Should the Quality and Outcomes Framework be abolished?

Steve Gillam argues that the general practice pay for performance scheme is not good value for money, but **Niroshan Siriwardena** believes it needs to be improved not removed

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Steve Gillam, general practitioner, Lea Vale Medical Group, Luton
sjg67@medschl.cam.ac.uk

YES

The impact of the Quality and Outcomes Framework (QOF) on general practice has, arguably, exceeded that of any other policy development since the Family Doctors' Charter of 1966. A sensible verdict needs to balance a nuanced assessment of health and other gains against its costs, many of which are hard to describe let alone quantify. But I believe that the evidence supports its abolition.

The £1bn (€1.2bn; $1.4bn) a year that the scheme costs has yielded remarkably modest improvements in measured quality of care and only slight reductions in disparities between socioeconomic groups.[1 2] In many cases, improvements in clinical indicators were in line with increases that might have been predicted on the basis of secular trends before the framework was introduced.

To what extent these improvements are the vicarious result of better recording remains unclear. What is clear is that commercially constructed evidence is driving up prescription rates for antidepressants, statins, and other drugs with little evidence of improvement in proxy outcomes.[3]

Distorted priorities

Incentives were not aligned to tackle inequalities in health, and other factors impair the framework's impact at population level. Setting targets below 100% and the process of exception reporting (which allows patients to be excluded from performance figures) reduces the public health effectiveness of population targets by shifting the focus away from harder to reach patients. More fundamentally, payment for adhering to guidelines cannot be assumed to improve health status, regardless of whether it improves "performance." The framework's evidence base will only ever be partial.

With the entrepreneurial dynamism characteristic of UK general practice, teams have adapted swiftly to its imperatives, but core activities have been distorted around the framework. For many practices, clinical governance and audit have become synonymous with the framework. Quality of care is narrowly focused on domains and indicators included in the framework to the exclusion of other areas for practice development, innovation, and quality improvement. The framework promotes a mechanistic approach to managing chronic disease, reducing clinical practice to a series of dichotomised decisions. Both doctors and nurses are concerned about the "box ticking culture": the intrusive impact of computerised templates that turn people into codes, to the detriment of person focused care.[4]

Although research has found little evidence of gaming, the corrosive cynicism that pay for performance engenders is almost more destructive. Last year my practice earned £289 for

A Niroshan Siriwardena, foundation professor in primary care, Faculty of Health, Life and Social Sciences, University of Lincoln, Lincoln nsiriwardena@lincoln.ac.uk

NO

Strong primary care is a cost effective solution to better population health and reducing inequalities.[1] The Quality and Outcomes Framework (QOF), the most comprehensive national primary care pay for performance scheme in the world, was introduced in 2004 to encourage evidence based practice and reduce variations in care for chronic conditions.[2] It is a complex intervention comprising several elements including financial incentives, support for structured and team based care, and the pursuit of evidence based care.

There are early indications that the framework is associated with better recorded care, enhanced processes, improved intermediate outcomes,[3] and reductions in inequalities[4] and that it provides value for money in some but not all its clinical domains.[5] It has helped consolidate evidence based methods for improving care by, among other things, increasing the use of computerisation, decision support, provider prompts, patient reminders (and recalls), skill mix, and teamwork.[6] Many of these features were introduced before the framework but continue to be strengthened as a result of it. We should concentrate on addressing the criticisms rather than throwing away the gains.

What to measure

The indicators were developed from guidance or consensus, and even critics acknowledge that many are based on sound evidence.[7] However, action is needed on indicators for which evidence is poor, or when evidence changes, and the involvement of the National Institute for Health and Clinical Excellence (NICE) should support this.[8] There will always be a fine judgment about timing, level of evidence required, and whether to accept a consensus rather than evidence based indicator. An argument for greater consistency of care should not prevail where evidence is lacking: when there is uncertainty about the best treatment option a flexible approach to management is needed.

Effects are real

Quality of care has improved for some clinical areas since the framework was introduced.[9] Although it is true that benefits have been small, these cannot simply be an effect of better recording because gains have also been reported in clinical domains that are not included in the framework.[10] Some commentators have argued that care would have continued to improve along

administering a second patient health questionnaire to each depressed patient; by comparison, recording blood pressure in a patient with known hypertension earned us £9. Is this a sensible way of apportioning public money?

Professional shifts

The framework is accelerating the transition to a nurse led primary care system in various ways. It has introduced new hierarchies and helped stratify medical roles.[5] Salaried doctors and nurses with special interests are increasingly seen as a more efficient option when medical members of the primary health team need to be replaced. This is helping to open up the primary care market to private providers. The exigencies of the market will drive the numbers of costlier general practice principals down and limit the potential for career advancement for doctors entering general practice. These consequences are not all necessarily negative—nurses have long been the future of primary care—but they are at odds with the public's desire for "general practitioner led services."

