

Editorial

The Quality and Outcomes Framework: triumph of technical rationality, challenge for individual care?

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The pace of organisational change within the National Health Service over the last two decades has been bewildering. Yet for all that, the rituals and routines of day-to-day general practice have seemed to endure without significant alteration. By contrast, the impact of the Quality and Outcomes Framework (QOF) has, arguably, exceeded that of any other policy development since the Family Doctors' Charter of 1966. This huge national experiment in performance related pay has understandably attracted much international attention and is likely to continue to do so.^{1,2}

Since its introduction in 2004, the effects of the QOF on quality of care have been the subject of pained debate. Six years on, that debate is being informed by an accumulating body of research. As the political and economic environment in the UK heralds further organisational disruption, searching analysis of this evidence is timely. This themed issue of *Quality in Primary Care* provides just such a multifaceted and state-of-the-art analysis of the QOF.

Lester and Campbell begin by examining the origins of the QOF framework dating back to precursors that attempted to promote evidence based primary care. Much of the development of performance indicators was undertaken in their own National Primary Care Research and Development Centre. The metamorphosis of what began as a scheme for quality and improvement into a regulated, contractual framework now requires burgeoning technical support for development and implementation of 'feasible, valid, reliable and piloted "Qofable" clinical indicators'.³

Peckham and Wallace show us the broad canvas of international evidence on pay-for-performance (P4P) schemes. It is striking to what extent the empirical research they amass already relates to the QOF. They find that, while P4P schemes can affect clinical behaviour

and processes, the impact on more widely defined aspects of quality such as patient experience or outcomes is less clear. Many of the concerns arising from implementation of this new scheme were predictable on the basis of previous research on P4P.⁴

Partly because of its scale and complexity, the impact of the QOF will always be hard to quantify. Thus far, there is weak evidence for what in North America is sometimes called the 'street lamp effect': activities outside the glare of financial scrutiny being neglected. Steel and Willems, in their review of research on the QOF, find that care for patients with conditions included in the QOF broadly increased in line with preceding secular trends, while care of conditions outside the remit of the QOF has neither improved nor deteriorated. They also conclude that there were significant, albeit small, improvements for some conditions, such as diabetes and asthma, better recording for others, such as epilepsy, and narrowing in some aspects of inequitable care.⁵

A central rationale for the QOF was longstanding variation in the quality of primary care provision. In particular, successive reports had highlighted poor quality care in more deprived, urban areas. Ashworth and Kordowicz also support the notion that QOF has increased the quality of chronic disease management for some conditions and narrowed, if only slightly, inequalities in healthcare delivery.⁶ To some extent, these improvements are more apparent than real – the product of better and more comprehensive data collection. Although these authors find little evidence of large scale 'gaming', there are indications in other studies of recording bias⁷ and data manipulation.⁸

Focusing their attention on population-wide health improvement and reduction of inequalities, Dixon and Khachatryan examine differences in performance

between practices in areas with the worst health and deprivation indicators and those in other areas. Their research finds some evidence of narrowing in the gap but this cannot be attributed with certainty to the QOF. They suggest that the limited impact of the QOF reflects the absence of incentives explicitly addressing health inequalities. This should be an area for future development of QOF indicators.⁹

In essence, judgements on the QOF involve balancing sensitive evaluation of the health gains against assessment of its costs, many of which are hard to quantify. Just how hard is apparent from the contribution by Checkland and Harrison.¹⁰ In their analysis of the effects of the QOF on the front line of practice and organisation, they illustrate the law of unintended policy consequences: in this instance, the transformation of the primary care workforce and labour market. They find that greater specialisation among practice nurses has in turn promoted extension of the role of other cadres such as healthcare assistants in some practices. New roles and hierarchies have been created and accepted within practices. Practice staff have frequently seen their roles expanded in the past as now but have not always shared the financial benefits. This may explain loss of motivation and demoralisation among staff encountered in other studies.¹¹

The transition to a nurse-led primary care system is being accelerated by the QOF in other ways. Since 1997 and the introduction of Personal Medical Services, it has been possible to employ salaried practitioners. Eventually this opened up the primary care market to private providers. The QOF has accelerated the stratification of medical roles. Salaried doctors and nurses with special interests are increasingly being seen as a more 'cost efficient' option when senior medical members of the primary health team need to be replaced.¹² The exigencies of the market may over time drive the numbers of 'expensive' GP principals down with the negative consequence of limiting the potential for career advancement for doctors entering general practice.

Doctors are divided in their views on QOF. While acknowledging that the QOF may have improved quality of care and team-working in some areas, many are concerned about the depersonalising impact of the 'box ticking culture', the intrusive impact of computerised prompts and the move to a more biomedical model of care and away from person-focused care and continuity. This ambivalence is partly explained by the concept of the 'indeterminacy/technicality ratio' where 'technicality' refers to scientific evidence and rationality whilst 'indeterminacy' is synonymous with uncertainty, and individualisation.¹³ Some practitioners remain sceptical about the evidence base supporting new indicators. Others feel that the QOF is reducing continuity of care and promoting an overly mechanistic approach to chronic disease management, in which

'medicine by numbers' reduces clinical practice to a series of dichotomised decisions and reinforces a reductionist view of quality. The old aphorism, 'not all that can be measured is important, not all that is important can be measured', is often cited. Ironically, many important consequences of the QOF might evade measurement.

