The use of targets to improve the performance of health care providers: a discussion of government policy

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SUMMARY
The aim of this discussion paper is to examine the advantages and drawbacks of employing targets, or performance indicators, to improve the performance of those delivering health care services. The paper is based on an examination of two target-setting policies initiated by Government: the 1992 Health of the Nation strategy and the 1990 General Practitioners’ Contract.

It is argued that the introduction of both the General Practitioners’ Contract and the Health of the Nation have indeed been accompanied by improvements in performance, however, there are a number of problems with targets. They tend to focus on those things that are most easily measured, and they may foster complacency on the part of providers who have already achieved upper target limits, and defensiveness on the part of those performing badly. National targets may skew local priorities; they may also be unrealistic and unattainable for particular, less privileged population groups. They may serve to widen inequalities in health, and can exacerbate the ‘inverse care law’ by encouraging providers to direct their efforts at the more advantaged sections of society, where such efforts are more likely to pay off in terms of overall improvements in the target level achieved. Finally, the achievement of some targets will not necessarily result in better health outcomes.

The paper concludes that a target-setting approach to improving the quality of care must be based on the use of appropriate indicators, and must take account of differences between more and less advantaged sections of society. It is argued that the introduction of both the General Practitioners’ Contract and the Health of the Nation have indeed been accompanied by improvements in performance, however, there are a number of problems with targets. They tend to focus on those things that are most easily measured, and they may foster complacency on the part of providers who have already achieved upper target limits, and defensiveness on the part of those performing badly. National targets may skew local priorities; they may also be unrealistic and unattainable for particular, less privileged population groups. They may serve to widen inequalities in health, and can exacerbate the ‘inverse care law’ by encouraging providers to direct their efforts at the more advantaged sections of society, where such efforts are more likely to pay off in terms of overall improvements in the target level achieved. Finally, the achievement of some targets will not necessarily result in better health outcomes.

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Keywords: Health of the Nation; target setting; General Practitioners’ Contract; financial incentives.

Introduction
This paper discusses the appropriateness of adopting a target-setting approach to improving the quality and effectiveness of care. This question is addressed through an examination of the government’s 1992 Health of the Nation policy and the 1990 General Practitioners’ Contract. No attempt is made to review comprehensively the literature on the contribution of financial incentives to improvements in the performance of health care providers. Rather, the purpose of this paper is to explore some of the strengths and limitations of a target-setting approach to care.

The Health of the Nation
The Health of the Nation was an attempt to bring about improvements in health status by setting targets. However, a number of commentators have drawn attention to problems with targets. These have been summarized by Smith. First, Smith argues that targets may lead to a spurious priority being given to that which is easily measurable. Secondly, he suggests that targets may be unrealistic and dismissed as unattainable. Thirdly, Smith suggests that targets may represent an oversimplified description of policy.

A ‘spurious emphasis on the measurable’? Quantitative versus qualitative targets
Despite its recognition of the problem that ‘the sorts of things which may easily be measured may not be measures of genuine success’, it is undeniably the case that the Government’s own Health of the Nation targets focus only on those things that are most easily measured. A number of commentators have been critical of the way in which the Health of the Nation targets rely almost exclusively on rates of illness and death as indicators, to the neglect of indicators of the ‘quality of life’. The Royal College of Nursing (RCN) has suggested a number of ‘quality of life’ targets. For example, alongside the Health of the Nation cancer targets, which are exclusively about reducing premature illness and death, the RCN suggests that targets could have been set that were related to pain control and the delivery of care at a patient’s home.

Targets: unrealistic and unattainable?
The government was aware that targets must be attainable. The Health of the Nation Green Paper states that ‘a target which is beyond realistic expectations may . . . be a disincentive to action’.

Far from being unrealistic and unattainable, it has been suggested that targets might foster complacency. Akehurst et al point to the fact that when performance indicators were introduced into the secondary care sector of the National Health Service they did not encourage those districts and units that were performing well to improve. Similar misgivings have been expressed in relation to some of the targets set in the primary health care sector as part of the 1990 General Practitioners’ Contract. As we shall see below, there is a danger that performance indicators in the form of cervical screening targets may foster complacency in those general practices that are performing well. There is evidence too that targets may provoke a defensive reaction in those performing badly. Instead of challenging providers whose performance is poor, targets may be viewed by such providers as a threat, and as a disincentive to improving performance.

