

The Review

Payment for Performance and the QOF:

are we doing the right thing?

The new general practice contract introduced in 2004, fundamentally changed the professional landscape for British GPs. It moved from a largely capitation based system of remuneration to a system that aimed to reward quality, where a significant proportion of income could be earned by achieving evidence-based quality targets. These targets were set out in the Quality and Outcomes Framework (QOF) and represented £1.6 billion in investment contributing to 20% of practice income. Never before has there been such a large-scale system of payment for performance (P4P).

The aims of the new contract were to improve the quality and unequal distribution of care in general practice, to help the retention and recruitment of GPs, as well as reward practices for the delivery of existing high quality care.¹ While there is some evidence that change has been in a positive direction towards achieving these aims concern has been expressed regarding the unintended opportunity costs of the new contract.² The new contract has also generated areas of moral controversy that need to be acknowledged, debated, and addressed.

A MORAL DILEMMA?

I had worried that, by being paid to implement evidence-based guidelines, my work would become a restricted, target-driven exercise that shifted the balance of my consultations to a doctor and disease-centred agenda. I had been concerned that this created conflicts of interest and how that might undermine, not only trust by my patients in me as a doctor, but also the trustworthiness of the profession. I worried that in some domains I was taking money to engage in work that I felt had limited value for my patients, money that could possibly be spent in more useful areas. Was I colluding in a wholesale folly of medical practice and worse still, why wasn't I doing anything about it? Had my mouth been effectively 'stuffed with gold'?

Lehman and Krumholz in their *BMJ* editorial, questioned the validity of the QOF glucose lowering targets '... the new QOF target encourages an outdated strategy and one that may not provide a net benefit to patients'.³ Hiding in the 'Rapid Responses' that followed this article, a 5th year medical student, rather like the little boy in the

Emperor's New Clothes, asked whether QOF was ethical?⁴ He questioned whether doctors could be expected to maintain their objectivity in interpreting and applying data to meet the needs of their patients if 'being presented with a cheque'. He said, 'That GPs are being forced into glaring conflicts of interest seems to me brazenly unethical ...'. One author claimed 'QOF has subtly corrupted the ethics of the medical profession and it is time it was abolished'.⁵ Other responses to this letter attempted to justify QOF with what seemed very weak and confused moral arguments. Mangin and Toop writing in the *BJGP* describe many of the potential ethical conflicts that QOF raises. They argue its very presence is 'deeply corrosive to the ethical practice of medicine'.⁶

The literature points towards several strands of ethical dissonance:

- the trustworthiness and transparency of the QOF process;
- the applicability of the evidence that underpins QOF;
- payment for performance affecting trust and the doctor-patient relationship; and
- the effect of payment for performance on professionalism.

THE DEVELOPMENT OF QOF

One of the key ethical concerns of any new policy development is one of transparency. When the new contract was introduced there was a feeling that it was negotiated behind closed doors between the Department of Health and the General Practitioners Committee of the British Medical Association. There was little clarity as to the process by which QOF indicators were established other than:

*'The quality standards have been developed by an independent expert group on the basis of the latest evidence and in line with current professional practice.'*⁷

While there is no wish to cast doubt on the process, the lack of transparency makes it difficult to provide adequate reassurance. It seems strange that a major new health policy development can be introduced to an entire population without ethical scrutiny.

Since 2005 there has been a more transparent stewardship of the QOF. From

2009 the National Institute for Health and Clinical Excellence (NICE) has led the process of developing QOF. This has given some reassurance about the clinical effectiveness and cost effectiveness of new QOF indicators. An added advantage of this change is that it may reduce political interference in clinical care.¹

THE APPLICATION OF QOF

Many of the QOF indicators are based largely on generally accepted evidence. Pay for performance incentives have encouraged implementation of sound clinical guidance. However, many practitioners are cautious of the blind application of guidelines. Evidence-based medicine and clinical guidelines are useful tools to help clinical management but are best applied in conjunction with wider holistic approaches to clinical decision making.

Concern has been expressed whether the evidence for which QOF indicators are based is generalisable to general practice populations. Evidence gathered from motivated trial participants may not be applicable to patients in general practice, who may have multi-system diseases and complex psychosocial problems.

Slowther and colleagues, writing on the ethics of evidence-based medicine in the primary care setting, conclude that:

*'The appropriate use of good research evidence to inform patient care must be encouraged, but its elevation to a position of overriding importance, particularly if associated with incentives to clinicians for its implementation, gives rise to ethical concerns in relation to both individual autonomy and distributive justice.'*⁸

By incentivising evidence-based guidelines through a P4P system, QOF risks promoting a public health goal that trumps what may be best for the individual patient. Does the end (improvement in public health) justify the means? We can draw comfort in contrasts with US health care that favours individual autonomy at the expense of distributive justice. However, we still need reassurance that, in the UK, we have got the balance right.

