# Proposal: Developing health care quality indicators and improving the QOF program for the Thai Universal Health Coverage – Part 1

## Introduction

Healthcare systems around the world are increasingly interested in performance measurements in order to ensure the quality of care and to enhance the accountability in health care (1). This is particularly relevant in the era of the universal health coverage (UHC) movement because financing quality health care will ensure the best use of public resources and impact (2). One of the most well-known scheme that links performance measurements with financial rewards is the Quality and Outcomes Framework (QOF) from the United Kingdom (3). This framework provides incentives to health care professionals to comply with quality indicators in order to earn points, which can be translated into financial benefits. Quality indicators has been defined as "a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality, and hence change in the quality, of care provided" (4).

Marshall et al. recommend that a good quality (appropriate) indicator should meet four criteria: (i) an indicator should be based on scientific evidence alongside professional consensus, (ii) there should be a clear link between the application of an indicator and identifiable health benefits for patients, (iii) panel members consider that a high compliance rate to an indicator by physicians is associated with a higher quality of service, and (iv) most factors that determine the compliance rate to an indicator are under the control of the physician (5).

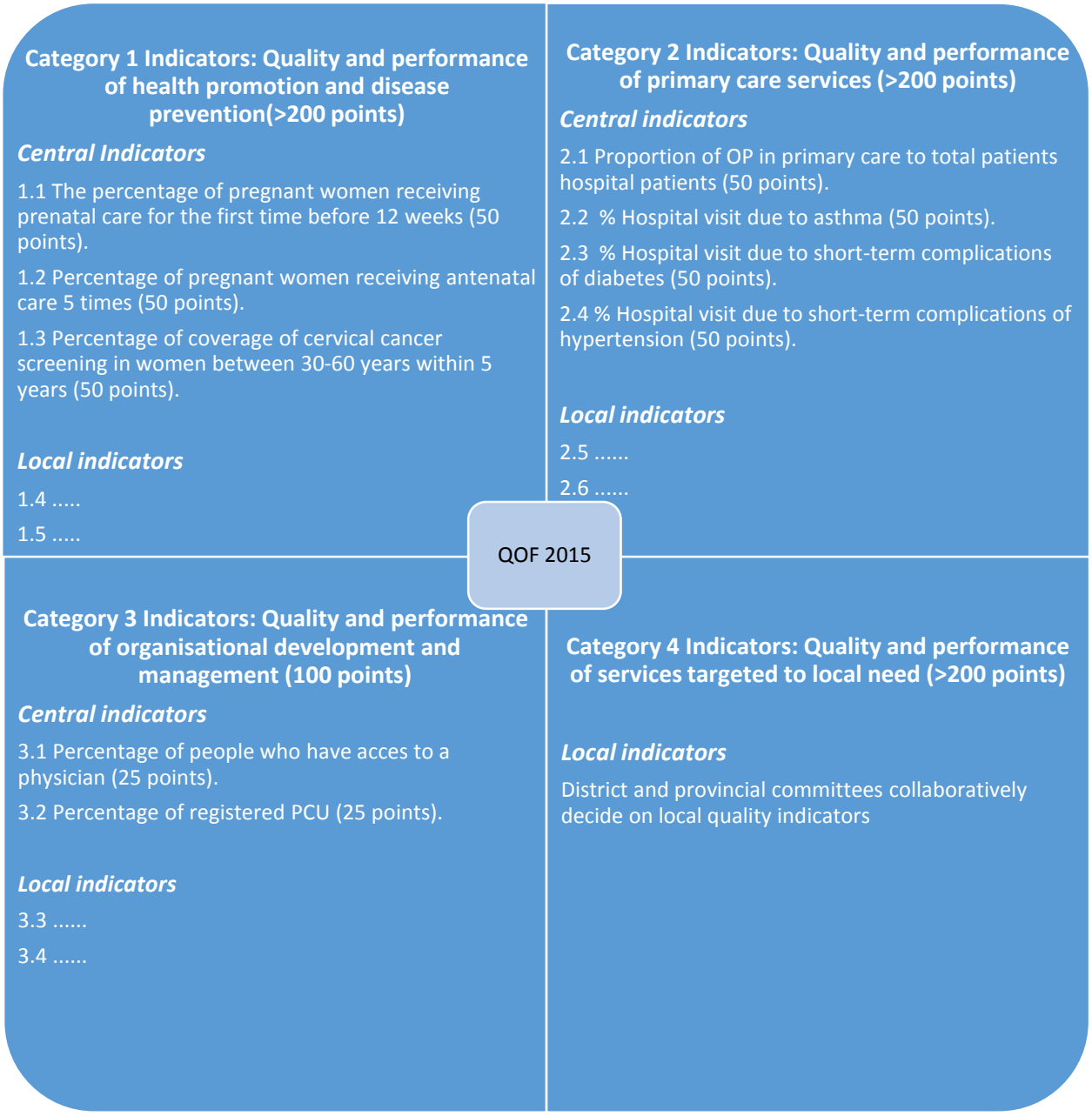
Findings on the introduction and impact of quality indicators to improve the healthcare quality has been inconsistent (6). For instance, studies in the United Kingdom have shown that in the short term, the pay-for-performance scheme increases the quality of clinical care (1, 6, 7). However, in the long term, no quality of care is gained when the target performance level has been reached. In developing countries such as Democratic Republic of Congo and Rwanda, it was found that performance-based payment systems positively affected both accessibility of care and quality of care (8, 9). Nevertheless, other studies have shown concerns regarding intentionally excluding patients from the pay-for-performance programs without any justifiable reasons (10, 11). For instance, excluding patients that might negatively influence the outcome is not justified unless the measurement tool is inappropriate to be used on patients with certain characteristics (12). In that case, patients who are not suitable for the pay-for-performance program should be systematically excluded. Another concern is that health care providers will focus less on certain unrewarded clinical activities (13).

