

# Is the QOF Failing to Motivate GPs or Improve Patient Care? Evidence from an Exploratory Study

**Sophie Hudson**  
*Graduate*

**Correspondence to:**  
**Sophie Hudson**  
[sophie.i.hudson@googlemail.com](mailto:sophie.i.hudson@googlemail.com)

## **KEY MESSAGES**

The QOF has had some worrying and unfavorable consequences for GP work motivation and patient well-being.

Much of the work that GPs do is tacit and often judgment-based; this thereby makes it hard to include performance related pay into their contracts.

The Government should work more closely with GPs to develop better system of performance related pay in the future.

## **ABSTRACT**

This paper is based on an undergraduate research study concerning the main problems and benefits with using performance related pay as a reward method for GPs. In particular the paper will focus on the consequences that such a method has for both GP work motivation and for patient well-being. It will use the Quality and Outcomes Framework (QOF) as the main example of the effects such a reward mechanism can have on the above two parties. As primary evidence, it will incorporate results from questionnaires sent to five GPs and evidence gathered from blogs written by GPs as part of the discussion. The paper will discuss how such a reward mechanism can affect GP motivation and patient well-being separately but also how particularly negative consequences for these two areas can be interrelated. The study will find that such a method of performance related pay can have its benefits but that the evidence overwhelmingly points towards the complexities and unfavourable effects that it can have on both GPs and patients.

## **WHY THIS MATTERS TO ME**

I have always been very interested in the psychological implications of performance related pay. It was an area I learnt about during my degree and then a year later I took another interesting course in public management. I wanted to team these two areas of interest, and on reading about the new GP contract of 2004 I saw a great opportunity to analyse the effects of a reward mechanism that involved performance related pay on an area of public services. My interest in the area only grew further when I started to read the internet based blogs by GPs who felt so strongly about the QOF that they seem to spend much of their time discussing it and often complaining about it online. This is an issue that affects every one of us, be it GP or patient, and I think it is important that the public take an interest in the way their public services are being managed behind the scenes and that they appreciate that management practices such as the QOF can have a big impact not only on GPs directly but also on the outcomes for patient well-being.

## INTRODUCTION

The introduction of the Quality and Outcomes Framework (QOF) as part of the new GP contract in 2004, hailed the arrival of a new form of performance related pay for GPs. The QOF awards GPs points for meeting certain targets and outcomes, which then translates into defining 30% of their practice income<sup>1</sup>. The system was designed to motivate GPs and improve patient care but it has been controversial. Here I discuss an exploratory informal scoping interview and blog-based primary research, conducted for a final year undergraduate dissertation.

Literature surrounding the issue of performance management and incentives is vast. In this paper literature will particularly focus on the areas of whether certain performances are measurable and how different forms of incentives can either help or hinder the work of professionals. The research in this paper aims to tackle whether or not this particular performance management technique, the QOF, helps or hinders both GPs and also their patients. The conclusions of the paper are directed at central Government. It is suggested that the QOF may have some worrying consequences for GP work motivation and for patient care.

## METHODOLOGY

There were two parts to my primary research. First, conducting informal, scoping interviews with five GPs about their experiences with performance related pay and particularly with the QOF. These interviews were informal, designed to enable me to gain a greater understanding of the QOF, and I assured all GPs that all information would remain anonymous. The limited number of respondents meant that the study could not claim its data to be comprehensive or representative, so these informal interview data were triangulated by an analysis of internet blogs. This was conducted in order to find out how other GPs felt about the QOF and performance related pay systems and whether the two data sources reflected one another.

I decided to use blogs because, in the literature that I read before beginning my research, blogs were often mentioned by GPs as a place where they shared their experiences of performance related pay and the QOF. Abu-Shalback Zid argues that

by mid-2005 there were already at least 300 physician blogs on the internet and that; “blogs offer doctors an opportunity to be more candid about what they are thinking about healthcare and patient care, and they are taking advantage of that opportunity”<sup>2</sup>. To try to overcome any problems with reliability that there can inevitably be with using a resource such as blogs, I only read and analysed blogs which attracted many readers and also sites which had been mentioned on other sites. It must be noted that biases may arise from using data of this kind, especially as it may be particularly opinionated doctors who utilise blogs to talk about their experiences.

This was a student research project and therefore not designed to be comprehensive and conclusive. Instead, it aims to be exploratory. Further research would be necessary for a more comprehensive paper, which could include interviewing more GPs.

## ANALYSIS AND RESULTS

The benefits of the QOF cannot be ignored. In particular benefits have been seen from the extra funding many practices have received. By September 2005 it emerged that an average-sized GP practice, scoring the average number of points (91%), received £74,299 extra. This was reinvested to provide better care for patients. For example Rosehill Practice in Burnley reinvested the money, so “the practice has been able to increase the frequency of diabetes...appointments, and patients with chronic obstructive pulmonary disease previously seen every 18 months are now seen every 9 months”<sup>3</sup>.

