

# The Quality and Outcomes Framework: what have you done to yourselves?

Six years ago we were asked to write an accompanying editorial to a paper by Julia Hippisley-Cox and Mike Pringle from Nottingham University looking at the time requirements to implement the National Service Framework for cardiovascular disease.<sup>1,2</sup> At that time we raised concerns that the content of the consultations was at risk of being taken over by the agendas of well-meaning single disease interest groups, and that there were potential opportunity costs of this change. The 2004 Quality and Outcomes Framework (QOF) contract, based on 146 outcome indicators, links income to performance on a scale never before seen in the UK. To outsiders it seems that UK general practice has moved from having an internal framework of professionalism that supports it, to an external framework that holds it up and embraces a market model of healthcare with performance linked bonuses and its own acronym: P4P (pay for performance).

New Zealand looks set to follow the same path. On reading through the QOF indicator list, our concerns have deepened. The mix of indicators looks like a hotchpotch of intermediate clinical and practice based 'outcomes'. The list has the hallmark of those who think in terms of contracts, numbers, and linear production-line performance targets. This all purports to be in the name of evidence-based care, but we have looked in vain for evidence underpinning this radical, risky, and very expensive policy.

The issue at the core of the relationship between QOFs and general practice is not the indicators chosen nor whether GPs should be paid what they are worth. The fundamental issue is a philosophical one that centres on the nature of professionalism, professional values, and the concept of good care.

State-driven clinical priorities are risking general practice's disciplinary identity. By allowing ourselves to be coerced into persuading patients to follow particular treatments in return for financial

gain, we risk further losing our professional identity and reputation. More importantly, the very presence of the framework is deeply corrosive to the ethical practice of medicine. What were you thinking?

To quote one UK GP: 'The profession has essentially been bribed to implement a population-based disease management programme that often conflicts with the individual patient-centred ethos of general practice.'<sup>3</sup>

The QOF incentivises (coerces) GPs, in turn, to persuade patients. Payments equate to 20% of NHS income (over £1 billion in total per annum).<sup>4</sup> What starts as an incentive becomes coercion when it represents such a large proportion of practice income that its loss becomes a credible threat.<sup>5</sup>

The intended outcomes are explicit; the unintended consequences are worrisome, unknown and, in many instances, unmeasurable. The costs in the short and long term include loss of respect for the autonomy of doctors and patients, loss of critical thinking, de-professionalization, and ultimately demotivation with a loss of core values.

Robin Downie has described the characteristics of a profession that underpin good care: a credible profession must be independent of the influence of the state or commerce; disciplined by its own professional association; have claim to and be actively expanding its unique knowledge base; and concerned with the education of its members.<sup>6</sup> Professional relationships and attitudes are special and require a combination of beneficence and integrity. If a profession is widely recognised as satisfying these conditions, then it will have moral and legal legitimacy, and its pronouncements will be listened to with respect.<sup>6</sup>

The progressive loss of independence to external influence is central to the de-professionalization inherent in the QOF. The medical profession is already struggling to disentangle itself from the

influence of the pharmaceutical industry, and now faces increasing, unwanted, and often unrecognised influence from the state. Both threaten its independence.

It has become unfashionable to talk of compliance in the framework of the doctor-patient relationship.<sup>7</sup> However, the notion of compliance has now moved up a level — one step removed from the patient — to include state-determined definition and micromanagement of what constitutes good care in general practice. The QOF payments amount to up to £42 000 per GP, with an average increase of £23 000 in the 2004–2005 year.<sup>4,8</sup> At this level, payments introduce a significant conflict of interest which arguably is no different, in principle, to taking payments from a pharmaceutical company for using a particular drug.

