GP PAY SCHEME REDUCES CARE INEQUALITIES IN DEPRIVED AREAS

Research suggests the GP quality and outcomes framework can reduce variations in quality of care and has helped to cut regional health inequalities. Nerys Hairon reports

The GP quality and outcomes framework (QOF) has helped to reduce inequalities in healthcare delivery between affluent and deprived areas, a study has found (Doran et al, 2008).

The research, published in The Lancet, concludes that financial incentive schemes such as the QOF have the potential to make ‘a substantial contribution’ to reducing health inequalities.

The government is committed to reducing health inequalities. Earlier this year, it published a report that outlined progress to date and plans to combat the problem (Department of Health, 2008; Hairon, 2008). This report found the health of the most disadvantaged groups had not improved as quickly as that of more affluent groups. The DH acknowledges that inequalities in health have persisted and, in some cases, have widened.

Meanwhile, a study published online by the journal Heart has found that giving GPs incentives improves clinical care. However, this does not promote healthier lifestyles nor improve patients’ quality of life (Cupple et al, 2008).

Reducing health inequalities is a complex issue. Practice nurses are vital in helping to cut inequalities between different population groups. This can be done by identifying those at risk of poorest health and targeting interventions towards these groups (Hairon, 2008).

BACKGROUND
The QOF is a financial incentive scheme that pays UK GP practices for their performance against a set of quality indicators. It was introduced after the government renegotiated GPs’ national contract.

In the first full year of the scheme (2004–2005), most practices reported high levels of achievement for clinical indicators. Levels of achievement have, on average, increased every year for most indicators.

However, there are concerns that practices serving deprived populations have achieved lower levels of performance and received less generous financial rewards. This could have the effect of widening the inequality gap.

Therefore, Doran et al (2008) examined the relationship between socioeconomic inequalities and the quality of clinical care delivered in the first three years of the QOF.

STUDY METHOD
The researchers analysed data from clinical computer systems for 7,637 GP practices in England, as well as data from the UK census and on characteristics of practices and patients from the 2006 general medical statistics database. The practices involved were divided into five equal-sized groups (or quintiles) based on the level of deprivation of the area they served.

The researchers calculated overall levels of achievement for 48 clinical indicators during the QOF’s first three years (from 2004–2007). The overall level of achievement was defined as the proportion of eligible patients for whom targets were achieved.

The clinical indicators studied had remained largely unchanged during the three years, and covered care for conditions including coronary heart disease, diabetes, epilepsy, asthma, hypertension, mental ill health and stroke.

KEY FINDINGS
The median overall reported percentage of patients achieving the targets was 85.1% in year 1, 89.3% in year 2, and 90.8% in year...
In the first year, the most deprived areas had a median achievement of 82.8%, compared with 86.8% for areas in the most affluent group. However, by the third year of the QOF, the most deprived areas had improved substantially, to reach a median achievement level of 90.4%, compared with 91.2% in the most affluent group. This means the gap in achievement between the most and least deprived areas narrowed from 4% to 0.8% over the three years. Median achievement increased by 4.4% for the least deprived group and by 7.6% for the most deprived areas over this period.

The study also found that the variation in reported achievement decreased at a faster rate for practices in the most deprived areas. These patterns of increasing median achievement and decreasing variation in reaching targets over time were consistent across all 48 indicators.

In addition, the researchers found that the worse a practice had performed in the past, the greater its improvement in achievement during the study period.

**Implications for care delivery**

Doran et al (2008) say their study has shown that variation in quality of care related to deprivation was reduced in the first three years of the incentive scheme.

While they acknowledge there are limitations in the study, they suggest the QOF could be ‘a rare example of a truly equitable public-health intervention’.

They argue this could be the case as improvements in quality were inversely proportional to performance at baseline, in that the worse a practice had performed in the past, the greater its increase in achievement. Improvements were also not linked to the level of deprivation in the surrounding area.

While the researchers concede there may be alternative explanations, they argue that, during the QOF’s early years, variation in quality of care for those aspects with incentives reduced. This has resulted in more equitable healthcare.

However, they add that whether this will lead to an actual reduction in health inequalities is unknown, partly because their root causes still remain.

Doran et al conclude that financial incentive schemes have the potential to make a ‘substantial contribution’ to reducing inequalities in the delivery of clinical care to patients.

They cite a DH (2007) report, which shows that more than 60% of the gap in life expectancy between the fifth of areas that have the greatest deprivation and poorest health in England and the rest of the country can be attributed to diseases targeted by the QOF.

**IMPROVING LIFESTYLE CHOICES**

A study by Cupples et al (2008) explored whether the financial incentives in the QOF have improved clinical care and patients’ lifestyle choices related to coronary heart disease.

They compared 16 GP practices in Northern Ireland, which follows the QOF, with 32 practices from the Republic of Ireland, which does not have performance-related pay.

Analysis of data on 903 patients with coronary heart disease showed that blood pressure and cholesterol levels were better controlled among patients in the Northern Ireland practices. More of these patients had also had these levels checked in the previous year.

However, patients in Northern Ireland ate a less healthy diet and took significantly less exercise than those in the Republic, who scored higher on validated measures of physical and emotional well-being.

The authors conclude that blood pressure and cholesterol are better controlled among patients in a primary healthcare system with a strong infrastructure that rewards performance but this is not linked to healthier lifestyle or better quality of life.

While this study did not specifically aim to examine health inequalities and deprivation issues, it highlights the importance of paying attention to improving patients’ lifestyle choices.

While improving clinical care is vital in reducing health inequalities, enabling and encouraging patients to make positive lifestyle choices is also important.

**CONCLUSION**

Doran et al’s (2008) study shows the GP QOF has reduced variation in the quality of care provided by practices and that it could reduce health inequalities.

This demonstrates that practice nurses who monitor patients under the QOF are vital in helping to cut health inequalities.

Cupples et al’s (2008) study also highlights the importance of improving lifestyle choices as well as clinical care.

The DH (2008) highlighted smoking, alcohol and obesity as areas where changes in lifestyle behaviour could impact substantially on reducing health inequalities. It also outlined five key areas in which early action will have the most impact (see below).