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The Quality and Outcomes Framework: Body commodification in UK general practice

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ABSTRACT

The UK's Quality and Outcomes Framework (QOF) is the largest pay-for-performance scheme in the world. This ethnographic study explored how QOF's monetary logic influences the approach to healthcare in UK general practice. From August 2013 to April 2014, we researched two UK general practice surgeries and one general practice training programme. These environments provided the opportunity for studying various spaces such as QOF meetings, consultation rooms, QOF recoding sessions, and the collection of computer-screen images depicting how patients' biomarkers are evaluated and costed through software systems. QOF as a biomedical technology has led to the commodification of patients and their bodies. This complex phenomenon breaks down into three main themes: commodification of patients, QOF as currency, and valuing commodities. Despite the ostensible aim of QOF being to improve healthcare in general practice, it is accompanied by a body commodification process. The interface between patients and care providers has been commodified, with QOF's pricing mechanism and fragmentation of care provision performing an important role in animating the UK economy.

1. Introduction

The National Health Service (NHS) has come to symbolise the spirit of solidarity of a nation that chose in 1948 to have a universal health system based on strong primary care services, within which general practice (family medicine) plays a central role. The existing cumulative evidence suggests that countries with health care organised by these kinds of principles generally have better health outcomes (McCarthy, 2014). Conceptually, the NHS represents a tax-based third party payment system, which 'attempts to socialise the financial risks of ill-health by a pooling of risk and of financial provision' (Harrison, 1998, p.16). This creates a situation that discourages the commodification of health care provision as a 'product' to be consumed according to patients' purchasing power.

In 1991, Margaret Thatcher's conservative government introduced a division into the NHS, a previously monolithic public structure, by creating a purchaser-provider 'split'. Self-governing hospital trusts became 'the providers', whereas the former health care authorities and General Practice (GP) fundholders became 'purchasers' (Laing et al., 1998). In this novel arrangement GPs would receive a budget to buy services on behalf of their patients from any public or private provider (e.g. hospital). The underlying idea was that money would follow the patients, increasing their choices and introducing competition within the system. Currently, the Clinical Commissioning Group (CCG) has a purchaser role in the NHS. Thus, rather than having an external relation with patients as consumers of health care services, the NHS has a built-in market relation amongst its own competing organisations. This market context provides a fertile ground for the increasing commodification of health and healthcare. According to Polanyi, the 'commodity concept is a mechanism of the market' (2001, p.72). Polanyi empirically defines commodities 'as objects produced for sale on the market; markets, again, are empirically defined as actual contacts between buyers and sellers' (*ibid.*).

In principle, not all things are alienable for selling due to either their symbolic meaning (Lock and Nguyen, 2010) or their very nature such as land, labour, and money (Polanyi, 2001). For Lukács commodification stems from the relation people assume with 'the character of things' (1971, p.83) and is a process of reification, since commodities have a 'phantom objectivity'. As Lukács contends, a commodity 'acquires an autonomy that seems so strictly rational

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and all-embracing as to conceal every trace of its fundamental nature: the relation between people' (*ibid.*). To regard a commodity as an object possessing intrinsic value is to deny its sociality. Thus, commodities can be considered objects of 'economic value … based on judgments about them by subjects' (Appadurai, 1986, p.4). This kind of commodity fiction is an essential step in the market economy to the extent that 'no arrangement or behaviour should be allowed to exist that might prevent the actual functioning of the market mechanism on the lines of the commodity fiction' (Polanyi, 2001, p.73).

Echoing this reasoning, Scheper-Hughes states that commodification transforms the body into a 'highly fetishized' object, one 'that can be bartered, sold or stolen in divisible and alienable parts' (2001, p.1). She argues that commodification encompasses 'all capitalised economic relations between humans in which human bodies are the token of an economic exchange that are often masked as something else - love, altruism, pleasure, kindness' (*ibid.*). This definition comprises two important stances when applied to the NHS: first, the notion of the body as a 'token of exchange'; second, the masking discourses around quality of care, health improvements, and disease prevention (Heath, 2010). Mirroring this definition, the introduction of the Quality and Outcomes Framework (QOF) in UK general practice, the largest pay-for-performance scheme in the world (Roland, 2004), represents a step further in the process of health commodification in the NHS. To determine this process, we first present a brief account of 1990 and 2004 contracts followed by the 2013/14 QOF contract to explain the mechanism underpinning QOF's rules. Second, we describe the way we carried out ethnographic fieldwork in two UK general practice surgeries and a GP training programme. We go on to demonstrate that the adoption of QOF has been accompanied by a literal commodification process in the NHS by not only commodifying general practice healthcare but also patients' bodies.

