David Misselbrook
on consulting with QOF

What is the right MODEL of medicine?

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key points

The Quality and Outcomes Framework (QOF) was introduced into UK primary care in 2003 and measures around 100 clinical and various non-clinical parameters believed to represent good quality in general practice. Typically, around 20% of a GP partner's pay is linked to attaining QOF points.

The author considers the benefits of QOF, the arguments against, and QOF's omissions. How far does QOF relate to the goals of medicine? And for Christians, what are these?

He concludes that QOF may push us further towards a biomedical model to the exclusion of a broader and more humane model of medicine.

Medicine is not a pure science like physics, rather an applied one like rocket engineering. It uses science to pursue goals. This is beautifully expressed in the motto of the Royal College of General Practitioners, my own: 'Cum Scientia Caritas' – 'with science I care'.

A central innovation of the 2003 'New Contract' for GPs was the Quality and Outcomes Framework (QOF). This was a mutually negotiated response to perceived quality problems in general practice and is a framework that measures around 100 clinical parameters and various non-clinical ones that are believed to represent good quality. Each is weighted to yield a number of possible points, with approximately 1,000 points attainable in total. About two thirds of QOF points relate to biomedical markers, eg the proportion of diabetics whose HbA1c is below 7.5%. These markers cover the main chronic disease areas that account for most preventable illness in the UK. About one third relate to administrative outcomes, including the result of patient satisfaction questionnaires.

QOF points are derived remotely from data entered in standardised ways in patients' electronic notes. Standardised data entry is therefore essential in many or most GP consultations. Typically, around 20% of a GP partner's pay is linked to attaining these points.

The benefits of QOF

Specific claims have been made in support:

- QOF finally addresses the quality 'tail' in GP
- QOF increases the implementation of evidence based medicine (EBM) in chronic disease management, and therefore should lead to increases in appropriate prescribing, improvement in health markers, and improved outcomes
- It is hoped QOF will reduce health inequalities

There is growing evidence to support these claims:

- Ashworth *et al* reported in 2008 that '…blood pressure monitoring and control have improved substantially. Improvements in achievement have been accompanied by the near disappearance of the achievement gap between least and most deprived areas'.[1]
- Prescribing in chronic disease has increased dramatically. Oliver reported that 'primary care prescribing in over 65s has increased 50% over the past three years'.[2]
- Lester states that 'the greatest contribution that [QOF] has made to practice will therefore be the largely unintended consequence of generating more equitable healthcare'.[3]
- In a *BMJ* letter responding to criticisms of QOF Roscoe commented '…what I am doing for my patients is improving their health so I will continue to do it…'[4]

Surely then QOF must represent a win-win situation? GPs are happy that hard work is rewarded. The DOH is happy that perverse disincentives are reduced, and the 'tail' of poor quality general practice has finally been addressed. And patients should be happy they can be confident of receiving the best quality of care.

But might there be unintended consequences? If so, do they matter? Overall, does QOF improve care?

The case against QOF

There are a number of arguments against:

- QOF represents 'one size fits all' medicine – what about patients' own priorities?
- Might QOF mean more computers but less communication?
- *Is* it good EBM?
- What about opportunity costs?
- Are there really fewer inequalities – could there be a potential for more?
- Might QOF deprofessionalise medicine?
- What about the conflict between individual patient care and public health?

Again there is evidence to support these charges:

- Heath *et al* argue that 'measurable differences do not necessarily translate into meaningful differences in patients' lives', and that 'clinical care

needs to be tailored to individual patients rather than using a mechanistic approach'.[5]

- Rouf found that '…exam room computers decreased the amount of interpersonal contact'.[6]
- Increased prescribing is a two edged sword – Oliver comments that 'Iatrogenic illness relating to polypharmacy accounts for many admissions of older people to hospital…'[7]
- Curtiss argues that managed care leads to greater medicalisation: '…preventing specific diseases and chasing pre-disease markers are not the same as promoting health'.[8]
- Starfield points out that '…fewer than a fifth of trials use health outcomes as criteria of benefit'.[9]
- Heath reminds us that 'Most randomised trials systematically exclude patients' symptoms, functional status, comorbidity, severity of illness, ideas, and preferences.Yet these are the factors which should fundamentally affect decisions about appropriate treatment.'[10] She further criticises the unthinking reliance on intermediate outcome measures, commenting 'none of the framework measures clinically important outcomes'.

