

## Incentives to improve primary care: Critiquing the Quality and Outcome Framework in England

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(Writing in a personal capacity.)

### *Introduction: The strategic context*

In the past decade, the NHS in England has led a revolution in the way in which it plans, resources and evaluates services. The separation of commissioners and providers—coupled with a radical approach to creating a market that includes statutory, voluntary and private sector providers—has challenged the assumptions that have underpinned the NHS since its inception in 1946.

For over ten years in England, the roles of those who commission health services and those who provide have become more and more distinct, with formalised relationships being established to clarify governance and accountabilities between the two. Primary Care Trusts—each responsible for between 125,000 and a million people—have been charged to develop commissioning relationships locally—to thoroughly understand the actual and future needs of the populations for whom they are responsible and to plan services accordingly.

Breaking the monolith of health services to introduce a separation between those who seek to understand the health needs of the population and plan accordingly and those tasked to provide services to meet those needs would result in a more effective use of resources, it was claimed. It would also engineer health care systems built on the needs of patients and not the interests of clinicians. Separating commissioning from provision would also enable the creation of a competitive market in which health services could be delivered. Providers would vie for the attention of commissioners and offer better value for money for the public purse.

### *Primary care*

The important role of primary care—and more specifically general practice - in improving health and reducing inequalities in health and wellbeing has been noted for some time; however the full potential of its public health role remains underdeveloped. In England, GPs are seldom fully integrated into local planning and delivery—although they have a special place in the hearts of their patients and remain trusted despite notable challenges in recent years. The World Health Organisation has been unequivocal in its support of primary care as a key driver of health. However, access to GPs remained uneven, with strong evidence that those people who were more likely to need services were least likely to use them. Tudor Hart's seminal studies make the case very well (1971; 2006).

General practitioners are seen as a central and important piece of the NHS family—although it seems that the contractual relationships they have with health service commissioners is as independent contractors; they essentially run small businesses. However, in the range of functions that Primary Care Trusts (PCTs) carry out, setting contacts with general practice is one of the most challenging and potentially beneficial to the health of local populations. Some GPs were entrepreneurial and innovative; others operated within a more traditional paradigm. Politicians and civil servants saw the potential in capturing the imagination of the

most outward looking and effective, to set the standard through which the performance of the rest would be measured, and through a series of transformatory steps, could be improved.

Patricia Hewitt, the then Secretary of State for Health saw the potential of general practice, as well as its uneven success across the country, and sought to find a framework that would drive up performance, especially in relation to those big public health challenges that projections suggested would become an unsustainable draw on NHS resources in coming years. Her belief that the future lay in managing demand for expensive secondary care services meant that general practice had to be improved; it had to change from a service that benignly awaited patients pitching up at the door to one which actively sought patients from those communities which carried the disproportionate burden of disease. This represented a significant shift in the culture of provision of general practice.

Active interventions were needed to get those patients through the door, who were falling through the net. GPs were generally busy and had high profiles, but inequities and inequalities were worsening. Notoriously, there were challenges in encouraging GPs to change their practice. Key to changing their behaviour, it was believed, were financial incentives. Something had to be developed which would encourage focus on so called hard to reach populations and the detection and management of chronic diseases. Therein lay the route to reducing expenditure in the longer term and reduce the costly burden of secondary care. The system that was developed was called the Quality and Outcome Framework—or simply QOF as it is now known. It was heralded as ‘an initiative to improve the quality of primary care that is the boldest such proposal on this scale attempted anywhere in the world’ (Shekelle, 2003).

Exemplary in summarising the scope and complexity of QOF is Nick Mays’ work (2008).

### *Changing remuneration for GPs—2004*

The New General Medical Services Contract, April 2004, made changes to the ways in which GPs were paid. They remained independent contractors—and were not, as is widely assumed or implied in the media, part of the NHS family, but in contract with it. The Contract was held with local primary care trust and payment would be made up of a blended system, with five distinctive components:

1. Weighted capitation payment for essential services
2. Weighted capitation for additional services
3. Enhanced services; voluntary arrangements with local PCTs which relate to locally defined needs (for example obesity management programmes)
4. Infrastructure payments, including premises and information technology costs
5. Quality and Outcomes Framework, a voluntary scheme that promised to revolutionise the nature of general practice—it is this innovation that is the focus of this critique.

