

The Quality and Outcomes Framework – transforming the face of Primary Care in the UK

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Background

- ❑ Introduced in 2004 in the UK
- ❑ >£1billion per annum
- ❑ 22% GP income
- ❑ Largest natural experiment in pay for performance (P4P) in the world
- ❑ Precursor schemes, e.g. PRICCE



Domains for quality indicators in QOF 2009

□ Clinical

- Secondary prevention of coronary heart disease
- Cardiovascular disease: primary prevention
- Heart failure
- Stroke & TIA
- Hypertension
- Diabetes mellitus
- COPD
- Epilepsy
- Hypothyroid
- Cancer
- Palliative care
- Mental health
- Asthma
- Dementia
- Depression
- Chronic kidney disease
- Atrial fibrillation
- Obesity
- Learning disabilities
- Smoking

□ Organisational

- Records and information
- Information for patients
- Education and training
- Practice management
- Medicines management

□ Patient experience

- Length of consultations
- Patient survey (access)

□ Additional services

- Cervical screening
- Child health surveillance
- Maternity services
- Contraception



Methods

- ❑ Secondary analysis of research including quasi-systematic review
- ❑ Medline, EMBASE, CINAHL, PsycINFO, Health Business Elite, Health Management Information Consortium, British Nursing Index, Econ Lit to January 2010
- ❑ 45 research papers



