute contracts (Director of Primary Care Commissioning, London PCT A).

According to another DPH, the independence and power of GPs requires PCT managers and commissioners to think sensitively about that relationship:

The relationship can be choppy at times because you may have real disagreements as to the best way forward but you would be very foolish to disregard the advice you are getting through the PEC and from practices through the LMC. Basically the relationship has to be continually crafted. You can't take anything from granted and make sure it is continually fit for purpose…you need to continuously update and renew your relationship with the GPs and other primary care people (Director of Public Health, London PCT A).

The somewhat fraught relationship between general practice and this PCT was also described by one GP. He suggested that this partly accounted for the failure to mobilise support for initiatives such as practice-based commissioning and public health commissioning more generally:

Yes I think it is partly down to the internal political situation. I don't think the PCT will organise themselves. You know, if you are an organisation that is leading the changes or reforms you need to have that intellectual flexibility to say 'ok, what is it that has come down from the top? How are we going to make it work down here and what are we going to need to support the practices to make it work' and I think there was a failure to connect you know?...you have got to understand the mentality of your GPs. If you don't understand what makes your GPs tick, you aint got a hope in hell because they are a powerful bunch. They can wreck you know? I think you need to understand them and I think there was a failure to understand them (GP Partner 2, London PCT A).

A similar account was given from a PCT perspective in another London PCT where we were told that the biggest barrier to better joint working between general practice, other primary care professionals and the PCT was a mutual lack of trust:

I have worked in primary care a number of years and the abuse that you get – perfectly honestly – is just incredible and that is just part of my day job to some extent. I have been to our biggest (practice based commissioning) consortium to introduce myself and one of the GPs said 'but

******* *I haven't trusted the PCT in the last 10 years so I am not going to trust you'. He hadn't met me and that is what you get you know? I have been called an 'effing nazi' by a GP, not in* ****** *but in another patch – completely unacceptable but you know…and they are very abusive to each other and therefore they feel they can be unacceptably abusive and offensive to managers at the PCT…*(Director of Primary Care Commissioning, London PCT B).

It is probable that such strained relationships are not new (and maybe not typical), but the interesting issue here is how this forms a back drop to the current policy direction towards more formal, increasingly contractual partnerships in local health systems. There appears to be entrenched power dynamics in some areas which are bound to mitigate attempts to work in partnership and incentivise general practice to conduct work that will improve population health. This set of tensions is set to intensify as the QOF and commissioning is increasingly localised.

In terms of utilising non-financial incentives, one PCT we visited is in the process of disseminating comparative performance data as a means of incentivising better standards of care in some GP practices:

I think part of the process, certainly in previous PCTs where I have worked, disseminating comparative information is helpful for practices as benchmarks because no practice wants to feel they are the worst on their patch for doing x, so there is a type of peer quality type pressure that I have certainly seen work quite well in the past. We haven't got around to doing that but I think that will work – not for all practices obviously – but for some I think it will work (Director of Public Health, London PCT B).

Most GPs did not express much interest or awareness of non-financial incentives. One or two said they would value extra ring fenced funding to employ extra staff or invest in their premises. However, one GP did suggest another form of incentive other than financial. He argued for a different type of relationship in the course of producing public health in which PCTs offered better guidance and support for practices:

The incentive would be to try and identify those issues which I think are relevant to my population and those things that I can make a material difference to. The incentives would be to have a local public health department that actually actively works with us to say these are the areas we need to focus on…I mean public health to me ideally ought to be within practice. This is what I have been arguing for years, you can't have a public health department that sits out there somewhere. It ought to be going into the practices and looking at the dynamics, the population dynamics. It ought to be looking at the structure and content of a practice and say 'actually let's help you shape the way you run things here to the people you are actually serving…I would rather have the PCT say to me 'instead of 5 grand, you know what we will give you a practice manager to help you sort this out'. That is what I would value, them saying to me, we will give you the latest tools on your computer so you can make graphs for the things you are doing or we can teach you how to do varied analysis or this or that you know…That is what I would like to see, I would like to see them say to me well okay we would rather have standardised equipment across the PCT so right we all use standard scales and we all know we are doing the same thing. We know all our height measures are the same so we are doing all that across the patch you know. That is the kind of thing that I would see as an incentive (GP Partner 2, London PCT A).