### *Quality and Outcomes Framework*

The Quality and Outcomes Framework has two underpinning objectives:

1. To improve the general quality of primary care
2. To eliminate variation between providers, resourcing and rewarding best practice

The QOF is a detailed catalogue of procedures and standards that, once met, produce financial rewards for GPs. Payment is not received per intervention, but thresholds are set that trigger payments. Points are awarded in direct linear relationship to achievement. The thresholds alter depending upon the relative importance of the issue being addressed. Importantly, annual changes are made to stretch performance and encourage improvements. The differential weighting of QOF points reflects the importance of the intervention and the relative impact it will have on the effectiveness and quality of patient care. Each QOF point is worth approximately £120.00. There are 1050 points available per practice (approx £130k, in addition to other payments; approximately 25% of practice income).

The QOF seeks to reward GPs in relation to their performance in addressing a series of domains. The domains are designed to address areas of general practice that needed to be improved across the country. Each domain is made up of numerous sub areas—each clearly labelled—which form comprehensive approaches to securing desired improvements in a range of clinical and managerial areas.

A full list of the domains and each component part is available on the Department of Health website: [www.doh.gov.uk](http://www.doh.gov.uk).

The domains correspond to priorities highlighted more generally in public health and health service policy. There are four domains:

1. **Clinical** standards linked to the care of patients suffering from chronic diseases - recognising that chronic diseases are a growing risk to the health of the public and represent a challenge to health services in coming years which will be a significant draw on the public purse. The domain focuses on 10 critical areas, each with numerous component parts.
  - CHD
  - Hypertension
  - Diabetes
  - Asthma
  - COPD
  - Mental health
  - Stroke or transient ischaemic attack
  - Epilepsy
  - Cancer
  - Hypothyroidism

### *Example one: Hypertension*

There are five component parts to the hypertension sub domain:

BP 1. The practice can produce a register of patients with established hypertension: 9 points available overall (that is to say a one off payment of £1080.00 is made to the practice if a register is established)

BP 2. The percentage of patients with hypertension whose notes record smoking status at least once since diagnosis: 10; 25-90% (that is to say that for each threshold of 6.5% of patients with hypertension who have their smoking status recorded the practice receives a QOF point payment: £120.00)

BP 3. The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered at least once: 10; 25-90% (that is to say that for each threshold of 6.5% of patients

who smoke who and referred to a smoking cessation service the practice receives a QOF point payment: £120.00)

BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the past 9 months: 20; 25-90% (that is to say that for each threshold of 3.75% of patients with hypertension who have their blood pressure taken in the last nine months the practice receives a QOF point payment: £120.00)

BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less: 5; 25-70% (that is to say that for each 9% threshold of patients who are in control of their blood pressure the practice receives a QOF point payment: £120.00)

### *Example two: Epilepsy*

EPILEPSY 1. The practice can produce a register of patients receiving drug treatment for epilepsy: 2 (a one off payment of £240.00 is made to the practice if a register is established)

EPILEPSY 2. The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months: 4; 25-90% (that is to say that for each 16.25% of patients on treatments have a recorded seizure frequency in the past 15 months, the practice receives a QOF point payment: £120.00)

EPILEPSY 3. The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of medication review in the previous 15 months: 4; 25-90% (that is to say that for each 16.25% of patients on treatments have a recorded medication review in the past 15 months, the practice receives a QOF point payment: £120.00)

EPILEPSY 4. The percentage of patients aged 16 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the last 15 months: 6; 25-70 (that is to say that for each 7.5% of patients on treatments have been seizure free in the past 12 months, the practice receives a QOF point payment: £120.00)

2. **Organisational standards** relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management - recognising that many GPs, especially those operating as single handed practices were not making best use of available technology, or adopting relevant guidelines and protocols. The domain focuses on 5 critical areas, each with numerous component parts:

- Records and information
- Clinical and practice management
- Education and training
- Communication with patients
- Medicines management

3. **Additional services**, covering cervical screening, child health surveillance, maternity services and contraceptive services—recognising that there are numerous interventions that general practice could lead that would have swift and preventative impacts on the health of local people, which were not always being fully realised. The domain focuses on 5 critical areas, each with numerous component parts.

- Cervical screening
  - Child health surveillance
  - Maternity services
  - Contraceptive services
  - Flu immunisation
4. **Patient experience**, based on patient surveys and length of consultations—recognising the growing and central importance of patients' voices in expressing levels of satisfaction with primary care services and determining local improvements. The domain focuses on 5 critical areas, each with numerous component parts:
- Patient survey
  - Consultation length
  - Holistic care payment
  - Quality practice payment
  - Access bonus

The clear focus of the domains on distinct and complementary areas of general practice points to the desire of the government to improve access and quality in primary care. Never before had a framework of this form been implemented and linking performance so squarely to payment of clinicians has been controversial. The criticisms and observations have been manifold.

#### *Challenges to the Framework—syntheses of others' views*

Paying for performance has changed the way in which health services are delivered. In light of such change it is inevitable that there have been challenges in implementation.