The Griffiths reforms of the mid-1980s first introduced private sector management methods into the NHS. In historical terms, from the perspective of policy makers, the QOF represents a high water mark in the onward march of what Harrison has elsewhere termed 'scientific managerialism'.¹⁴ The QOF provides commissioners with albeit crude tools for comparing providers as they seek to break the monopolistic stranglehold of traditional general practices in this health sector. But the 'McDonaldization' of general practice, as patients with multiple pathologies pass down various clinic-based production lines leaves little room for the deeper professional relationships patients want.¹⁵

Surprisingly little is known of what service users, the most important stakeholders, think but the QOF has begun another revolution in the assessment of primary health care quality through the incorporation of systematic patient feedback. Despite this, many patients probably do not understand the financial framework that general practice operates within and the effect of payments on the actions of the professionals that care for them.

Finally, as we look to the future, we should not ignore important lessons from the past. In the confusion over whether QOF is a quality improvement mechanism or part of a regulatory framework, we should remember that QOF is part of a wider complex system, 'which is perfectly designed to get the results it achieves'.¹⁶ Many of the principles underpinning the QOF, the internal market, competition, regulation and many other aspects of the system we are now operating within are a direct challenge to the philosophies of improvement pioneers of the past. Deming's five 'deadly diseases'; lack of constancy of purpose, emphasising profits and targets, changing management, relying on annual ratings of performance and using visible figures only, are rife in the NHS. This suggests, from at least one perspective, that the current system is not geared for improvement.¹⁷

For all those interested in the development of primary care in the UK, these contributions provide much to reflect upon. This themed issue will be expanded with a number of other chapters from these and other international experts, including Barbara Starfield, into a forthcoming book entitled *The Quality and Outcomes Framework – transforming general practice*. The QOF is a natural experiment in progress; verdicts even at this stage of its evolution must be qualified. The QOF and lessons from it are being considered in other countries: for comparing system performance¹⁸ and

improving on the indicators used.¹⁹ The potential for its adoption is being examined elsewhere.²⁰ Policy makers and politicians should be minded to heed the emerging evidence.

REFERENCES

- 1 Roland M. Pay-for-performance: too much of a good thing? A conversation with Martin Roland. Interview by Robert Galvin. *Health Affairs (Millwood)* 2006;25: w412–w419.
- 2 Shekelle P. New contract for general practitioners. *British Medical Journal* 2003;326:457–8.
- 3 Lester H and Campbell S. Developing Quality and Outcomes Framework (QOF) indicators and the concept of 'QOFability'. *Quality in Primary Care* 2010;18: 103–9.
- 4 Peckham S and Wallace A. Pay for performance schemes in primary care: what have we learnt? *Quality in Primary Care* 2010;18:111–16.
- 5 Steel N and Willems S. Research learning from the UK Quality and Outcomes Framework: a review of existing research. *Quality in Primary Care* 2010;18:117–25.
- 6 Ashworth M and Kordowicz M. Quality and Outcomes Framework: smoke and mirrors? *Quality in Primary Care* 2010;18:127–31.
- 7 Carey IM, Nightingale CM, Dewilde S, Harris T, Whincup PH and Cook DG. Blood pressure recording bias during a period when the Quality and Outcomes Framework was introduced. *Journal of Human Hypertension* 2009;23:764–70.
- 8 Maisey S, Steel N, Marsh R, Gillam S, Fleetcroft R and Howe A. Effects of payment for performance in primary care: qualitative interview study. *Journal of Health Service Research and Policy* 2008;13:133–9.
- 9 Dixon A and Khachatryan A. A review of the public health impact of the Quality and Outcomes Framework. *Quality in Primary Care* 2010;18:133–8.
- 10 Checkland K and Harrison S. The impact of the Quality and Outcomes Framework on practice organisation and service delivery: summary of evidence from two qualitative studies. *Quality in Primary Care* 2010;18:139–46.
- 11 Edwards A and Langley A. Understanding how general practices addressed the Quality and Outcomes Framework of the 2003 General Medical Services contract in the UK: a qualitative study of the effects on quality and team working of different approaches used. *Quality in Primary Care* 2007;15:265–75.
- 12 Griffiths P, Murrells T, Maben J, Jones S and Ashworth M. Nurse staffing and quality of care in UK general practice: cross-sectional study using routinely collected data. *British Journal of General Practice* 2010;60:36–48.
- 13 Jamous H and Peloille B. Changes in the French University-Hospital system. In: Jackson JA (ed) *Professions and Professionalisation*. Cambridge: Cambridge University Press, 1970, pp. 111–52.
- 14 Harrison S, Moran M and Wood B. Policy emergence and policy convergence: the case of 'Scientific Bureaucratic Medicine'. *British Journal of Politics and International Relations* 2002;4:1–24.
- 15 Ritzer G. *The McDonaldization of Society* (5e). Thousand Oaks, California: Pine Forge Press, 2008.
- 16 Nolan TW. Understanding medical systems. *Annals of Internal Medicine* 1998;128:293–8.
- 17 Deming WS. *Out of the Crisis*. Cambridge, MA: Massachusetts Institute of Technology, 1962.
- 18 Crosson JC, Ohman-Strickland PA, Campbell S *et al.* A comparison of chronic illness care quality in US and UK family medicine practices prior to pay-for-performance initiatives. *Family Practice* 2009;26:510–16.
- 19 Mabotuwana T, Warren J, Elley CR *et al.* Use of interval based quality indicators in blood pressure management to enhance quality of pay for performance incentives: comparison to two indicators from the Quality and Outcomes Framework. *Quality in Primary Care* 2010; 18:93–101.
- 20 van den Heuvel H, Mand P, Heim S and Hummers-Pradier E. Views of German general practitioners on the clinical indicators of the British Quality and Outcomes Framework: a qualitative study. *Quality in Primary Care* 2010;18:85–92.

PEER REVIEW

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CONFLICTS OF INTEREST

None.

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