Is QOF politicising diabetes care?

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The Quality and Outcomes Framework (QOF) is changing again. Some of these modifications came into effect on 1 April 2009, and others are subject to negotiations between the General Practice Committee (GPC), the Royal College of GPs (RCGP) and the Department of Health (DH) in England.

The QOF was introduced for the whole of the UK in 2004 as an important part of the GMS contract for GPs at the time. It was intended to reward practices for delivering high-quality diabetes care. Although it was designed to be voluntary, when individual practices discovered that up to one-third of their income would come from QOF-related activity, 99.8% of UK practices became involved in the scheme (Lester and Majeed, 2008). There have been year-on-year improvements in the achievement of diabetes points, with most practices throughout the UK now achieving over 98% of available diabetes points, as well as providing useful information by tracking prevalence both locally and nationally (Anon, 2008).

With UK Government spending on the whole of QOF now £1 billion per year (15% of primary care costs; Lester and Majeed, 2008) it is understandable that governments seek to obtain value for money for taxpayers. However, the most recent changes introduced appear to politicise the process ahead of the science or contemporary evidence, as well as potentially alienating primary care teams working hard to improve patient care on narrow financial margins.

Changes in nationwide QOF indicators

Since 1 April this year, the new indicators now award the previous 17 points for up to 50% of patients' HbA_{1c} results being 7.0% or less, create a new indicator worth 8 points for up to 70% of results being 8% or less, and replace the 10% indicator with one at 9%, maintaining the upper threshold at 90% and reducing the available points by one to 10. There are no achievement points for HbA_{1c} scores over 9% (NHS Employers and the General Practitioners Committee, 2008).

In a recent editorial in this journal, it was argued that, while there is some evidence underpinning these changes, it is contradictory in parts, particularly when taken across the full age spectrum encountered by primary care teams caring for people with diabetes (Hadley-Brown, 2008).

The UKPDS (UK Prospective Diabetes Study) has shown that lowering HbA_{1c} reduces the risk of microvascular complications (Holman et al, 2008). Contemporary guidance from NICE and EASD/ADA (European Association for the Study of Diabetes/American Diabetes Association) suggests HbA_{1c} targets of 6.5–7.5% (National Collaborating Centre for Chronic Conditions, 2008; Nathan et al, 2009). More recently some of this guidance has been confounded by the ACCORD (Action to Control Cardiovascular Risk in Diabetes) trial and VADT (Veterans Affairs Diabetes Trial), which pointed to the risks associated with hypoglycaemia in an older age group, and the ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicron Modified Release Controlled Evaluation) study failed to show an improvement in macrovascular risk with improved glycaemic control over 5 years (ACCORD Study Group, 2008; ADVANCE Collaborative Group, 2008; Duckworth et al, 2009).

Commenting on the editorial mentioned above, Brown (2009) argued that given such targets, primary care teams have been both pragmatic and proactive. Targets have been used to make incremental changes, to identify undiagnosed diabetes, and to review levels of patient support. Historically, with the intimate knowledge that primary care teams have of the person with diabetes and any accompanying frailty and comorbidity, case-by-case patient management decisions need to taken, with judicious use of exception reports, which can be useful and have not been misused (Doran et al, 2006).

Two additional facets of the changes in QOF have also been the subject of debate. Since 2005 there has been a tension between the group overseeing the evidence and the DH and GPs. The academic group scrutinising the evidence is composed of more than 40 senior primary care academics, who receive supplementary evidence from patient groups, healthcare professionals

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and the public. Reviewing the evidence, negotiators from GPC have tended to take a pragmatic approach to what is achievable in a primary care setting, acutely aware that there can be a "tipping point" at which it is no longer financially worthwhile to manage people with diabetes in primary care.

The DH has responded to this by making NICE responsible for developing and reviewing the Framework's clinical and health improvement indicators (NICE, 2009). At this stage it is not clear if the three other nations in the NHS will follow this lead. This apparent regionalisation seems to be exacerbated by a suggestion that local quality frameworks may be introduced in 2010, politicising the process further. QOF is important for people with diabetes as they are entitled to expect the same care wherever they are in the UK. It is understandable that both GPC and the RCGP are opposed to this apparent regionalisation, arguing that the opportunity for local enhanced services already exists. GPC and NHS Employers will still be able to negotiate on which of the QOF indicators suggested by the new NICE committee are to be implemented.

Achievements as a result of QOF

Although the quality of care of people with type 2 diabetes was improving before the introduction of the 2004 contract, results suggest that the introduction of this payment-for-performance scheme was associated with a modest acceleration in improvement of this care (Campbell et al, 2007).

In the context of blood pressure control – a very important clinical indicator for people with diabetes – significant advances in control have already been demonstrated, as well as suggesting that this may also be improving in areas with more social deprivation (Ashworth et al, 2008). It has been also found that median achievement scores increased across the board, and that the gap in median achievement narrowed from 4.0% to 0.8% between practices in the most deprived and least deprived areas.

Additionally, evidence suggests that although performance in year one was associated with area deprivation, the subsequent increase in achievement was inversely associated with the practice's performance in previous years and was not associated with deprivation (Doran et al, 2006). Emerging evidence from practices in England confirms that targets continue to improve performance (Vaghela et al, 2009), but this may not be sustained across all ethnic minority groups (Millett et al, 2009).

Conclusion

With the large sums of money being invested in QOF it is inevitable that the whole Framework in general, and the diabetes clinical indicators in particular, will be subject to political scrutiny and attempts by government to micromanage it. All those involved in day-to-day case management, informed by the Payment by Results clinical indicators, can see that it has been a national force for improving the care of people with diabetes. It is regrettable, therefore, that these political imperatives, particularly where they may be diluted regionally, or may not have a true transferable evidence base, may reduce what has been the most important initiative to improve the UK's diabetes care over the past decade. ■

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