Should the Quality and Outcomes Framework be abolished? No

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It is increasingly recognised that 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 (P4P) scheme in the world, was introduced in 2004 to incentivise evidence based practice and reduced variations in care for chronic conditions.[2] The QOF is a complex intervention comprising a number of elements including financial incentives, support for structured and team-based care, and the pursuit of evidence based care. As part of the new General Medical Services contract it included other changes such as an opt-out from out-of-hours care and greater skill-mix.

There are early indications that the QOF might be associated with better recorded care, enhanced processes, improved intermediate outcomes,[3] reductions in inequalities[4] and provide 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 prior to the QOF but continue to be strengthened as a result of it.

Detractors argue that the QOF is based on flawed evidence; that it has not led to real improvements in care or outcomes; that it will lead to worse unincentivised care and widen inequalities; that unintended consequences of gaming, overtreatment and a focus on pharmaceutical rather than psychosocial care will result; that by emphasising ‘vertical’ disease management rather than horizontally-integrated holistic care it is not patient centred; that it de-professionalizes doctors; and finally, that it is not a good use of resources.[7, 8] We should examine each of these arguments in turn.

Is the QOF really based on flawed evidence? Indicators were developed from guidance or consensus and even critics acknowledge that many QOF indicators are based on sound evidence.[8] However, where this is not the case, or when evidence changes, it does need to be addressed and the involvement of the National Institute for Health and Clinical Excellence (NICE) should support this.[9] There will always be a fine judgement 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.

Quality of care has improved for some clinical areas since the QOF.[10] Although it is true that benefits attributable to the QOF have been small, these cannot simply be an effect of better recording because gains have also been reported in non-QOF clinical domains.[11]. Commentators that care would have continued to improve along secular trends for long term conditions such as asthma, diabetes or cardiovascular disease but it may have been over-optimistic to expect the QOF to deliver significant improvements above pre-existing trends, given the considerable investment already made through nationwide strategies such as National Service Frameworks; and yet, there have even been modest improvements above the secular trend for care of asthma, diabetes[10] hypertension and cholesterol [12] as well as considerable improvements for epilepsy which became a focus since the QOF was introduced.[13]

Although care of clinical conditions not included in the QOF has not improved there has not been the worsening of unincentivised care that some have warned of.[14] The QOF was not designed to reduce health inequalities due to socioeconomic disadvantage and it is unlikely to do so. Despite this, inequalities in care have shown narrowing between the most and least deprived areas;[4] although the reason for this is less clear,[15] a possible explanation is that the QOF encourages greater consistency of care irrespective of deprivation.

Gaming is a concern - it is known to be a feature of many systems including those that are P4P driven. However, there has been little evidence of gaming in the QOF in spite of or perhaps due to a rigorous system of checks at various levels.[16] On the contrary, it has been reported that practices could have treated an eighth fewer patients without falling below upper QOF thresholds[17] and levels of exception reporting continue to fall year on year.[18] Nevertheless, vigilance and systems to detect and prevent gaming are needed.

Finally, is it really plausible that the QOF is turning GPs 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 QOF achievement or practice profits; they are not motivated solely by money but rather aim to provide the best care for their patients.[19] 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.[19]

Many GPs themselves are concerned about the unintended consequences; that QOF might adversely affect care by reducing time for patients, failing to address patients' concerns or impairing continuity of care.[6] A background of speciality training, years of experience and embedded ethical practice have led most GPs to try and integrate and normalise[20] the complex organisational demands of the QOF into their current work by investing in staff, developing

teamwork and re-organisation aligned to improving reliability of care.[21, 22] Rather than subverting person centred care the essential features of general practice[23] are alive and well; 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.[24]

The QOF 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 base that underpins it. Indicators with poor evidence should be removed, some which have reached a ceiling may need to be retired [25] and new indicators should be introduced after piloting.[26] A finessed approach at improving it rather than a premature attempt at abandonment is what is needed.

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Acknowledgement
My thanks to Martin Marshall for his insightful comments on the paper.

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