A major source of discontent however is what QOF leaves out. Mangin comments: 'QOF will never deliver on the elements that patients value so much: the giving of hope…trust, reassurance, faith, the complexity of general practice…greater status is given to what is coded than to what is spoken between doctor and patient'.[11]

It seems unlikely QOF will greatly reduce health inequalities. Crawley comments that 'The quality of chronic disease management in England was broadly equitable between socioeconomic groups before this major pay for performance programme and remained so after its introduction'.[12] Ashworth echoes this view.[13]

The 'target culture'

And what of the effect of the 'target culture' of which QOF might be seen as the paradigm case in the NHS? Davies states that 'excessive supervision and micro-management will destroy the motivation of many professionals, and so ultimately reduce the quality of service'.[14] This is echoed by Mangin: 'The progressive loss of independence to external influence is central to the deprofessionalisation inherent in the QOF. The medical profession is already trying to disentangle itself from the influence of the pharmaceutical industry, and now faces an increasing, unwanted and often unrecognised influence from the state. Both threaten its independence'.[15]

Jeffries views QOF as a Trojan Horse, creating an ever increasing target workload. He states 'As each target is attained so it is removed from the equation and a new one introduced…now that NICE is getting in on the act, financial considerations will loom ever larger, and decisions about QOF will be made with less and less reference to working GPs.'[16] Abholz points to the inherent conflict between individual patient care and public health. He asks 'will QOF push us away from individual patient care, further towards public health?'[17]

The goals of medicine

Christians believe that men and women are special because we are made in God's image – we are not just clever apes.[18] If this is true then each person is of immense significance and worth. As doctors we are fortunate to be able to reflect God's own care for each, but we must remember we are part of the creation; let us not confuse ourselves with the creator! Doctors are not always strong on humility – we should be.

So what sort of medicine should Christians be standing up for? Or, what are the goals of medicine? Aristotle stated that 'the end of the medical art is health'.[19] However this leaves us with a small problem – although we are prepared to spend dizzying sums on healthcare no-one seems quite sure what health is. Of course the World Health Organisation made a bold offer. Their definition of health is 'not merely the absence of disease or infirmity but a state of complete physical, mental and social wellbeing'. But this utopian vision is an unattainable ideal, bearing no relation to the struggles of real people in an imperfect world.

The WHO definition however represents the logical aim of the biomedical model. If we are closed knowable systems then imperfections should be fixed. As none of us is in this complete state of wellbeing, we are all in need of medical intervention to correct 'abnormalities' that obstruct our path to perfection. But should we view any deviation whatever from perfection as pathology needing treatment? Is the biomedical model *sufficient* as a target for medicine?

A biomedical model fails to capture critically different meanings of *ill-health*:

- **Disease** is defined by pathology, and is traditionally capable of being established as objective fact. However, this simple definition has recently become extended by 'surveillance medicine'.[20]
- **Illness** is the patient's ill-health experience, and has a large individual subjective element greatly influenced by psychological and social factors. It is experienced within a life narrative, not as a scientific construct. Its relationship to disease is extremely variable.
- **Disability** is impairment of function. It has a large subjective element, and is partially socially determined.

Health as the attainment of biomedical norms is becoming by default our dominant definition. It is the only definition that makes sense within a biomedical model. But a norm-referenced definition of health ignores the difference between disease and illness.

The WHO definition should also alert us to another paradox. It seems dated. Its faith in an attainable Nirvana is touching, but not credible. It is a flagrantly modernistic statement, and, like a statue of Lenin, appears now as the ironic icon of a bygone age. Perhaps our definition of health will be linked to the thinking of our time, and will have a sell-by date.

Medicine needs values

Medicine needs values, but values cannot be derived from facts. Much of the current confusion surrounding medical goals is because we have become scared of

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We should practise medicine in a way that responds first to the patients' agenda.

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being clear about our values and have sought to retreat into facts. QOF makes the implicit assumption that it in some way represents our goals in practising medicine, but is this true? Is health just the absence of disease, or is it a more positive concept? Can we go beyond normative facts and admit values into our concept of health? Can we go beyond a disease model and encompass the patients' experiences of illness and disability also?

