1 Department of Primary Care and Public Health, Imperial College London, London, UK

2 Department of Population Health Sciences, King's College London, London, UK

Correspondence to: A Majeed
a.majeed@imperial.ac.uk (or @Azeem_Majeed on X)
https://orcid.org/0000-0002-2357-9858

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Impact of pay for performance in primary care

Lessons from the UK Quality and Outcomes Framework

Azeem Majeed, [1] Mariam Molokhia[2]

When introduced in 2004, the UK Quality and Outcomes Framework (QOF) was one of the largest pay-for-performance programmes globally. The programme offered financial incentives to general practices based on their achievement against specific clinical targets.[1] Two decades later, a linked systematic review by Ho and colleagues (doi:10.1136/bmj-2024-083424) evaluated the programme's effectiveness. The findings raise important questions about the value of pay-for-performance programmes for patients, clinicians, and policy makers.[2]

Ho and colleagues did a systematic review with quantitative synthesis to evaluate studies that assessed the impact of the introduction of QOF incentives (83 indicators) and their withdrawal (31 indicators). The study found that the introduction of QOF incentives was associated with an initial improvement in recorded quality of care at one year (median increase 6.1%), although this effect decreased by three years (median increase 0.7%).[2] Conversely, incentive withdrawal led to a decline in recorded quality at both one and three years (median decreases of 10.7% and 12.8%, respectively). This suggests that the effects of pay-for-performance programmes are often not sustained without financial motivation.[3] Complex process indicators, such as foot screening in patients with diabetes, had larger declines than simple process indicators (for example, blood pressure measurement), intermediate outcomes (for example, blood pressure control), and treatment indicators (for example, antithrombotic therapy).

The study findings highlight both the potential and the limitations of incentive based quality improvement.[4] Although the initial gains in quality indicators suggest that structured incentives can drive better data recording and adherence to guidelines, the lack of sustained improvement at three years raises concerns about long term clinical benefits. The reversal of quality gains following incentive withdrawal underscores the risk that financial incentives may encourage superficial compliance rather than deeply embedded improvements in care delivery.[5] Pay-for-performance schemes such as the QOF provide structured targets that can standardise data recording and improve care. But the study also suggests that such incentives do not foster enduring improvements, thereby raising concerns about whether the financial rewards justify the associated administrative burden on primary care teams.[6] Moreover, "crowding out" effects may also be seen, whereby the focus on incentivised conditions may have come at the expense of important but non-incentivised aspects of healthcare.

Ho and colleagues' work highlights the importance of robust evaluation to distinguish true changes in quality of care from underlying trends.[7] The study also identifies some key gaps in knowledge that warrant further research. For example, what are the underlying mechanisms that lead to the decline in quality following incentive withdrawal? Is it a reflection of reduced documentation, or do structural and behavioural changes revert in the absence of financial motivation? Secondly, how do pay-for-performance schemes interact with broader system factors, such as workforce shortages, workload pressures, and funding shortfalls? The study also raises important methodological considerations for future evaluations. The reliance on recorded quality metrics as opposed to patient reported outcomes means that some of the observed improvements could be artefacts of better data entry rather than true clinical benefits. Future research should aim to disentangle these effects and explore alternative incentive structures that promote sustained quality improvement in the delivery of healthcare.[8]

For policy makers, the study offers an assessment of the long term impact of the QOF. Although the scheme showed initial quality gains, its failure to sustain improvements over time suggests that financial incentives alone are insufficient to drive lasting changes in quality of care. This has important implications for the design of future pay-for-performance programmes. Policy makers must consider how to transition from short term financial incentives to mechanisms that embed quality improvement into everyday practice—for example, by promoting greater continuity of care.[9] The findings also suggest that incentive structures should be designed with a focus on their sustainability.

The mixed results of the QOF programme in the UK illustrate that although financial incentives can drive short term improvements, they do not necessarily build a resilient, self-sustaining system of high quality care. Policy makers must therefore be wary of over-reliance on pay-for-performance programmes and consider integrating financial incentives within a wider strategy for quality improvement.[10] As health systems globally continue to grapple with the challenge of improving quality of care in an era of financial restrictions, the lessons from the QOF programme in the UK can help in developing more effective and sustainable approaches to incentivising high quality primary care.

The UK has already begun to diverge in its approach to the implementation of the QOF in primary care, with Scotland abolishing its own programme in

2016.[11] In England, and in other countries that have similar schemes, we need to retain the most effective elements of programmes such as the QOF, particularly areas focused on the early detection and management of long term conditions (such as hypertension and heart failure), while discarding the less useful parts (for example, non-clinical indicators such as those focused on workforce). The aim should be to incentivise long term quality improvements while minimising administrative burdens and unintended consequences.[12 13] An effective QOF programme that focuses on key clinical areas and that makes best use of developments in information technology remains essential for the NHS if we are to reduce health inequalities, increase healthcare efficiency, and improve health outcomes.

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