1.1. General Practitioner's 1990–2004 contracts

Since the creation of the NHS, GPs have managed to maintain the role of independent contractors. This arrangement produced non-homogeneous clinical care standards that challenged the government aspirations to standardise quality across general practice (Pereira Gray, 1977). The 1990 contract increased GPs' accountability by implementing targets to improve quality standards. A greater specification of the terms of services delivered was introduced through a fee-for-service pay modality, built around health promotion activities such as health checks for new patients or those aged between 16 and 74 who have not seen a GP within the previous three years, and regular checks for the over-75s (Lewis, 1998). GPs' dissatisfaction with the 1990 top-down contract was registered as follows:

> [It was] one thing to have clinical advice issued as guidance, but to be told when to measure blood pressure, test a urine sample, or ask for a family history in the regulations of an act of parliament is another dimension altogether. (BMJ, 1989, p.414)

The 1990 contract also reduced the 'practice basic allowance' (a standard salary component) from 60% to 45% in order to increase capitation fees and competition among GPs (Day, 1992, p.168). These changed conditions challenged GPs' professionalism since disagreements persisted between GPs and the government around the definition of quality standards in general practice (Lewis, 1998).

The question then becomes why GPs as a professional body decided, in 2004, to accept QOF in order to be told, as stated above, when 'to measure blood pressure, test a urine sample, or ask for a family history'? The NHS internal market played an important role in this process, alongside a cultural transformation in general practice required to absorb the government's quality aspirations. It took more than 10 years to acculturate GPs to the requirements of an evidence-based medicine (EBM) model of learning and practice (Roland, 2004). EBM allowed the British government to build a strong clinical governance system (Harrison et al., 2002) aiming to reduce variability in clinical care, thereby facilitating the conditions for the introduction of the GPs' 2004 contract.

Although portrayed as 'voluntary' (Roland, 2004), the QOF scheme constituted a vertically imposed framework for it represents roughly 25% of GPs' annual income (Checkland et al., 2008). Thus apart from the political and epistemological changes summarised above, the 2004 contract was financially very attractive to them. It secured both a 'Minimum Practice Income Guarantee' (MPIG) – a form of income protection (National Audit Office, 2008, p.15), and money to improve practices' IT systems in connection with the QOF (Peckham, 2007). Additionally, GPs could opt to renounce the out-of-hours care duty as long as they were willing to lose £6000 year, this despite most of them already paying an average of £13,000 year for a deputising service (National Audit Office, 2008, p.19)! Thus the majority of GPs gave up their 24/7 commitments and obtained an average pay rise of £7000 year. As well as these economic advantages, mechanisms within the QOF scheme enabled further financial gains. For example, in 2006 a major change to QOF raised the number of clinical domain indicators from 11 to 19 clinical areas (BMA, 2006). The average payment to GP partners increased by 58% in the first three years of the new contract (National Audit Office, 2008, p.19).

1.2. QOF 2013/14 contract year

In April 2014, QOF marked its tenth anniversary. Although its efficacy remains disputed, as documented in a systematic review (Gillam, 2012), and despite it having cost the NHS an estimated £1 billion a year (Raleigh and Klazinga, 2013), the government renewed its commitment to QOF by producing a sixth edition of the QOF contract. This 2013/14 contract aimed at further improvements to quality by tightening up GPs' points achievements, reducing the total number of points available, and changing the indicators for which points could be won (Gillam and Steel, 2013). A total of 900 QOF points were available, with each QOF point on average worth £156.92. Table 1 summarises the whole 2013/14 QOF scheme including its four domains and points allocation.

Being a points-based system, QOF functions as an audit mechanism that sets criteria and standards intended to measure the quality of care (Gillam, 2012). Criteria refer to QOF's clinical indicators (Table 1), and the standards establish a range of point achievements, whose number is set by policy-makers, for each criterion. Due to the amount of money linked to a particular QOF indicator, GP practices can be driven to prioritise certain targets. Table 2, for example, describes the clinical criteria, standards, and points' allocation for hypertension indicators. Note that HYP002 is worth fewer points than HYP003, making the latter financially more significant. Based on two components (ratio and range of achievement) practices can calculate the level of achievement for each QOF indicator. For instance, the desired quality standard for achievement of the newly introduced HYP003 ranges from 40 to 80% of the target registered patients. QOF offers 50 points for this indicator. Thus, if 60% of a practice's registered patients aged 79 or under with hypertension have their last blood pressure reading of 140/90 mmHg or less in the preceding nine months the practice will receive 20/40 (i.e. half of the 25 points available, since 20 corresponds to what exceeds 40% which is the lower threshold).

Built into the mathematics of the QOF is exception reporting. Designed as a safeguard for patients, exception reporting aims to