The same GP went on to argue that Public Health departments should be using QOF scores as a tool for best practice:

A public health department really ought to be looking at, you know they ought to be doing our QOF analysis and saying actually 'do you know you are 2% lower than the practice next door on I don't know thyroid problems, let's see why that is'. They don't do that. They don't look at my practice… How does it help me when the PCT has a department out there who can do all sorts of research and do reviews of papers and that and doesn't actually say 'best practice is this'. Yeah we can get it from our journals of course we can, but have you tried reading the British Journal of General Practice? The most boring paper in the world I don't even read it. I let my dog sleep on it. It is so boring, there is hardly anything that is ever of value. So, I want to see a PH department that is actively engaged with the practices, that is linked to the practices to say 'ok we have got a named link for you. You have got a public health type issue, you come to

this guy and he will be the conduit through which the rest of the department will work with you'. I mean I don't know if they do anything like that but that's what I think a public health department should do.

This contrasted with the perspective of a Director of Public Health at another PCT who thought objectives were reasonably aligned between general practice and the Public Health department, but there remained difficulties in getting GPs to take on additional work:

Well, I mentioned brief interventions in alcohol and interestingly enough the ones that have taken it on say it is not a problem, it is reasonable etc, the others that say they can't take it on, say there is a lot of paperwork involved, which is there isn't…We pay for some of the stuff to be done and have had robust discussions with some GPs when they say about the amount of money and I say 'well I think it just about covers the cost', but I say 'I am not interested in negotiating whether it does or it doesn't' because for example asking people particularly if they have got gastric symptoms or whatever about alcohol is regarded as good practice and the Royal College of General Practitioners is advocating it; screening for all these people is regarded as core general practice which everybody should be doing and we are paying you even more money to do this sort of thing and we regard it as an incentive…they never come back on that but it doesn't persuade them either (Director of Public Health, NW England PCT).

Conclusion

This paper has attempted to sketch out how the QOF as a P4P scheme in the UK NHS is part of a new set of arrangements for primary care which to some extent renegotiates the role and meaning of general practice and its relationship with primary care managers and commissioners. Increasingly, GP practices are financially incentivised to undertake chronic disease management and quality improvement. This raises interesting questions about how GP practice responds to the QOF and how PCTs seek to both manage the QOF and locate it within a broader strategic commissioning framework. As a starting point in trying to frame this discussion, we reviewed some of the relevant literature around P4P schemes and their implications for effective general practice before moving onto present some early findings from our fieldwork. This data seeks insights into the internal impact of the QOF on practices and practitioners and the impact of the

current contractual arrangements – of which QOF is an integral part – on the workings of the PCT and its shifting relationship with general practice. In particular we focused on the effects of directly incentivising and therefore codifying clinical practice and the new ways in which general practice is scrutinised and governed. Our early analysis reveals that GPs do not believe that the QOF has significantly altered their clinical practice beyond offering modest expansions in immunisation and screening programmes. The biggest impact has been on the organisation of care and on other primary care staff such as practice nurses who have often taken on greater clinical responsibility to meet the demands of the QOF. GPs appear to be aware of the tradeoffs that a P4P scheme represents in terms of a single pathology approach to care and the dispiriting effects of targets, but this would appear to vary with the age of the practitioner and be mitigated by the increased earning potential that flows from the QOF. PCT managers and commissioners expressed unease about the predominance of financial incentives as a means of mobilising GP practice as a resource for improving population health and their seems to be a range of tensions and difficulties being played out as PCTs and practices are thrown together in pursuit of strategic policy goals. At the moment, it appears that the QOF has achieved a reasonable level of consent from GPs, probably due to the financial rewards on offer and the relatively modest targets imposed upon them. Whether this translates into sustained improved outcomes for patients' remains to be seen, but (theoretically at least) the QOF has provided PCTs with some degree of leverage over GPs and provided access to important epidemiological information about disease prevalence and ensured that new modes of clinical governance are inscribed within the core practice of GPs.

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