QOF does, of course, protect clinical judgement and respects the autonomous right of patients to dissent through the

process of 'exception reporting'. However, exception reporting may raise more issues of moral ambiguity for GPs. High levels of exception reporting can be viewed as evidence of clinicians 'gaming' the system, although it could equally be interpreted as evidence of being inherently patient-centred. Low levels of exception reporting could indicate an over-zealous system-centred approach to disease management.

Where it is harder to reach the payment threshold target there is an incentive for clinicians to 'game',⁹ however, it is probable that patients in lower socioeconomic groups need much more input and clinician time and are more likely to be on 'maximal tolerated therapy'. This is in contrast to patients belonging to a practice that serves an affluent, healthier, more health-literate, self-managing population who require little input to achieve payment thresholds. Levels of exception reporting may correlate more to the characteristics of individual GPs and practices rather than the demographics of their patients. Finally, there is concern that once patients have become exception reported they receive less attention.¹⁰

PATIENT TRUST

Paying physicians to undertake certain clinical activity represents a potential conflict of interest. Tonelli identifies some of the unintended problems of P4P systems;¹¹ their potential to exclude the sickest patients and improve documentation with little effect on actual quality. An inherent assumption is that the QOF is structured so that clinicians' interests correlate with those of their patients and is therefore ethically defensible. Tonelli cautions that the clinician needs to be aware that this may not apply to the individual patient who may have different value systems.

Should the clinician disclose to the patient that while she believes it is good practice to recommend a specific treatment her income also benefits? Doctors may worry that such a disclosure would affect the patient's decision making and reduce the uptake of beneficial treatments (and reduce income). Patients may distrust the doctor because they have a financial interest and feel unduly coerced. They may question whether the doctor is acting solely out of altruistic intention for their benefit.¹² In contrast, a doctor may be uncomfortable asking a patient to complete a depression severity questionnaire if she perceives it is more about financial interest than clinical need.

Studies in the US suggest disclosure of financial incentives has a positive affect on

patient trust.¹³ It would be useful to clarify whether this is an issue in the UK health system, which has very obvious differences. Work needs to be done to see if doctors' incentives are ethically worrying to patients. If so, disclosure may be best achieved through a public information campaign.

Finally, there is a possibility that patient satisfaction in their encounters with clinicians may be undermined with the suggestion that QOF supports a doctor-centred agenda and undermines shared decision making.¹⁴ There is evidence that patient-centred medicine has a positive effect on patient satisfaction, empowerment, concordance, clinical outcomes, and cost-effectiveness.¹⁵ GPs and patients will need reassurance that patient-centeredness is not being undermined.

PROFESSIONALISM

Mangin and Toop discuss Downie's concept of professionalism and the importance this has on moral and legal legitimacy.⁶ They argue that QOF and payment for performance risk undermining professional independence. This allows health care to become overly influenced by external forces such as the state and the pharmaceutical industry. Relman expands on how the introduction of commercialisation and the free market threatens medical professionalism and endangers the ethical foundations of medicine.¹⁶ He suggests:

'When physicians think of themselves primarily in business, professional values recede and the practice of medicine changes.'

This can have many undesired consequences: the state, for the sake of political imperative, can coerce doctors through P4P to undertake clinical activity which they feel is of limited value to their patients. It also restricts their ability to offer services that may be of more value to their patients. For instance, GPs could offer extended hours in a part of the country that has little demand for such a service whereas it might be preferable to use that funding to run a more meaningful service.

Medical professionalism in turn can act as a public safeguard against political or commercial zeal. If professionalism is undermined and weakened, doctors may be forced into morally questionable activity. This can cause work saturation, demoralisation, and disempowerment and undermines clinical leadership. One author has described QOF as a 'Trojan Horse'¹⁷

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presumably allowing others to infiltrate and undermine the professionalism of GPs. Despite his outrage there was a sense of powerlessness and capitulation; 'I am sick to death of it, and can't wait to retire'.

CONCLUSION

Moral ambiguity and ethical concerns arise out of P4P, which can pose a threat to our value systems. GPs need reassurance that the process and opportunity costs are just.

There is a need for further research not only to evaluate the nature and extent of moral concerns that health professionals may have under an incentives-based contract, but also those of their patients. There is always the reassuring possibility that patients may be less anxious than their doctors in this regard.

New challenges lie ahead for general practice with the introduction of commissioning and competition. It seems possible that general practice will be subsumed to the ideology of the free markets.

This poses serious challenges to the integrity and trustworthiness of the profession but also ultimately, the quality and safety of patient care. With this in mind there is an overriding need for ethical debate, evaluation, and guidance to safeguard the values of general practice that gives both patients and professionals moral confidence and reassurance.

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