Furthermore, the way that the QOF encourages data collection, such as patients’ height and weight can produce benefits. The Department of Health notes advantages of developing such records, namely; “convenience and confidence [for patients]; integration of care; improving outcomes; better use of evidence; better audit; improving efficiency”<sup>4</sup>. Indeed, some of the GP’s interviewed mentioned areas of improved efficiency, such as; “Some patients who have not been seen recently were picked up and their care improved.” (GP3).

However, measuring medical professionals’ judgment-based knowledge and practice using a

system such as the QOF can result in problems including ‘gaming’, which Bevan and Hood defined “hitting the target and missing the point or reducing the performance where targets do not apply”<sup>5</sup>. Bevan and Hood as note that regulators devote very few resources towards detecting gaming, so usually assume data to be accurate. McGivern and Ferlie’s studies of consultant appraisal, found that because they did not believe in the efficacy or legitimacy of a process they were unable to participate in “consultants played tick-box games to create the impression of accountability, while continuing to practice in a traditional professional way, less visible to those outside the medical profession”<sup>6</sup>. Similar patterns of behaviour have been detected in relation to GP appraisal too<sup>7</sup>.

In much of the evidence, particularly collected from the blogs, there is a strong indication that gaming is often present with the introduction of the QOF. For example, a blogger known as NHS Blog Doctor writes of this in one of his articles, telling of how at the end of the year GPs sometimes feel compelled to lie, or bend the truth, about their patients’ conditions in order to maximise their income from the government. So, for example, instead of writing that a patient has heart failure, they would instead write ‘short of breath’, explaining that; “If a GP has a patient with heart failure who has not had an echocardiogram, the GP loses QOF points and thus loses income... so GPs will not be making diagnoses that may cost them money”<sup>8</sup>.

These problems have led to great concern that such a reward system can take the GP’s focus away from their intrinsic care for the good of the patient and introduce a system where GPs are more worried about profit and meeting targets. One GP writes a comment about this on a related blog by NHS Blog Doctor, arguing; “I agree with you 100% about the malign effect of QOF payments. There is not the slightest doubt that GPs have altered what they do considerably to make sure they maximise income. I know. I have insight. And their altered behaviour has not always been in the best interests of the patient”<sup>9</sup>.

Shah is another critic of QOF who feels this way; “the advent of QOF has engendered a ‘tick-box’ mentality among primary care staff, where the

patient is reduced to a series of targets”<sup>10</sup>. This ‘tick-box mentality’ was often a theme picked up on in many of the blogs studied. One blogger, known as Dr Rant, even wrote a play about a patient visit, with a distinctly sarcastic tone, writing at the beginning that, thanks to the QOF, patients no longer have to endure the ‘cowboy’ service he once provided. Here is a short extract;

“Mrs. Jones: I can't sleep since my husband died.

Me: Er...do you smoke? No?  
[Tick...KERCHING]

Mrs. Jones: I'm so dreadfully lonely. I've been having terrible thoughts....

Me: Yes, yes, ok...now, how many units of alcohol do you drink per week?  
None? [Tick...KERCHING]

Mrs. Jones: (pressing on) You know, doctor, I mean, like there is nothing to live for....

Me: Quite, quite. Now, we don't seem to have done your blood pressure in the last 15 months.....there now 140/80, perfect!  
[Tick...KERCHING]”<sup>11</sup>

It seems that gaming has been made possible due to one of the typical problems of the principle/agent relationship. In this situation “aspects of the productive environment that are important to the principal cannot be observed”<sup>12</sup> and this can lead to great problems where the work that the agent is doing is not always understood by the principal who is measuring it.

And GPs themselves can not only use this as a mechanism for gaming it seems, as shown above, but it can also result in a feeling of bitterness towards the Government for trying to measure and manage a profession which they do not fully understand. Indeed as GP4 points out; “In reality, the government made the huge mistake of trying to introduce performance related pay into a job it had absolutely no understanding of.” (GP4).

Further to these malign effects, Checkland et al have noticed that the statistic-checking nature of

the QOF has often resulted in GP-patient appointments becoming more formal with a list of 'tasks' that a GP has to perform rather than it being a more informal 'chat' between the two parties, with no set structure, and this can make patients less relaxed<sup>4</sup>.

One of the GPs interviewed also commented on this, saying; "QOF demands data collection, this can negatively impact on the consultation. The main aim of the consultation is to not miss pathology and to allow the patients needs and expectations to be met with both dignity and empathy shown by the doctor, the extra burden of data collection puts a huge strain on time". (GP5)

And in fact it is these many tacit based elements of medical practice which makes systems such as the QOF, which are attempting to measure the work of a GP, even more unsuccessful. Schon discusses this, writing; "In his [a doctor's] day-to-day practice he makes innumerable judgments of quality for which he cannot state adequate criteria and he displays skills for which he cannot state the rules and procedures"<sup>13</sup>.