In their analysis of 36 research studies, entitled Financial incentives, healthcare providers and quality improvements, Christianson et al (2009) comment '[s]tudies on the effect of payer initiatives that reward providers for quality improvements or the attainment of quality benchmarks have mixed results. Relatively few significant impacts are reported, and it is often the case that payer programmes include components in addition to incentive payments, making it difficult to assess the independent effect of the financial incentives'. Furthermore, they note 'the accumulated body of research... is not yet sufficient to shed light on the validity of the concerns that have been raised about potential barriers to the effective design and implementation of pay-for-performance initiatives'. These ideas are important when considering the significance of QOF. However, it is also important to remember that evidence is drawn from what is known, and by the admission of the authors the evidence is currently scant. Indeed, it has been noted that the majority of studies hitherto are observational and the methodological validity of such research remains contested.

Since its inception, there have been specific concerns expressed about QOF; summarised here in no particular order:

- Local commissioners expressed misgivings about the feasibility of the programme initially, reflecting upon the passionate independence of GPs and the historical lack of influence managers had achieved over their practice; commissioners have characterised working with GPs as 'like herding cats'.. .
- Numerous alarming letters to the British Medical Journal confirmed commissioners' fears as the system was branded 'Orwellian' and 'racist and colonial' and calls for mass resignation were common. Activists have expressed concerns that the development of QOF

is part of the creeping privatisation of the health service, that it seeks to break down the practices of clinicians into discernible elements which can be attributed a value and delivered as part of a monetary exchange on behalf of patients. Critics suggest that such a careful classification is preparing the system, clinicians, and most importantly, patients for the advent of privatisation (see the Keep Our NHS Public Campaign: [www.KeepOurNHSpublic.com](http://www.KeepOurNHSpublic.com)).

- Some sociologists and political commentators have expressed worries that QOF supports and contributes to the ongoing commodification of health. It attributes relative values to patient experiences through its careful and deliberate classification of illnesses and interventions. The fixed fees associated with each QOF point and the relative allocation of points to various interventions serve to commodify intensely personal experiences, they argue, further alienating individuals from their conditions. In the disconnection of individuals from their health and illness, patient centredness is lost. These assertions are ideological and difficult to corroborate empirically.
- Others have reflected upon the ever growing concerns of the State in the minutiae of individuals' lives and the development of regimen which encourage the active participation of citizens in their own surveillance and regulation. They argue that QOF is yet another example of this form of government. For these scholars and activists, the promise that greater freedom lies at the heart of these plans is the ruse through which individuals find themselves open to ever more control; the details of their lives are scrutinised and laid amenable to public view. It subjects willing patients to subtle and nuanced classification (cf Foucauldian commentators, including Nicholas Rose and Deborah Lupton). The potential of the Framework might be represented as liberatory, but the effects are surveillant, they suggest. Central to these critiques is an analysis of the role of IT and its function in revolutionising patient record keeping. Whether or not the argument is persuasive about surveillance, it is irrefutable that the provision of IT has changed general practice; QOF was a significant driver in improving information systems.
- Some medics have reflected upon the changing nature of clinical delivery and noted that the administrative nature of the Framework undermines their professional identity; their role is not one to count and quantify, but to listen, relieve the burden of disease and cure. For them QOF stifles innovation and constrains their professional judgment. For others, it has provided the security of a set of approaches validated by their peers and considered the best option for patients (see for example, Mangin and Toop, 2007).
- There were doctors who saw QOF as another piece in the creeping managerialisation of medicine, the slow but persistent attack on their autonomy as clinicians and the pernicious standardisation of their practice, regardless of the individual contexts in which they operate and the various needs of their patients (Lipman, 2003). For them, it is important to see the interaction with patients not just as series of micro-practices but a global experience that needs to take into consideration the complexity of their lives. GPs were advocates for their patients, not administrators, they argued (for example, Thomas 2003). Patient groups did not always share the view that GPs' role was one of advocacy, but nonetheless they concurred that the Framework was an attack on the altruism of their doctors.
- Initially, there was concern expressed by some public health colleagues that the Framework would worsen inequalities, because GPs would focus on bringing in those patients

who were relatively easy to reach, at the expense of others who would continue to carry the burden of disease. As such a widening of inequalities of access and outcomes would be seen, they contested. However, research has not been able to draw any hard and fast conclusions. The challenging nature of the thresholds and the stretch that each year brings has been focused on reducing inequalities, policy makers claim. It seems that QOF is not worsening inequalities, although such an impact is small comfort as inequalities in health and wellbeing are widening across the nation; stopping the tide is challenging enough, narrowing the gap seems almost impossible. Commentators share the view that a watchful eye is needed (Doran et al, 2006 and 2008).