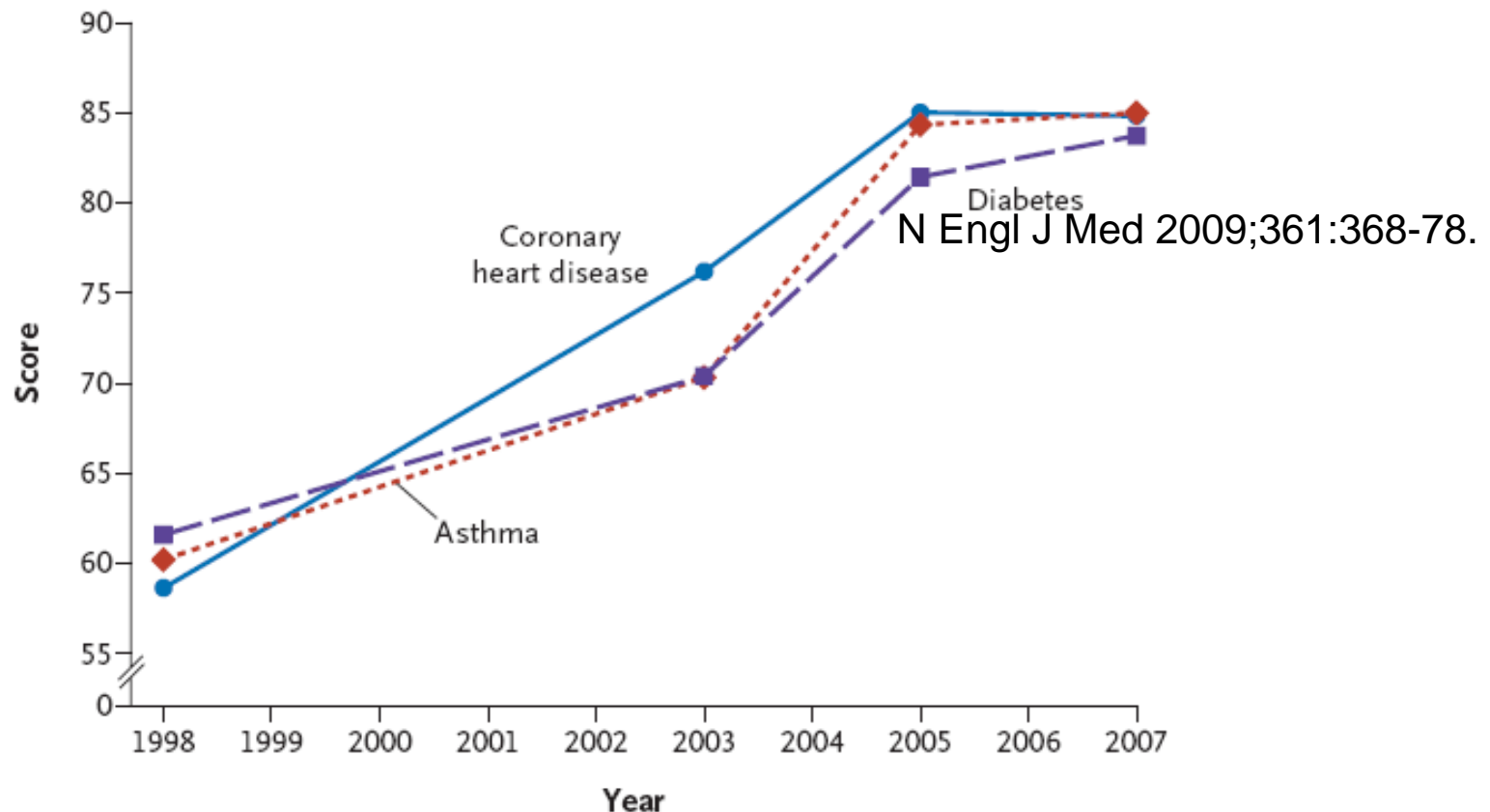
Results

- ❑ Health care gains
- ❑ Effects on population health and equity
- ❑ Costs and cost effectiveness
- ❑ Impact on providers and team climate
- ❑ Patients' experience and views



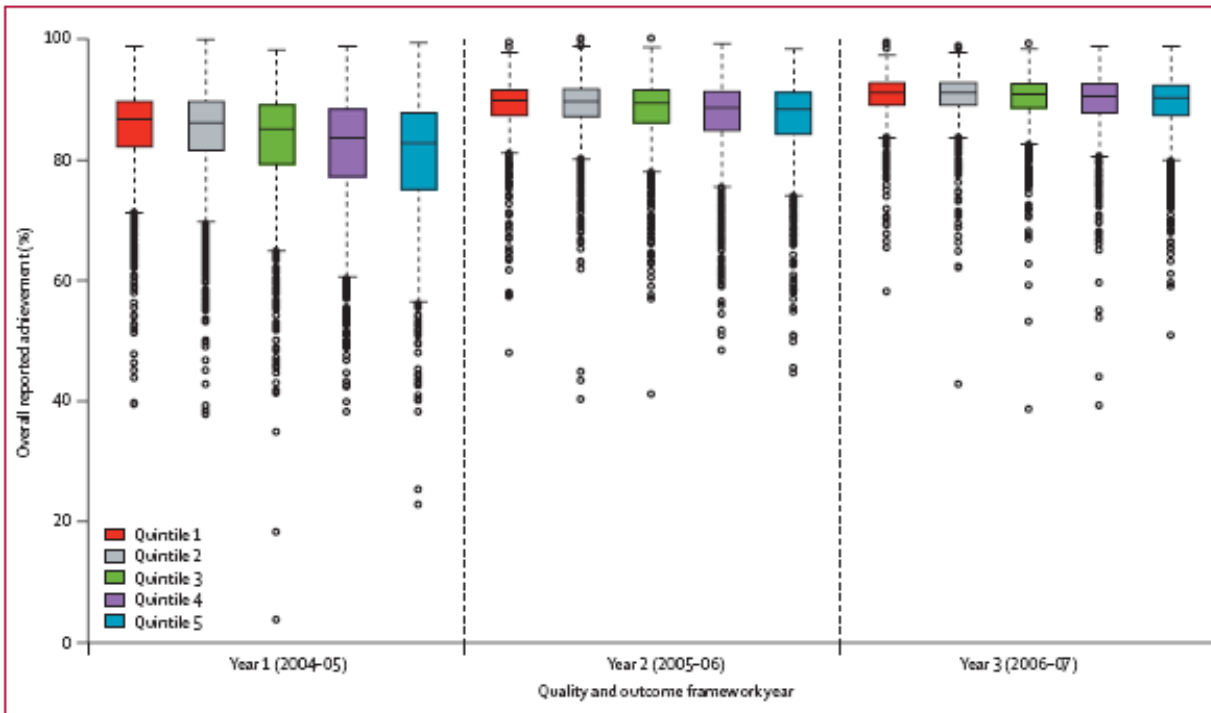
Health gains

- Real but modest gains in some areas, e.g. asthma, diabetes
- No definite improvement in CHD related to QOF
- Better recording in QOF but not untargeted areas
- No improvement in outcomes, except epilepsy



Population health and equity

- ❑ Inequalities related to deprivation slowly narrowing
- ❑ Reductions in age-related differences for CVD/diabetes
- ❑ Variable effects for e.g. gender related differences in CHD