In Thailand, the National Health Security Office made a notable attempt to introduce the QOF under the Universal Health Coverage (UHC) at the end of 2013. After the establishment of the QOF, the program was implemented nationwide. Compared to other performance-based financing projects, a relatively large budget was provided to the QOF. In 2015 the program received more than 3.2 billion baht, which is equivalent to approximately 3% of the total UHC budget.

The Thai QOF has four categories of indicators (see Figure 1) including, (i) quality and performance of health promotion and disease prevention, (ii) quality and performance of primary health care services,

(iii) quality and performance of organizational development and management, (iv) quality and performance of services targeted to local need.

*Figure 1 Quality and Outcome Framework of Thailand (total points: 1000), OP = Out Patient, PCU = Primary Care Unit(14)*




There are concerns that the quality indicators used in the Thai QOF have not been developed in a systematic, participatory and evidence-based manner. Without supportive evidence, the quality indicators cannot guarantee the health impact. Furthermore, there are variations in the implementation

and financing of the QOF by different geographical regions (15). The NHSO allows regional and provincial health authorities to differently design on how to pay health care providers based on performance measures. For example, in some regions most of the QOF fund was allocated to providers based on the eligible population registered rather than on quality indicator scores. It is noteworthy that the NHSO already pays providers for ambulatory care based on pre-payment capitation (16).

At the request of the NHSO, this proposal was developed to review the current QOF program for further improvement; to revise and retire existing quality indicators, if appropriate, as well as to develop new indicators that are evidence-based; to provide recommendations for effective QOF program management, implementation, monitoring and evaluation.

## Objectives

**General objective**

To improve the current QOF program

**Specific objectives**

1. To review the current QOF program in terms of appropriateness of quality indicators, effective program implementation and evaluation (Part 1)
2. To analyze and prioritize health problems and problems related to the quality of primary care (Part 1)
3. To revise and to retire existing quality indicators as well as to develop a new set of quality indicators for the fiscal year 2017 in a systematic, transparent, participatory and evidence-based manner (Part 2)
4. Developing policy recommendations for an effective QOF program management, implementation, monitoring and evaluation (Part 3)

## Study design and methods for part 1

This study will employ qualitative and quantitative techniques in order to address the aforementioned objectives of part 1. These include:

1.1 Review of relevant documents, including those produced by the NHSO, regional- and provincial health authorities and health care providers in order to understand the barriers and facilitators of the current QOF implementation in Thailand. This review will include the development of quality indicators, program management and implementation.

1.2 Review of published literatures in order to understand the development of quality indicators in Thailand and other countries. Particularly, the experiences of the National Institute for Health and Care Excellence (NICE) regarding the development of quality indicators, QOF program management and implementation will be reviewed.

1.3 Secondary data analysis of relevant databases, including national health surveys, elderly health survey and Ministry of Public Health (MOPH)'s databases, if available, to explore important health problems among Thai population. Also, data about quality indicator

measurements gathered from health facilities throughout the country will be analyzed to explore the achievements of the current QOF program as well as the problems related to the quality of primary care.

1.4 Self-administered questionnaires developed by the research team for the QOF program managers, key decision makers at regional and provincial health authorities in selected settings, key decision makers at health facilities, and health practitioners in respective settings, in order to understand their perspectives and attitudes towards the current quality indicators, the QOF implementation, and to explore its barriers and facilitators

1.5 Individual and focus group interviews of relevant stakeholders, including key informants at the Ministry of Finance, QOF program managers at the central and regional level, hospital directors, health care providers, and key informants at the Hospital Accreditation Institute

1.6 Stakeholder consultation meeting to verify and validate preliminary findings, and prioritize health problems.

Time line – Part 1

| Activity | June | | | | July | | | | August | | | | September | | | | October | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| 1. Meeting among researchers and staff from NHSO to develop a working and monitoring plan, and research framework | | | | | | | x | | | | x | | | | x | | | | x | |
| 2. Steering committee meeting | | | | | | | | | | | x | | | | | | | | x | |
| 3. Reviewing documents provided by relevant stakeholders | | x | x | x | x | x | | | | | | | | | | | | | | |
| 4. Reviewing published papers and grey literature from domestic and international databases | | x | x | x | x | x | x | x | | | | | | | | | | | | |
| 5. Analyzing secondary databases | | | | | x | x | x | x | | | | | | | | | | | | |
| 6. Developing, sending out and analyzing self-administered questionnaires | | | | | x | x | x | x | x<br>x | x | x | x | | | | | | | | |
| 7. Conducting focus group discussions and in-depth interviews | | | | | x | x | x | x | x | | | | | | | | | | | |

| Activity | June | | | | July | | | | August | | | | September | | | | October | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| | | | | | | | | | x | x | x | x | | | | | | | | |
| 8. Analyzing all data from phase I and preparing a preliminary report | | | | | | | | | | | | x | x | x | x | | | | | |
| 9. Stakeholder meetings to verify and validate preliminary findings | | | | | | | | | | | | | | | | x | | | | |
| 10. Revising the preliminary report according to the suggestions from the stakeholder meetings | | | | | | | | | | | | | | | | | x | x | | |
| 11. Submitting the report to NHSO | | | | | | | | | | | | | | | | | | | x | |

## Research team

| Health Intervention and Technology Assessment Program (HITAP) | |
|---|---|
| Dr. Yot Teerawattananon | Principal Investigator |
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| Regional staff (TBC) | Co-investigator |
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| Dr. Rachel Foskett-Tharby | International expert and co-investigator |
| **National Institute for Health and Care Excellence (NICE)** | |
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## Literature


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