- The area of prevention is one which has exercised colleagues in public health. Whilst they recognise that chronic diseases pose the greater threat to the health of the nation and agree that the focus of the clinical domain is right - they applaud the development of disease registers, for example - they also suggest that many of those conditions are preventable - yet the focus of the Framework is on managing the conditions, not preventing them. There have been calls for incentivising GPs, through QOF, to take a much more proactive role in disease prevention and health promotion. This would be especially powerful, they argue, if it were linked to a sharper focus on inequalities (Guthrie et al, 2007).
- Patient activists have commented that the development of QOF did not take sufficient notice of what patients want from their interactions with general practitioners and their teams. In response policy makers have pointed to standard four which seeks to capture the views of patients locally. However, it has been suggested that patients should have greater control over the questions posed and should report on how reassured they are that their complaints and suggestions for service improvements are adopted.

Whether the Framework attains the avowed improvements in quality is a hotly debated topic. The fundamental definitions of what quality is are challenging enough to clarify, and the focus on process of many of the measures does not, either in isolation, or in conjunction with others assure better delivery (for example, measuring patients' body mass index does not indicate any progress, unless it is coupled with assertive support for those patients who are overweight and obese). Commentators have pointed to the need to include clinicians in the development of meaningful indicators (Raleigh and Foot, 2010).

Studies of improvements of quality do not state definitively that they are related to QOF alone, but were possibly in train before the Framework was adopted and a trajectory of improvement had already been achieved. Critically, those areas that were not included seemed to experience a decline in related quality (Campbell et al 2007). Above all, it is clear that QOF alone does not ensure quality—professional responsibility and carefulness do. The Framework provides the means through which those attributes can be enhanced, complementing sound clinical practice (Smith, 2009).

Early commentators noted that there were sufficient incentives built into the Framework to encourage gaming, such that inflated pictures of GP performance would be found to ensure maximum financial gain. This has since been challenged; spot checks and patient surveys seem to suggest that the honesty and altruism - as well as the desire to maintain a good reputation - of GPs have won the day. However, it has been asserted that the scheme effectively rewards the reporting of the intervention and action rather than the intervention or

action itself. Conversations with other clinicians, commissioners and journalists often include reflections upon the extraordinary increase in GPs' income as a result of QOF. Some seem motivated by concerns about value for money and whether payments reflect health gain (Fleetcroft and Cookson, 2006); others by envy.

Some researchers have challenged the evidence upon which the indicators have been predicted—suggesting that they are effectively incentivising practice which is known not to be good (for example, Lehman and Krumholz (2009) queried the direction in the Framework in relation to managing diabetes). Since 2008, the National Institute for Health and Clinical Excellence (NICE) have been working with the Department of Health to ensure that doctors are driving improvements. The indicators are developed in light of what is known about cost effectiveness as well as clinical benefit. NICE's decisions have been contested in the past, leaving the process open to accusations that they seek only to drive down costs. This has been refuted ([www.nice.org.uk/aboutnice/qof/qoffaq.jsp](http://www.nice.org.uk/aboutnice/qof/qoffaq.jsp)).

Finally, in the day to day running of practices, it has been noted that nurses and healthcare assistants are feeling the burden of the additional resultant activity, and the financial benefits to the GPs and the practices are not always felt more widely.

### *Conclusions*

The challenges to the scheme are considerable. However, the benefits are becoming clearer too. What is clear is that for those colleagues who wish to discern elements of the scheme and assess their effects in isolation will be thwarted in their simplicity. The enterprise of general practice is complex and the elements which have an impact on the experience of patients are many. It is important that a whole system view is taken; one which cites the development of QOF in a raft of reforms of health services and one which sees the importance of the doctor-patient interaction as a cultural and social one as much as a clinical or financial phenomenon. In pursuing our yearning for the evidential silver bullet that will right all of the systemic wrongs, including tackling inequalities in access to services and health outcomes, we will continue to fail. The question we should pose is: 'What place might incentives have in public service reforms?' Not: 'How will incentives fix all systemic ills?'

It is clear that GPs' focus in hitherto neglected areas of practice has increased. In that sense, the Framework is successful. Questions remain about whether the Framework focuses activity in the right areas—and as some researchers have shown, progress has not been made in those areas that have no associated QOF points (Campbell et al 2007). QOF's effects on tackling inequality, promoting health and wellbeing and reducing the burden on secondary care remain underdeveloped, as do systematic efforts to link its workings with other areas of social policy (Gilthorpe et al, 2005). Whether or not the system will be able to maintain paying in such a way—or whether there will be a shift away from process on to real improvements in the health of populations rather than individuals - will surely be the focus of politicians in the next parliament.

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