By following a medicine-by-numbers, pay-for-performance path under the QOF, the profession cannot lay claim to its own knowledge base and priorities. There is a real risk that general practice will lose its ability to deconstruct evidence and apply it critically in a biopsychosocial model. The systematic mistrust of general practice implied in paying for performance, and in care driven by 'one size fits all' treatment guidelines, undermines the moral imperative of beneficence. Evidence shows that using external incentives to drive behaviour decreases internal motivation.<sup>9</sup>

At what point do we switch from educated professional to technician? Patient centredness is still (we think) a core value of primary care for GPs and for patients. In a systematic review of patient priorities for GP care, humaneness ranked as the top priority ahead of competence and accuracy. The emphasis was quality of care rather than quality of data.<sup>10</sup> QOF will never deliver on the elements that patients value so much: the giving of hope, appreciation of context, trust, reassurance, faith, the complexity of general practice, and the management of multiple chronic conditions with their

attendant pharmacological intricacies. In an era that values respect for autonomy, it beggars belief how we could have arrived at a point where the very nature and content of the doctor–patient encounter is prescribed by the state.

This loss of professionalism has profound implications and may result in a change in professional values, in particular for new GPs. The message is that these QOF priorities are the most important aspects of care. The focus has shifted from patients and the diseases that make them suffer, to the diseases themselves and their measurement within the patient.

QOF by its nature promotes simplicity over complexity and measurability over meaningfulness. Unfortunately, these latter dimensions are usually inversely related. There are likely to have been short-term gains, with the formula encouraging GPs to be more rigorous in control of diabetes, blood pressure, and perhaps stricter with themselves about certain targets, but in the long term this is not a good way to practise medicine.<sup>11</sup> There is the obvious danger that the QOF will be ‘gamed’: data can be massaged by diagnosing milder symptoms or risk factors to inflate denominators and reduce average severity measures. This will be music to the ears, and to the cash registers, of the pharmaceutical industry; most recent and obvious examples are for pre-diabetes and pre-hypertension.<sup>12</sup> Since April 2004, sales of QOF-related drugs have contributed to an annual increase in the national medicines bill by 15%, compared with 10–12% previously.<sup>13</sup> A quarter of all points relate to medication use and achieving medicine-related targets. Industry is using the achievement of QOF targets to assist in their marketing strategies and are also targeting non-physician prescribers.<sup>13</sup> Influencing the QOF represents a surer return on investment than even influencing guidelines. Pharmaceutical reps are advised to:

‘... prove that your visit is truly on the practice’s agenda, this raises the prospect of your becoming a genuine business partner who can provide products and services that are business-critical to your key practices,

while significantly improving access and sales for yourself.’<sup>13</sup>

The putative benefit for QOF is the promotion of evidence-based medicine in addressing specific population health issues that results in population health gain. There is evidence that these changes were well under way before the QOF.<sup>14</sup> The QOF rewards GPs for what they had already achieved. There is nothing inherently wrong with doing this; however, the impression that GPs performed much better than expected has reinforced the widely held perception that UK GPs will only do something worthwhile for additional money. This threatens public confidence in and respect for the profession.

There is a certain irony in this as the other putative benefit of the QOF is public accountability for providing quality care. Professional development has transformed into professional management. There is a loss of trust implied by political and regulatory initiatives, that is, removing professional self-regulation and enforcing micromanagement to force ‘quality’ care. This, together with portrayals of physicians as self serving and money driven, is at odds with public opinion polls that consistently place doctors and nurses at the top of the list of trusted occupations.

The QOF measure has poor discriminatory value (with the median achievement of 97% of the available clinical indicator points), and the narrow interquartile range makes a nonsense of ranking tables.<sup>8</sup> Information management is in danger of becoming an end in itself. The burden of disease for populations and individuals risks transformation into the burden of data.

*Where is the Life we have lost in living?  
Where is the wisdom we have lost in knowledge?  
Where is the knowledge we have lost in information?*

Choruses from ‘The Rock’. TS Eliot

There is little spare capacity in general practice. It is implicit in the QOF payment

schedule that other areas of care will be accorded lower priority and less time. The effects of accepting substantial money for this tiny subset of general practice will inevitably cause significant change in activity. Some suggest that with such large sums available no fence is too high to jump.<sup>15</sup> Self-fulfilling surrogate endpoints, like recording of risk factors and smoking status, will improve — if you pay for physicians to record something, they will record it. It is unknown whether these recordings will translate into health gains, or what harms may occur as a result of activities no longer carried out as a result of QOF prioritisation.

The worry about disempowerment of the physician is not about power and hubris but the risk of damaging the confidence of doctors to make decisions in the best interests of the individual in the face of uncertainty and fragments of evidence. Evidence should be integrated into care but its known flaws mean that it should inform, not drive good care.