Indeed the GPs interviewed often agreed with this sentiment, one arguing that; "There are many aspects of a GP's work that are not measurable e.g. the trust aspect between patient and doctor, the desire for continuity, the individual doctor's knowledge of patients, their family, social, and past health and well being. The meeting of a patient's need and expectation is difficult to measure accurately." (GP5)

Further to this, they argued that there is a feeling of great frustration that activities rewarded by the QOF are not ones that motivated them as a GP and are not activities that they felt should be part of their main job description; "Sorry, never does collecting data of work already done motivate me as much as going out and doing a bit more work instead. It's clinical care of patients to make their lives better that motivates me, not number crunching." (GP4). So it seems that not only is this data-collecting aspect of the QOF making appointments more formal, as pointed out above, but it is also undermining GP work motivation which could therefore in turn have harmful effects on patient well-being.

Also important here is the theory of the sociology of the profession, as discussed by Macdonald. One of the main theories relevant here is that the work of a doctor is tacit, it requires applying judgment and because of this, doctors desire autonomy in the work that they do<sup>14</sup>. They feel that there are many aspects of their work that are not measurable, and especially not when the parameters of measurement are devised by someone outside of their profession. As one GP states; "There are aspects of general practice that in my opinion are of great benefit to patients such as continuity of care, trust of known doctors... all these help to improve patient health and well being. All too easily these can be destroyed by politicians wanting quick fixes and sound bites which have no lasting benefit." (GP5).

## CONCLUSION

The QOF was designed to motivate GPs to practice in the best interests of patients, but we can see evidence, all be it based upon a small research study, of the complex and unfavourable effects that the QOF and performance related pay can have on both GPs and patient care. In particular the QOF may undermine GP motivation, encourage them to 'game' the system and possibly disregard the less measurable aspects of patient care. More research is needed on this topic however.

The findings of this small research project may be because, "two important elements of the classical management techniques- a clear acceptance of the role of management to control activities and a possibility for standardization- are missing in many parts of the public services"<sup>15</sup>. Only time will tell if eventually the QOF can be tweaked to better motivate GPs and improve patient care but this seems more likely if the government works more closely with GPs themselves when setting out and maintaining the guidelines, so that they will buy into their efficacy and legitimacy.

---

## REFERENCES

- 1 Department of Health. Quality and Outcomes Framework. 2007. Available: <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/>

[Primarycare/Primarycarecontracting/QOF/index.htm](#) (Accessed: 31/08/08)

- 2 Abu-Schalback Zid L. Web of Words. Marketing Health Services, 2005; 25 (3): 40
- 3 Practice Nurse. [GMS contract bonanza](#). Practice Nurse, 2005; 30 (4): 8-8
- 4 Checkland K, McDonald R, Harrison S. Ticking Boxes and Changing the Social World: Data Collection and the New UK General Practice Contract. Social Policy and Administration. 2007; 41 (7): 693-710
- 5 Bevan G, Hood C. What's measured Is what matters: targets and gaming in the English public health care system. Public Administration. 2006; 84 (3): 517-538
- 6 McGivern G, Ferlie E. Playing tick-box games: inter-relating defences in professional appraisal. Human Relations. 2007; 60 (9): 1361-1385
- 7 McGivern, G. & Adams, R. (2006) Clinically-Owned Reflective Practice and Tick Box Exercises: Comparative Analysis of GP and Consultant Appraisal in Practice. Clinician in Management, 14, 129-141.
- 8 Crippen J. Keeping poor people out of hospital- more barriers to health care. 2008. Available: <http://nhsblogdoc.blogspot.com/2008/03/keeping-poor-people-out-of-hospital.html> (Accessed: 31/08/08)
- 9 GP commenting on article by Crippen J. Keeping poor people out of hospital- more barriers to health care. 2008. Available: <http://nhsblogdoc.blogspot.com/2008/03/keeping-poor-people-out-of-hospital.html> (Accessed: 31/08/08)
- 10 Shah R. The Threat of the Tick Box. Update. 2007; 74 (1): 7-7
- 11 Dr Rant. How QOF has Improved my Practice. 2006. Available: <http://www.drrant.net/2006/09/how-qof-has-improved-my-practice.html> (Accessed: 31/08/08)
- 12 Besanko D, Dranove D, Shanley M, Schaefer S. Economics of Strategy. John Wiley & Sons; 2004.
- 13 Schon D. The Reflective Practitioner: How Professionals Think in Action. Aldershot: Avebury; 1983.
- 14 Macdonald K. The Sociology of the Professions. London: SAGE Publications Ltd; 1995.
- 15 Broadbent J, Laughlin R. Public Service Professionals and the New Public Management. New York: Routledge; 2002.

## ACKNOWLEDGEMENTS

I would like to thank Dr Gerry McGivern for his invaluable advice throughout this project and for some extremely helpful editing.

---

Submitted: September 2008  
Comments to Author: 23 October 2008  
Accepted for Publication: 6 August 2009