BMJ QOF editorial

Twelve years of QOF. Nicholas Steel, Paul Shekelle

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The recent 'Brexit' referendum result reminds us that behaviour is not simply determined by economic self-interest, yet the notion of paying physicians to perform remains remarkably popular. Medicare payments in the USA are increasingly linked to the quality of services, and pay for the 32,000 UK general medical practitioners working for the National Health Service has been linked to quality of care through the Quality and Outcomes Framework (QOF) since 2004.[1, 2]

Back then, quality indicators for general practice were new, and electronic medical records had become widespread in British general practice.[3] The UK Department of Health wanted to improve population coverage of evidence based healthcare processes linked to improved health outcomes, and invested £8 billion ($11 billion) over the first 3 years of QOF to reward performance in four areas: clinical, organisational, patient experience, and additional services. There were 80 clinical indicators in 2004 and 77 in 2016, covering cardiovascular disease, diabetes, respiratory disease, dementia, mental health, cancer, chronic kidney disease, epilepsy, learning disability, osteoporosis, rheumatoid arthritis, palliative care, obesity, smoking, cervical screening, and contraception.[4]

Twenty-five of the original 80 indicators had research evidence for reduced mortality, and applying that evidence to the UK population showed that QOF had the potential to reduce mortality by 11 lives per 100 000 people, as performance improved from baseline to the target for full payment.[5] Twelve years later, Ryan et al measured the actual reduction in mortality, which turns out to be 12 per 100,000 (before correction for trends in similar countries) and 4 after correction (not statistically significant).[6] The authors point out that their analysis might be underpowered, but it is as good as we are likely to get and consistent with other findings.[6, 7] QOF was not designed primarily to reduce population mortality, and appears to have achieved pretty much exactly what was expected.

What else have we learned from the first 12 years of QOF? No trials were conducted and the evidence is weak, but clear benefits are the new source of publicly available population data on major conditions, and the modest improvements seen in quality of care for chronic diseases in the framework. However, quality improvement for non-incentivised conditions such as osteoarthritis may have stagnated, continuity of care may have declined, and quality improvement may have become too narrowly focused on QOF to the detriment of other initiatives.[6, 8] There are concerns that guidelines in general, and QOF in particular, risk subverting patient-centred care, may inadvertently encourage unwanted polypharmacy and drug interactions as multimorbid older patients become the norm, and may have uncertain relevance to primary care patients.[9, 10]

QOF will become a teenager in 2017 and changes are needed. The focus should move from manipulating process measures such as blood glucose and lipid levels, to improving health in a way that has meaning for the individual patient. Examples of patient-centred quality measures include medication reconciliation after hospital discharge, and patient self-assessment of health status.[1] Most patient-centred quality measures will be less directly under the physician's control than current QOF indicators, and so caution will be needed if payments are to be attached. Financial incentives in QOF are far larger than they need to be

(one QOF point for 2016/17 is worth £165 ($223)) - indeed economists tell us that whilst financial incentives work for simple repetitive tasks they are ineffective for more complex tasks and may even be counterproductive.[11] There is a case for abandoning QOF payments altogether and simply monitoring and reporting on quality at practice level, with the resulting savings reallocated to the global sum for general practice.

Applying population evidence to diverse individuals in primary care is difficult and uncertain, and so needs to be guided by patient preferences as much as evidence. The National Institute for Health and Care Excellence (NICE) has the responsibility for managing QOF, and is developing guidance on multimorbidity and patient preferences that will be highly relevant. Good resources to share decisions on patients exist (eg http://optiongrid.org/), but more are needed and their routine use in practice needs to develop. QOF quality indicators should be accompanied by brief and clear decision aids about the benefits and risks of treatment options and the time to net benefit in cases where (small) harm is immediate and (greater) benefit delayed, to help combine evidence with patient preferences. QOF has the potential to lead the charge in the widespread implementation of patient-centred care to improve quality, if NICE have the will and courage to innovate and evaluate.

We have read and understood the BMJ Group policy on declaration of interests and declare the following interests: NS was a member of the NICE Primary Care Quality and Outcomes Framework Indicator Advisory Committee from 2009-2013.

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