In the mid 20th century Maslow developed within the psychology literature a model of human flourishing. He proposed that humans have a *hierarchy* of needs[21] and described five levels, aiming for a mature human autonomy:

Level 1: Physical survival needs, eg air, water, food, sleep, warmth, basic health, exercise, sex

Level 2: Safety and security needs, eg physical safety, economic security, freedom from threats, comfort, peace

Level 3: Social needs, eg belonging, acceptance, group or team membership, love and affection

Level 4: Need for self-esteem, eg important projects, recognition, intelligence, prestige and status

Level 5: need for self-actualisation, eg opportunity for innovation and creativity, autonomy, self-awareness

We need to link a positive concept of health with a renewed concept of human flourishing. We can immediately see that healthcare is relevant to level 1 survival needs. But perhaps we underestimate the effects both illness and healthcare may have on a person's overall wellbeing at Maslow's other levels. Serious illness may threaten ability to flourish at any of these. Unfortunately healthcare interventions themselves may impair flourishing, for example by reducing a person's sense of autonomy or self-esteem.

Swimming against the stream

If we truly believe in a multidimensional model of health, which includes the biomedical, social, psychological, anthropological and spiritual dimensions, then we are swimming against the stream. The current NHS reforms are staunchly biomedical and managerial in their gaze. Evidence based medicine is predominantly biomedical. We are in a culture that pays lip service to the needs of the patient, but ignores any attempt to catalogue or understand those needs. Patients' needs are multidimensional. Can our gaze rise to the challenge to see them?[22]

Dietrich Bonhoeffer defined health as 'the strength to be',[23] saying that health is the ability to pursue our life story without insurmountable obstruction from illness. Thus health can be seen as the ability to flourish without being unduly impeded by illness or disability or, if necessary, by overcoming them.

So might this give us a clue as to what healthcare is *for*? However advanced our treatment of disease may be, we can never banish illness. At the very least medicine must recognise and deal with both disease and illness, and the disability that may stem from either. Healthcare exists for the benefit of the patient. Healthcare must therefore include both processes and outcomes that are valid primarily in the world of the patient, not primarily in the world of the doctor.

I would offer this goal: Healthcare should aim for the state of least possible illness or disability, or of maximal functional adaptation to illness or disability. We need such a definition unless we wish to see the whole population deemed unhealthy as defined by a utopian biomedical gaze, and thus in need of medical intervention. This definition does not decry the role of biomedicine, but rather redirects our attention as to its purpose and proper function.

If anything stands in the way of me fulfilling my life goals that biomedicine can fix, then this model tells me to fix it. But in reality there is so much sickness we cannot fix, and this model gives me a more dynamic and a more patient oriented way to seek ways round, or ways of coping with, the unavoidable.

We know that the ability to increase control of one's world improves health.[24] But the more we control, the less the patient controls. Medicalisation damages their ability to continue to control themselves, which is morally undesirable, and may actually damage their health. QOF must now be added to the list of drivers for medicalisation.

It amazes me that, faced with a call from help from an obviously blind man, Jesus asked 'What do you want me to do for you?'[25] He did not assume he knew the man's needs better than the man himself. Indeed Jesus' whole ministry is very focused on the needs that people express, not on 'one size fits all' solutions.

My verdict

My verdict on QOF would be that it may well offer some advance in the quality of some intermediate outcomes in healthcare, and this is likely to benefit some patients. But QOF also has three grave failings:

- QOF falls for the 'empiricist fallacy', ie the wrong belief that quantitative methods must always be better in human affairs
- QOF hijacks the patient's agenda and substitutes the doctors' and the politicians' biomedical one
- QOF risks deprofessionalising GPs. According to Dunstan we are society's 'accredited moral agents'.[26] We should not limit our vision to being merely biomedical technicians

QOF is a huge uncontrolled experiment whose outcome is too early to determine. While QOF has certain modest benefits to patients, it may not overall be in patients' long term best interests. QOF is probably best seen as a move within the politically driven control of the medical profession.

We should be encouraging a societal debate about the proper limits to medicine's domain. We should not pursue the problematisation of normality that is currently extending medicine's control over the healthy. We should practise medicine in a way that responds first to the patients' agenda.