A further criticism levelled against the Health of the Nation targets is that national targets may skew local priorities. Local circumstances may suggest different priorities than those set as national targets and, therefore, as a number of commentators have pointed out, there is a real danger that the pursuit of targets
may neither maximize health gains nor use resources in the most cost-effective manner.4,7,10,11

Targets: an ‘oversimplified description of policy’?
‘Health’ is not solely the responsibility of health care professionals. The achievement of health targets is dependent not only on the curative and health promotion activities pursued in the health care sector, but also requires government policies to combat the adverse effect on health of such factors as growing poverty, unemployment, homelessness, road traffic accidents, and environmental hazards.11 The Health of the Nation targets have thus been subject to the charge that they place an undue burden of responsibility on health care professionals to counteract the effects of social ills. As we shall see below, there is some evidence that the pursuit of the targets set out in the 1990 General Practitioners’ Contract have failed to overcome the effects of poverty and deprivation.

Targets and equity
The Health of the Nation targets are concerned with the goal of improving the nation’s health but they are not concerned with the goal of promoting equity between different groups in society. The failure to include the promotion of greater equity as an explicit objective of the Health of the Nation strategy has been criticized in many quarters.6,7,12 There is the danger that, in trying to achieve both the Health of the Nation targets and the targets set out in the 1990 General Practitioners’ Contract (see below), health promotion and preventive efforts will be directed at the more advantaged sections of society where it is known that such efforts are more likely to pay off. The failure to pursue the objective of reducing inequalities in health means that any overall reduction in, for example, rates of heart disease, may well mask widening differentials between different social groups.

Target setting and the general practice contract
The 1990 General Practitioners’ Contract
The introduction of the 1990 General Practitioners’ Contract signifies a concern on the part of Government to ensure that general practitioners (GPs) delivered a more cost-effective service. Towards this end, the contract required GPs to provide, for remuneration, a number of services, including health checks for new patients and elderly patients, cervical cytology, immunization and vaccination services for children, and health promotion clinics. In addition, GPs can provide child health surveillance and minor surgery for additional fees.13 Other changes in the new contract include a ‘deprivation supplement’, which is calculated on the basis of the Jarman index. As part of the new contract, targets were set in relation to cervical screening and childhood immunization. Cervical screening targets were set at 80% and 50%. Immunization targets were set at 90% and 70%. Differences in the level of fees received by practices achieving the higher target, the lower target, and no target respectively were introduced.

Targets and cost-effectiveness
The general practice contract and cost-effectiveness
Two economists (Scott and Maynard) question whether the 1990 GPs’ contract is likely to lead to more cost-effective primary care. They argue that too little attention has been devoted to the outcomes of the services provided by GPs; that is, too little attention has been devoted to the question of whether the provision of the services set out in the contract results in improvements in health status. Attention has been focused instead on the process; that is, on the establishment of a strong link between GP income and the level of service provided. But, improving the process is no guarantee of a better health outcome. Comparing the costs and benefits of health checks, Scott and Maynard conclude that the evidence points to the fact that such activities provide little or no benefit to the patient in terms of reducing mortality and morbidity, and incur substantial costs.13 Similar conclusions concerning the health benefits of health checks have been reached by others.14,15,16

Iliffe and Munro question whether financial incentives ‘raise the health status of the population as much as they do the income of the practice’.17 Similarly, Scott and Maynard suggest that priorities within general practice are now determined partly by the relative profit each service generates, rather than the relative improvements in health status each generates. The contract has assumed, of course, that these two are linked, but Scott and Maynard stress that such a link cannot and should not be assumed. They believe the proposals have been adopted with ‘scant regard to their relative costs and their relative effectiveness in terms of improvements in health status’.13

