

Impact of the 2004 General Practitioner Contract on health improvement and inequalities in cardiovascular disease and diabetes: findings from a systematic review and national and local quantitative studies

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Executive Summary

Background

Despite overall improvements in morbidity and mortality levels, health inequalities remain pervasive in the United Kingdom. For example, inequalities in the prevalence and outcomes of cardiovascular disease between socio-economic and ethnic groups have been well documented.

Inequalities in cardiovascular disease outcomes may result from inequitable access to high quality health care. A number of recent studies suggest that inequalities in chronic disease management have persisted despite publication of the National Service Frameworks for Older People, Coronary Heart Disease, Diabetes and Long Term Conditions.

The Quality and Outcomes Framework within the 2004 General Practitioner contract ties about one quarter of general practice income to the achievement of quality standards. The framework aims to raise and standardise the health care being delivered to all patients with selected chronic diseases. The contract therefore provides an important opportunity to address existing inequalities in chronic disease management and related health outcomes.

This report presents the methods and results from a 30 month project funded by the National Institute of Health Research Service Delivery and Organisation programme on the impact of the Quality and Outcomes Framework on inequalities in the management of cardiovascular disease and diabetes.

Aims

- Examine the impact of the Quality and Outcomes Framework (QOF) on trends in diabetes management and inequalities in care and outcomes at patient and general practice level using a nationally representative dataset
- Examine the impact of QOF on trends in CVD and diabetes management and inequalities in care and outcomes at patient group and general practice level in multi-ethnic, deprived inner city areas
- Explore associations between exception reporting for diabetes care and patient and practice characteristics in a multi-ethnic, deprived inner city area
- Examine the impact of QOF on inequalities in the prevalence and management of smoking and obesity in primary care

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Methods

- A systematic review of the research literature on the impact of pay for performance programmes on health care inequalities
- Longitudinal studies on the impact of QOF on inequalities in diabetes management using the General Practice Research Database (GPRD)
- Longitudinal studies examining the impact of QOF on inequalities in CVD and diabetes management using electronic patient extracted from general practices in inner London Primary Care Trusts serving multi-ethnic populations with considerable health needs
- A serial cross sectional study in Brent to examine associations between patient and practice level characteristics and exception reporting for diabetes quality indicators

Results

Our observational studies were designed to investigate the impact of QOF on inequalities in chronic disease management. Our findings suggest that the introduction of QOF was associated with accelerated overall improvements in the control of blood pressure in patients with diabetes, hypertension and stroke but not CHD in the initial post introduction period. These improvements continued between 2005 and 2007 for systolic but not diastolic blood pressure (i.e. greater than those predicted by the underlying trend). The introduction of QOF was associated with accelerated improvements in the control of cholesterol in patients with diabetes and stroke but not CHD in the initial post introduction period. These improvements were not sustained between 2005 and 2007. The introduction of QOF was not associated with any additional improvement in HbA_{1c} control in patients with diabetes and mean HbA_{1c} actually increased significantly during the period between 2005 and 2007.

The initial improvements in intermediate outcome control associated with QOF identified in our studies are likely to confer important clinical and public health benefits in the different age, gender, ethnic and socio-economic status groups that we studied. However, the magnitude of the improvements seen were greater among women than men in diabetes, thus narrowing existing sex inequalities in the management of these risk factors. Conversely, younger patients with diabetes appear to have benefited less from QOF than older patients, resulting in some widening of existing age group inequalities in the management of HbA_{1c} and cholesterol. Older patients (75+ years) with diabetes appear to have derived a similar level of benefit as other groups from QOF thus

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leaving existing inequalities in blood pressure control largely intact. Patients living in affluent and deprived areas appear to have had similar levels of risk factor control before QOF and derived a similar level of benefits from this financial incentive.

Our findings suggest that the impacts of QOF on inequalities in chronic disease management between ethnic groups are mixed. This pay for performance programme appeared to reduce some inequalities in risk factor control (white-black differences in systolic blood pressure in patients with diabetes) while increasing others (white-black differences in cholesterol in patients CHD). A number of other inequalities in risk factor control largely persisted after the introduction of QOF (white-black-south Asian differences in HbA1c control).

Conclusions

QOF could be developed in a number of ways to better address inequalities in health care. These include raising treatment thresholds, rewarding improvement as well as absolute achievement, developing and expanding quality indicators where inequitable care has been identified and directly rewarding reductions in health care inequalities.

Assessing the impact of QOF on health care inequalities is currently hampered by an absence of patient level data within the QMAS (Quality Management and Analysis System) national reporting system and continued poor recording of ethnicity and of individual measures of socio-economic status within primary care information systems. QMAS should be modified to allow patient level analyses of quality of care, in addition to the practice level measures of performance that are currently available. Where possible this assessment should include both local and national analyses of patient level data, consider different dimensions of inequality including age, gender, ethnicity, socioeconomic status, take into account underlying trends in inequality and involve longer term follow up of impacts.

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.