James Willis presented a challenge for modern society: ‘the proper use of central authority’.<sup>16</sup> He argues that: ‘the greatest challenge facing contemporary medicine is for it to retain ... or perhaps *regain* its humanity — without losing this essential foundation in science ... To find a middle way.’<sup>17</sup>

Reframing Willis’ analogy of the ‘sea monster and the whirlpool’,<sup>17</sup> general practice will have to plot a course between the Scylla of state-regulating micromanagement and the Charybdis of the pharmaceutical industry’s commercial interests. It would seem sensible to try to navigate rather than close our eyes and trust that all will be well.

General practice has accepted an initially very well paid, but disempowering, system of micromanagement, characterised by an increasing focus on a small number of measurable yet relatively meaningless indicators. Greater status is given to what is written or coded than to what is spoken between doctor and patient.

We do have an alternative. Most GPs wish to do a good job. Most recognise that where there is clear evidence that a particular course of action or inaction will result in benefit or harm, then their role as

advocate for their patients is to make them aware of those options. Patients value their physician's independent opinion on the quality and relevance of that evidence for them.

We can advocate for a system which promotes evidence-informed care supported by a professional education system which uses evidence and feedback, guidance not guidelines, and provides options (with attendant uncertainties) for GPs and patients to interpret for themselves.

So, six years ago we looked at a National Service Framework — 'Not So Fast perhaps'.<sup>1</sup> Now you, and perhaps soon we, have a QOF which is Quite Obviously Flawed.

#### Dee Mangin

Senior Lecturer in General Practice, University of Otago, Christchurch, New Zealand

#### Les Toop

Professor of General Practice, University of Otago, Christchurch, New Zealand

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#### ADDRESS FOR CORRESPONDENCE

#### Dee Mangin,

Department of Public Health and General Practice, University of Otago, Christchurch, New Zealand

Email: [derelie.mangin@chmeds.ac.nz](mailto:derelie.mangin@chmeds.ac.nz)

## A truly global partnership for health

Despite health being a global right, available data show that in many countries, this right is not yet realised. This is starkly illustrated in the health statistics from around the world. For example, figures show that life expectancy in Liberia for a woman is only 44 years (compared with 81 years for a woman in the UK), and that the maternal mortality ratio in Afghanistan is a staggering 1600/100 000 live births (compared with 11/100 000 live births in the UK). Malaria still kills more than 1 million people annually, most of them children under 5 years of age, and contributes to an under-5 mortality rate in some African countries of over 200 deaths per 1000 live births (or roughly one in five). Up to 45 million people worldwide are living with HIV, two-thirds of them in sub-Saharan Africa.<sup>1</sup>

At the start of the millennium, the world's leaders united in a global commitment to reduce poverty, health and other

inequalities through the Millennium Development Goals. These goals call for countries to work collectively to make changes in current practice and to commit the necessary resources to eradicate extreme poverty and hunger, reduce child mortality, improve maternal health, and combat HIV and AIDS, malaria, and other diseases by the year 2015. Achieving the Millennium Development Goals is a central tenet of the UK's current development assistance. To date some progress has been made towards reaching the targets set, but in many countries, particularly in sub-Saharan Africa, the gains are either patchy or non-existent.<sup>2</sup> According to current projections the targets will not be met in many countries, highlighting the need for an urgent and considerably enhanced effort from the global community.

One of the greatest challenges to strengthening the health sector in many

countries, and delivering on the health Millennium Development Goals, is the availability of trained health staff to support the health system. In 2006 the World Health Organization (WHO) published its annual report highlighting the serious shortage in human resources for health. It was estimated that 57 countries have critical shortages in health staff, equivalent to a global shortage of some 2.4 million doctors, nurses, and midwives, or 4 million health workers if managers and other public health workers are included. This shortage is felt most acutely in low income countries with a combination of factors leading to the current situation, including under-investment in the health system; the impact of AIDS on life expectancy of health staff; and the loss of trained staff to other countries, including the UK. The 2006 WHO report marked the launch of a 10-year Global Plan of Action to tackle the issue.<sup>3</sup>