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GLENN MATFIN

Introduction

In the UK, the NHS funds and delivers about 95% of medical care. The aim of the NHS 60 years after its creation remains to deliver comprehensive, high-quality medical care to all based on need and not the ability of the individual to pay.

In contrast, healthcare delivery in the USA is more diverse and complex.¹ Huge differences exist in healthcare funding, regulation, and access (e.g. prevention and screening, diagnostic tests, treatments, and primary and specialist care). The quality and availability of US healthcare depends largely on the ability of the individual to pay for it, either directly (e.g. personal healthcare insurance, 'fee for service' payments, and co-payments for consultation or treatments) or indirectly (e.g. job-related or government funded). One of the major problems with the current US system is that incredible inequalities exist with some individuals having access to cutting-edge, high-quality healthcare, while approximately 47 million Americans lack basic healthcare insurance and many others have inadequate coverage.¹ Many of the individuals with no healthcare insurance are also the most susceptible to certain chronic conditions such as diabetes, hypertension, obesity and associated complications (e.g. due to ethnic predisposition, dietary factors, access to screening and therapies).

One of the emerging healthcare trends both in the UK and USA (and many other countries), is the development of 'pay for performance' incentives for healthcare provision. In the best traditions of the USA, pay for performance is also known locally as 'P4P'. The role of pay for performance incentives in diabetes primary care in England will now be briefly discussed.

Pay for performance incentives in diabetes primary care

The use of pay for performance incentives as a quality improvement tool in healthcare is increasing. In England, a novel system of contractual financial incentives was introduced as part of the General Medical Services contract on 1st April 2004. These incentives called the QOF scheme of the NSF, have been

introduced to reward GPs for achieving clinical targets across a range of chronic diseases such as diabetes, stroke, and coronary heart disease. Approximately one-quarter of general practice income is now derived through the achievement of quality targets through the QOF. The QOF has five main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement. The QOF consists of up to 1,000 points, which cover clinical care, practice organisation, patient experience, holistic care, and additional services (e.g. maternity services).

Diabetes is one of 19 disease areas within the clinical domain of the QOF. In the 2007/8 QOF, 99 points were available for diabetes care. This constitutes almost 10% of all incentives. Data are extracted from general practice computer systems on 31st March each year, and the most recent diabetes quality indicator measures are used to evaluate targets. The QOF quality indicators are reviewed on a regular basis with important changes in indicators of glycaemic control in diabetes being introduced for 2009/10. The previous payment triggers, at an HbA_{1c} of 10% (11 points) and 7.5% (17 points), have now been replaced by three new indicators. Seven points have been added (reallocated from other QOF areas), and the revised indicators stand at HbA_{1c} of 7% (17 points, thresholds 40–50%), 8% (8 points, thresholds 40–70%) and 9% (10 points, thresholds 40–90%).

It is widely acknowledged that the introduction of pay for performance incentives has improved the quality of care offered by GPs since being introduced in 2004. The majority of practices achieve many of the higher QOF targets set for chronic disease management. There have also been real improvements in diabetes care with more patients being diagnosed, and risk factors such as raised BP, hyperglycaemia and raised cholesterol are managed more effectively.² However, a number of concerns regarding the QOF scheme have been raised including the direct and opportunity costs of the financial incentives paid to GPs, the costs associated with extra testing and therapies aimed at achieving more stringent targets,³ the adoption by GPs of a 'box-ticking' culture to patient care, the QOF indicators being inconsistent with current guidelines (e.g. NICE), decreased referral rates to diabetes specialist services with the additional detrimental effects on training of future diabetes specialists, and the proportion of diabetes subjects excluded from evaluation of each indicator target as 'exceptions'.⁴ Exceptions arise because practices are permitted to identify some individuals as ineligible for evaluation if the target is regarded as clinically inappropriate. Overuse of exception reporting can lead to exaggerated overall QOF scores.

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Abbreviations and acronyms

ACCORD	Action to Control Cardiovascular Risk in Diabetes
BP	blood pressure
GP	general practitioner
HbA _{1c}	glycated haemoglobin A _{1c}
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
P4P	pay for performance
QOF	Quality and Outcomes Framework

In addition, Diabetes UK has stated that the QOF indicators are too focused on biometric outcomes, with little emphasis on individual holistic care.⁵ Concern has also been raised about the new QOF glycaemic targets introduced for 2009/10 as not being evidence based and potentially being more risky for the individual patient (e.g. greater risk of hypoglycaemia). The lower QOF HbA_{1c} target of 7% has also provoked debate in light of the ACCORD study controversy.⁶ This study showed that in intensively treated type 2 diabetes patients (target HbA_{1c} < 6.0%) mortality was increased. The level of HbA_{1c} chosen in the recently published NICE diabetes clinical guidance 66 (< 6.5%), is also not consistent with the 2009/10 QOF HbA_{1c} target for GPs of < 7.0%.⁷ This seems surprising as the NSF is charged with setting the standards by which NICE provides the appropriate tools to achieve these standards. However, it is likely that NICE will be in charge of setting QOF indicators in the near future.⁸

Two recent studies related to the impact of the QOF pay for performance scheme on primary care diabetes in England were published in the March 2009 edition of *Diabetes Care*. The first study showed that the proportion of GP practices (98% of all GPs in England were analysed) reaching the HbA_{1c} target (< 7.5%), BP target (< 145/85 mmHg), and total cholesterol target (< 5 mmol/L) had all improved significantly from 2004 to 2008.⁹ Lower performing practices showed the greatest improvements over the timeframe, and regional variations in care were also reduced.⁹ The study concluded that the benefits observed could not be conclusively caused by the QOF programme, as evidence of improvement of care was available before the introduction of QOF. The second study examined the impact of the QOF pay for performance programme on trends in the quality of diabetes care in various ethnic groups in southwest London.¹⁰ This study again confirmed the significant improvements in the same intermediate outcomes (i.e. HbA_{1c}, BP, and total cholesterol) as the first study in all ethnic groups. The magnitude of improvement, however, appeared to differ between ethnic groups (i.e. the HbA_{1c} decrease in the black and south Asian groups was not as great as predicted). They concluded that this may result in further widening of existing health disparities and could lead GPs to 'cherry pick' healthier patients.

Conclusions

The QOF pay for performance programme in England has been rightly praised by many plaudits internationally. The positive

effects on diabetes primary care are also welcome. However, a number of concerns remain as highlighted above.

In the USA, several pay for performance schemes have been introduced or are in development. However, the complexity of US healthcare means that the scope and impact of P4P programmes on diabetes care are difficult to assess, especially as many individuals at risk of, or who have, diabetes do not have any current healthcare coverage.

Having recently worked in diabetes clinical practice in both the UK and USA, it is clear to the author that pay for performance schemes are becoming firmly established in primary care. However, the introduction of P4P in US diabetes secondary care is being resisted by diabetes specialists due to fears about potential negative effects on physician earnings, in part due to the more difficult diabetes patients seen in secondary (and tertiary) care clinics compared to those seen by primary care physicians (i.e. patients have higher baseline HbA_{1c}, greater polypharmacy, more complications, etc). Whether pay for performance programmes will extend into UK diabetes specialist care, only time will tell.

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Erratum

Irwin *et al*. *Br J Diabetes Vasc Dis* 2009;**9**:44-52. Acronym, p44, should read:

AMIGO AC2993: Diabetes Management for Improving Glucose Outcomes