The Quality and Outcomes Framework (QOF): does it reduce health inequalities?

Executive Summary
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Executive summary

Background

On coming to power in 1997, the Labour government committed to reducing health inequalities and gave significant policy attention to achieving this goal throughout its period in office. Despite significant improvements in the life expectancy of the most socially and economically deprived, the gap between the poorest and the richest has actually widened and the targets will not be met by the end of 2010. Policy documents have repeatedly identified primary care, and general practice in particular, as having an important contribution to make to reducing health inequalities. A new contract for general practice was introduced in 2004 in the UK which included a pay-for-performance element called the Quality and Outcomes Framework (QOF). This rewarded practices for meeting a range of quality targets, including improving the management of chronic diseases.

Aims

This research study set out to evaluate the impact of the Quality and Outcomes Framework (QOF) on the public health activities of general practices in deprived areas, and whether the QOF has contributed to reducing the gap in life expectancy as defined in national targets. The specific aims of this study were to:

- Assess practice performance on key public health and health gain indicators in England.
- Explore differences in practice performance on key public health and health gain indicators by characteristics of practices and their populations.
- Examine whether improvements in practice performance on the QOF are associated with other measures of health gain as measured through hospital admissions.
- Explore how general practitioners (GPs) and other practice staff in deprived practices respond to the incentives within QOF, and how they see their role in delivering public health and reducing health inequalities.
- Explore the influence of the primary care trust on the public health activities of practices in deprived areas.
- Identify the potential for the QOF to support the delivery of national health inequalities targets as measured by the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (so-called Spearhead areas) and the population as a whole.

Public health can encompass behaviour, health education, community development, empowerment, prevention and protection. However, public health activities undertaken by general practice generally include screening and clinical interventions aimed at preventing ill health, preventing recurrence of episodes of ill health, or ameliorating morbidity and mortality of those persons who already experience ill health.

**Methods**

At the outset of the study, we undertook a literature review on the role of general practice in public health, pay-for-performance schemes and the impact of the QOF. The study combines quantitative analysis of routine data at national level with in-depth qualitative interviews at practice and primary care trust (PCT) level in four case study areas in England. There were two strands to the project.

The first strand involved quantitative analysis of the following secondary data: QOF data (2004/05 to 2007/08); Hospital Episode Statistics (HES) (2004/05 and 2005/06); General Medical Services (GMS) data set (2005 and 2006); Spearhead status of PCTs; GMS/Primary Medical Services (PMS) status of primary care practices; attribution data set; and estimated prevalence (models) published by the Association of Public Health Observatories (APHO).

We conducted descriptive analysis, correlations, univariate and multivariate analysis regression modelling in STATA. The primary outcome variables were mean QOF achievement on a subset of clinical indicators (26 in 2004/05 and 2005/06; 20 in 2006/07 and 2007/08) and standardised ambulatory care sensitive (ACS) admission rates. The main independent variables were practice-level deprivation, Spearhead status, and practice characteristics. We also analysed exception reporting, population achievement and differences between reported and estimated prevalence.

The second strand comprised interviews with PCT staff (N=11), primarily Directors of Public Health and Primary Care Commissioning, in four areas of England (three Spearhead and one non-Spearhead) and general practice staff in 11 deprived practices (N=33) selected on the basis of deprivation and performance in the first two years of QOF. The majority of interviews comprised GPs and practice managers. Interviews were conducted during 2009 using a semi-structured interview schedule.
The aim of this strand of our research was to gain an in-depth understanding of how local staff working with and in general practice saw their role in reducing health inequalities and their perception of how the QOF was impacting on public health activities at a local level. The interviews were recorded and transcribed. Data were analysed thematically using a coding framework in NVIVO.

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**Results**

A review of the literature concluded the following:

- GPs have an important public health role and contribute to improving population health.
- Pay-for-performance schemes are effective in changing physician behaviour, but may lead to some gaming.
- Pay-for-performance schemes can result in a focus on areas of activities within the scheme, sometimes at the expense of other activities.

**QOF achievement**

Based on our analysis of national data, we found that the least deprived practices outperformed the most deprived practices on those clinical indicators within QOF which, according to the evidence, contribute to health gain. On average, practices in Spearhead areas performed worse than practices in non-Spearhead areas; however, the differences were small.

Differences in QOF achievement between the most and least deprived practices have narrowed since QOF was implemented in 2004/05. Differences in performance between practices in Spearhead and non-Spearhead PCTs have also reduced, suggesting that the QOF may have provided incentives for poor-performing practices in deprived areas to improve.