We know remarkably little about what patients make of these changes. Adherence to single disease based guidelines can override respect for patient autonomy, ignoring the comorbidities that are today's norm.[6] The "McDonaldisation" of general practice—as patients with multiple conditions pass down various clinic-based production lines, leaves little room for the deeper professional relationships patients want.[7] Continuity of care isn't (yet) Qofable.

In historical terms, the framework represents a high water mark in the onward march of what Harrison has termed "scientific bureaucratic medicine."[8] Indicators and guidelines threaten professionalism in various ways. The framework has encouraged external control of clinical practice by "experts" and reduced clinical autonomy. It has provided commissioners with blunt tools for comparing providers and for crude performance management.

Benefits and costs

It is hard to argue against the framework's benefits to individuals—the reductions in morbidity and mortality. Many of the health gains will be longer term; the benefits of more structured chronic disease management and extensive computerisation may spill over to other areas of practice. The framework has also had positive effects on practice organisation—for example, team working and the diversification of nurse roles.

The question is not whether the framework has had an effect but whether it is cost effective, and here the evidence is sparse. Although indicators in some domains may have been cost effective,[9] the opportunity costs are, by any reckoning, considerable. Could the money have been better spent on other public health initiatives? Could these limited improvements have been promoted through other means and other staff?

"The framework promotes a mechanistic approach to managing chronic disease, reducing clinical practice to a series of dichotomised decisions"

I am mindful of the myth of a golden age and professional self interest. The development of evidence based medicine, guidelines, and contractual flexibilities all predated the Quality and Outcomes Framework. They were driven by a myriad of policy, regulatory, workforce, and other changes that are changing the face of general practice. However, much can be laid at the framework's door.

The framework will shrink in time because it won't deliver what politicians want: savings, public health, quality, or contented users. I look forward to a QOF informed—if not yet QOF-free—future.

Competing interests: The author has completed the unified competing interest form at www.icmje.org/coi_disclosure.pdf (available on request from him) and declares (1) no financial support for the submitted work from anyone other than their employer; (2) no financial relationships with commercial entities that might have an interest in the submitted work; (3) no spouses, partners, or children with relationships with commercial entities that might have an interest in the submitted work; and (4) SG sits (unpaid) on the QOF advisory committee at NICE.

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secular trends for long term conditions such as asthma, diabetes, or cardiovascular disease where initiatives already existed, but there have even been modest improvements above the trend in these areas[9 11] as well as considerable improvements for epilepsy, which became a focus after the framework was introduced.[12]

Although care of clinical conditions not included in the framework has not improved, there has not been the worsening that some predicted.[13] The framework was not designed to reduce health inequalities from socioeconomic disadvantage and it is unlikely to do so. Despite this, inequalities of care between the most and least deprived areas have narrowed,[4] perhaps because the framework encourages greater consistency of care irrespective of deprivation.

Gaming is known to occur in many systems that are driven by pay for performance. However, there has been little evidence of gaming in the framework despite, or perhaps because of, a rigorous system of checks at various levels.[14] On the contrary, practices are exceeding the upper payment thresholds[15] and levels of exception reporting continue to fall year on year.[16] Nevertheless, vigilance and systems to detect and prevent gaming are needed.

"GPs realise that high quality care is not synonymous with either achieving framework thresholds or practice profits"

Motivation

Finally, critics argue that the framework is turning general practitioners into unthinking automatons pursuing money at the expense of good patient care. Fortunately, most thinking GPs realise that high quality care is not synonymous with either achieving framework thresholds or practice profits; they are not motivated solely by money but rather aim to provide the best care for their patients.[17] The balance of fixed versus performance related funding may be wrong. In fact, there is evidence that the structural changes to practice systems may have led to similar outcomes but with lower levels of incentive.[17]

Many GPs are concerned about the unintended consequences—that the framework might adversely affect care by reducing time for patients, failing to address patients' concerns, or impairing continuity of care.[6] A background of specialty training, years of experience, and embedded ethical practice have led most GPs to try to integrate the complex organisational demands of the framework into their current work by investing in staff, developing teamwork, and reorganisation aligned to improving reliability of care.[18 19] Despite the added administrative pressures most GPs are endeavouring to provide holistic care, by integrating vertical systems of disease management into horizontal coordinated care for their patients.[20]

The framework is by no means a perfect system for improving quality—it needs to be improved and modified based on careful analysis of its effects, both intended and unintended, and the ever changing evidence that underpins it. Indicators with poor evidence should be removed, some for which performance has reached a ceiling may need to be retired,[21] and new indicators should be introduced after piloting.[22] A finessed approach at improving the framework rather than a premature attempt at abandonment is needed.

I thank Martin Marshall for his comments.

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