Do target payments increase uptake?
Childhood immunization
The system of target-linked payments introduced in the 1990 General Practitioners’ Contract was based on the assumption that financial incentives would have an effect on performance in general practice. However, the relationship between financial incentives and performance is not simple. Lynch points out that payment contingent on a given level of uptake does not reflect a straightforward relationship between activity and payment, since excesses over a target do not attract additional financial rewards, and shortfalls can result in uncompensated direct costs.19 GPs need to balance expected financial rewards not only against direct costs, but also against opportunity costs (the income foregone by not providing other services). Lynch has attempted to determine how much payment really does improve performance. In a study carried out in the early 1990s on a sample of GPs in the Greater Glasgow Health Board, Lynch found that financial incentives did have an impact, although they failed to account for much of the variation in performance between different practices. Using the relative weight of past immunization payments in total fees and allowances as a proxy for the impact of financial incentives, Lynch found that the greater was the relative weight of past immunization payments in total fees and allowances, the higher was the rate of uptake of immunization services. However, this variable accounted for only 28% of the cross-practice variation in uptake rates.19 Lynch’s study also found that socio-economic factors had a significant effect on the ability of general practices to achieve high immunization targets. General practices serving populations living in socially deprived areas were less likely to achieve the high target for childhood immunization.18 Thus, a one point increase in the percentage of patients living in a high Jarman score area gave a decrease of 14% in the odds of practices achieving the high target.19 Lynch’s findings reinforce the conclusion from a wealth of other studies that the ‘inverse care law’ is still very much in operation, despite the introduction of the General Practitioners’ Contract.20 21
Lynch acknowledges that financial incentives do have an impact, but concludes that:
there may be a case for recognition, beyond the deprivation-related payments, that in the case of some practices the effect of exogenous constraints cannot be offset by financial
...some practices perform excellently but still do not reach performance targets. The implication is that these practices will, despite their best efforts, not qualify for target payments. The fear is that without some acknowledgement for their effort they will either artificially manipulate their list to exclude ‘problem’ patients or they will stop trying to attain high uptake.30

Indeed, Jones and Moon cite two published examples of attempts to change the composition of a list by excluding problem housing estates or problem groups.31,32

Cervical screening
A study by Reid et al has looked at the question of whether changes in the cervical screening service since the introduction of the 1990 General Practitioners’ Contract have increased uptake rates.33 Reid et al’s study, which took place in a small Scottish unit, Perth and Kinross, found that rates of uptake did increase after the introduction of the new contract. However, before the introduction of the new contract, the Perth and Kinross Unit had already completed a computerized cervical screening call programme that had produced an increase from 71% to 78% in the mean percentage of women who had had a smear test in the previous 5.5 years. Six months after the introduction of the contract, coverage was increased further to 85%. The authors concluded that the performance-related payment system had brought about “a further sustained increase in population coverage for cervical screening.”33

However, as Smail34 has pointed out, it is not at all clear from the evidence presented by Reid et al to what extent the improvements in population coverage in their study could be attributed to the new contract, and the extent to which other factors were important. Smail believes that it was the improvement in the call system in Perth that had the more significant impact. A working group convened in Smail’s own area of the country (South Glamorgan), concluded that the most important contributory factors to improvements in the target level achieved were improvements in the call-recall system, improved training for practice nurses, and the provision of a ‘sensitive, flexible and timely’ service.35

Conclusion
No attempt has been made in this paper to review comprehensively the evidence concerning the effects of targets and incentive payments on the performance of health care providers. Rather, the purpose of this paper has been to suggest that while targets and incentive payments clearly can and do contribute to improved performance, they also have shortcomings. The most serious drawbacks of targets is that they provide little incentive to direct resources at those in greatest need. They are therefore ill-suited to combating the ‘inverse care law’. One important challenge therefore, with which GPs are currently grappling, is to find a more effective method of tackling the problem of poor uptake of services in deprived areas. A second important challenge is to ensure that appropriate indicators are chosen as targets. There is clearly a need for further research into what are the most appropriate indicators of quality and effectiveness in primary care, and the feasibility of employing such indicators constructively in order to monitor the services delivered and then to act on the findings.

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