

COMMENTARY

Unintended consequences: what of quality outside the QOF?

For over a decade general practice has been subject to increasing levels of governance, guidelines, incentives, and targets — what one professor of primary care has referred to as the ‘industrialisation’ of family medicine.¹ A key step-change in this came with the introduction of the new GMS contract and Quality and Outcomes Framework (QOF) in 2004. For the first time, a significant proportion (typically around 20%, but in some cases up to one-third) of general practice income was linked to performance — predominantly against biomedical indicators of quality of care, but also practice organisation, the provision of additional services and, to a lesser degree, attention to patient experience.

Gillies *et al*'s learning journey reveals an underlying disquiet with such trends; and with the QOF in particular.² While recognising the framework's potential to improve individual and population health, the authors cite ‘growing anxieties that the focus on the QOF, driven by financial incentives, may lead to the loss of something important but hard to measure in general practice’. Their concerns are widespread and justified.³

Looking purely at biomedical indicators of quality included in the QOF, the evidence suggests that GPs have been working to higher standards since its introduction, and for some indicators a causal relationship is likely. General practice returned an average of 91.3% of the maximum possible score on the QOF in the first year (2004/05), rising to 96.8% in 2007/08; significantly higher than was anticipated by the Department of Health. Concomitant with this there have been real step-changes in clinical quality for patients with certain chronic diseases, such as asthma and diabetes (though not CHD);⁴ and inequality in practice performance has fallen, with faster improvement in practices in the most deprived quintile reducing the difference in relation to the least deprived from 4.0% to 0.88%.⁵

However, as Gillies *et al*'s study shows, there is more to general practice than simply hitting QOF targets: we should always be concerned with the net effect of the framework. Quality of care is hard to conceptualise and measure in ways which capture the full range of issues that matter to patients and can be applied day-to-day. While ‘hard’ endpoints of care are incredibly important, follow the framework too rigidly and the consultation soon becomes an inhuman exercise in ticking boxes, devoid of thought and feeling. The QOF does not (and could never) include all medical conditions and the way they present in individual patients; nor capture the essence of the consultation, and the relationship between doctor and patient.⁶ Unintended consequences from the QOF's biomedical focus were anticipated, and are in evidence.

For one, quality can be substantially worse for those with conditions outside the framework, particularly the older people with complex medical problems. In face-to-face interviews in the English Longitudinal Study of Ageing, 75% of responders reported receiving endorsed quality of care for conditions included in the QOF, compared with 58% for those not.⁷ And the gap is likely to be widening. Across 18 practices, achievement against 15 indicators concerning depression and osteoarthritis increased by just one percentage point from 35% to 36% between 2003 and 2005, compared with a 16 percentage point improvement in incentivised indicators relating to asthma and hypertension.⁸

More worrying, however, is the effect of the QOF on the wider patient-centred and holistic strengths of general practice. You can never perform the gold standard of randomised control trials on every kind of patient GPs meet every day of the week, so two things remain vital. First, GPs must retain the freedom to use their experience and apply an ever-expanding base of sound research findings to individual patient care, particularly those with complex comorbidities.⁹ (The Department of Health, however, prefers to see exception reporting as ‘unacceptable’).¹⁰ Second, values remain vital. Without attention to ideals such as kindness, caring, good communication, honesty, and, above all, trust, the doctor–patient relationship is nothing¹¹ and clinical outcomes — dependent on many things that hinge on the doctor–patient relationship, including the initial recognition of patients' problems, more accurate diagnosis, and concordance with treatment advice — may well begin to flounder.^{12,13}

Although inherently difficult to measure, a number of qualitative studies (and numerous anecdotes) point to the QOF having negative effects in this area. In one survey, for example, 75.9% of nurses reported feeling the framework was undermining the patient focus of the NHS.¹⁴ The root cause of this is that the QOF has put an agenda in the clinicians' heads that is not necessarily consistent with the patients' perceptions: ‘There have been one or two occasions where I went through the cholesterol, the depression, the CHD, and everything else’, one GP reported,¹⁵ ‘... and the patient said “Well, what about my foot then?”, “What foot?”, I replied’. As one exploration into the impact of the QOF concluded:

‘The QOF scheme may have achieved its declared objectives of improving disease-specific processes of patient care ... but our findings suggest that it has changed ... the nature of the practitioner–patient consultation.’¹⁵

This is unlikely to be desirable — as those taking part in Gillies *et al*'s study well recognise. The traditional strength of general practice is precisely its conscious effort to be open-ended, inclusive, personal, and relationship-building. Whatever use the QOF has in driving clinical quality, we should forever be aware of unintended consequences and remember the wisdom of the German physician Martin H Fischer nearly 100 years ago: ‘In the sick room’, he said, ‘10 cents worth of human understanding can equal 10 dollars' worth of medical science’.

continued ...

James D Gubb

Director of Health Unit, Civitas: The Institute for the Study of Civil Society, London, SW1P 2EZ. E-mail: james.gubb@civitas.org.uk

Competing interests

The author has stated that there are none.

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