Lancet 2008;
372: 728–36

Cost effectiveness

- ❑ No relationship between pay and health gain
- ❑ Cost effectiveness evidence for 12 indicators in the 2006 revised contract with direct therapeutic effect
- ❑ 3 most cost-effective indicators were:
 - ACEI/ARB for CKD
 - Anticoagulants for AF and
 - Beta-blockers for CHD



Team working

- ❑ Changing structures, roles and staff – nurse-led care
- ❑ Greater use of information technology
- ❑ Restratisation: 'chasers' and 'chased'
- ❑ Emphasis on biomedical focus
- ❑ Commodification of care
- ❑ Narrative of 'no change'



Patient experience

- ❑ Little research on patient related/reported impact
- ❑ Continuity and relationship affected
- ❑ Fragmentation of care
- ❑ Little explanation provided to patients

“A slim, active 69-year-old patient attending for influenza vaccine was faced with questions about diet, smoking, exercise and alcohol consumption. There was no explanation for why these questions were asked; they seemed irrelevant to having a ‘flu vaccine.’ Blood pressure and weight had to be recorded and a cholesterol test organised. A short appointment lasted almost 15 minutes without the patient having the opportunity to ask a question about any aspect of ‘flu vaccine.’”

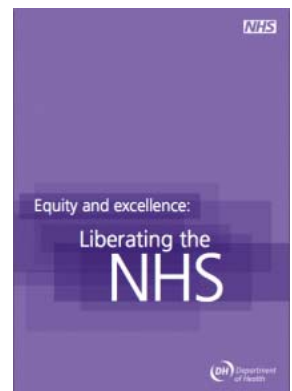
Discussion and debate

- ❑ Improved data recording and analysis
- ❑ Modest health benefits for individuals and populations
- ❑ Narrowing of inequalities in processes of health care
- ❑ Opportunity costs contested
- ❑ Unintended consequences: on workforce, professionalism
- ❑ Negative effect on care: 'McDonaldisation'
- ❑ Re-defined meaning of quality



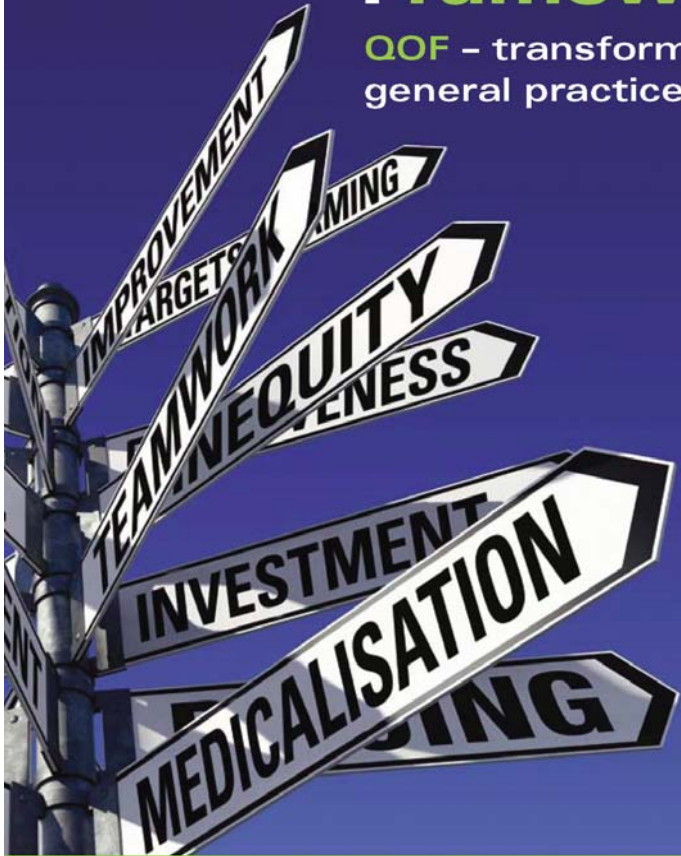
Conclusions and ways forward

- ❑ Leave indicators unchanged and anticipate higher achievement each year
- ❑ Add new indicators or conditions
- ❑ Select from a larger set of evidence-based measures
- ❑ Remove measures once agreed level achieved
- ❑ Rotate measures
- ❑ New Coalition government has other plans...



The Quality and Outcomes Framework

QOF – transforming general practice



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