Practices in non-Spearhead PCTs had a significantly higher number of GPs per practice, lower GP caseload, and a higher proportion of GPs who qualified in the UK in both years of the study – all factors associated with high levels of achievement. The weak explanatory power of the model suggests that there were other factors that we were unable to observe which may explain differences in performance.

**Exception reporting**

Although higher levels of exception reporting were significantly associated with higher levels of achievement, no associations were found between exception reporting and deprivation. Using "population achievement" as an
outcome (that is, including exception reported cases in the denominator) instead of reported achievement did not have a substantial impact on observed associations with deprivation.

**Prevalence**

The gap between estimated and reported prevalence increased with deprivation and was greater in practices in Spearhead areas for coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD) and stroke. However, the relationship was reversed for hypertension. Our findings suggest that for a number of conditions (CHD, COPD and stroke), despite incentives within the QOF to keep a register of these patients, deprived practices and areas are failing to identify all cases of disease within their practice populations.

For CHD, COPD and stroke, a larger GP caseload was associated with larger differences in prevalence, as was the proportion of GPs who did not qualify in the UK, and smaller practices. The opposite was true for hypertension.

We also found that practices which performed better on QOF also had more complete recording of disease prevalence after adjusting for other factors; better case identification is associated with higher performance. This suggests that practices are not gaming by failing to register patients.

**Ambulatory care sensitive (ACS) admissions**

Emergency hospital admissions for stroke and asthma were not significantly associated with mean reported QOF achievement for those conditions. Lower mean reported QOF achievement for CHD, hypertension, congestive heart failure (CHF), COPD and diabetes was significantly associated with higher ACS admissions for those conditions.

Correlation between ACS admissions and QOF achievement varied by area and practice deprivation, depending on the clinical condition studied. Emergency hospital admissions were strongly associated with area and practice deprivation after controlling for other factors.

**PCT perspectives**

Analysis of interviews with PCT commissioners and managers identified the following key findings:

- General practice was often viewed as a barrier to public health delivery because of practitioner intransigence or because of the pressures on resources generated by working with deprived populations.

- The QOF was viewed as delivering some improvements in general practice and being an effective incentive, but lacking an emphasis on prevention and open to gaming by some GPs.
• The limitations of the GMS contract were widely recognised by PCTs who were using Local Enhanced Services (LES) and other financial incentives to “plug the gap”.

• PCTs recognised the potential value of QOF data to support public health and to performance manage under-performing practices, but it was not being fully exploited.

• PCTs believed the GMS contract was discouraging GPs from taking a population health perspective, and entrenched a view that everything beyond the “core” of general practice has to be financially rewarded.

**Practice perspectives**

Analysis of interviews with practice staff in deprived practices identified the following key findings:

• Few GPs saw that they had a role in public health or reducing health inequalities, except in practices which had specifically been set up (usually under PMS contract) to address particular needs.

• There was little evidence of practices uncovering more undiagnosed disease because of the QOF. Passive, opportunistic case finding continues to be the dominant model within general practice.

• Practices have responded to the incentives on offer from the QOF by re-organising and systematising their approach to the management of chronic disease.

• The QOF has not encouraged significant primary prevention in general practice.

• There is some evidence that the challenges of serving populations with complex health and social needs are not adequately addressed by the QOF.

• Most believed exception reporting to be an important protection against non-attending patients.

• Effective practice organisation is not the only determinant of high QOF achievement, but well-resourced practices, many of which had these systems in place pre-QOF, appeared to perform better on QOF.

**Conclusions**

While the gap in performance between the least and most deprived practices and between Spearhead and non-Spearhead areas has narrowed, it does not appear that this has translated into reduced health inequalities. The impact of the QOF on preventable admissions, for example, appears modest. The QOF acts as a barrier to PCTs commissioning primary care that
is focused on the health needs of the local population, and does not provide appropriate incentives for practices serving populations with complex needs. More organised practices and those with more resources appear to achieve higher QOF scores. Overall, therefore, the QOF has had a limited impact on improving public health and reducing health inequalities.

The evidence from this research study suggests that it may prove challenging to shift the focus of general practice from providing medical services to taking responsibility for population health and reducing health inequalities. This will require changes to the current incentives. Practices serving deprived populations will need additional support if they are to address the health needs of their populations and prevent, as well as treat, ill health.
Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.