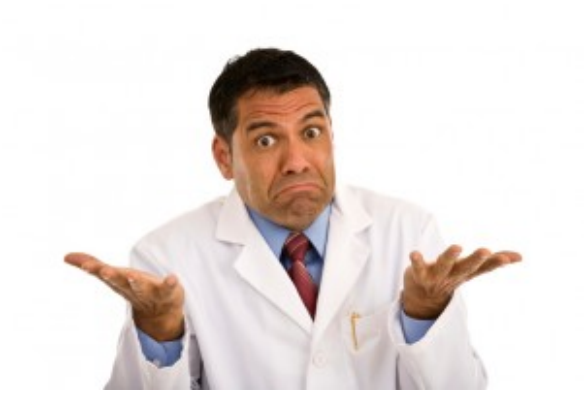
Doctors, smoking and money



Doctors: incentivised by payments for activity

Updated 26/10. The new NHS Five Year view was published this week*. There was much wailing about an £8 billion 'black hole' in the finances, and stirring exhortation about 'Getting Serious on Prevention'. The Health Secretary, Jeremy Hunt, declared he "wants a smoke-free Britain".

Not serious to the point of recognising that 700,000 ex-smokers are vapers, and that this massive prevention effect has happened without public spending and without the public health and medical establishments doing anything (other than trying to obstruct it). If they were truly radical, the leadership of the NHS would recognise this consumer based strategy for its enormous potential and get to work on making it happen rather than sabotage it. Oddly, the doctors' trade union, the BMA, has taken one of the most hostile lines on vaping. Is that a mistake? Or could there be money involved?

* Note to overseas visitors – the NHS is the National Health Service, a largely public sector healthcare commissioner and provider paid for from general taxation (£109 billion in 2012-13 for England) and available mostly free to all UK citizens.

The QOF – how doctors are incentivised to do things for money

Despite all the NHS worship that goes on in the UK, I think it is important to recall that doctors are – at least partly – *economic actors* and they respond to

economic incentives. Not everyone knows what these incentives are, but some of them are coded into a thing called the Quality and Outcomes Framework (QOF – usually pronounced as "quaff"). This includes payments for specified activities ('achievement payments') by general practitioners (GPs). This QOF framework forms part of their contract with the NHS. And, it pays out for doing stuff on smoking. As you'll see below, the activity in general practice covered by the QOF, and not including the smoking cessation services, on my calculation cost £88 million in 2012-13 – about £11,000 per practice and £9.56 per adult smoker – calculations in the rest of the post. In my opinion, £88 million is a lot of money in this field, and I'm not totally convinced that we need to spend this or couldn't spend it better. I don't wish to bash GPs – not least because they are highly heterogeneous and some are progressive beacons of hope in this field. However, it is always legitimate to look at how a system functions overall, what incentives it establishes and what value for money is achieved as a result.

Update. Correction 1: the earlier version did not correct properly for the underestimate of GP list size used in the official calculations. Correcting this *increases* my spend estimate from £74 million to £88 million. Post updated throughout and explanation here. Apologies.

Four questions on this public spending

Surely this is sum, £88m, worth asking some questions about now that the environment in which it was conceived has changed so much since over 2m people are now vaping with greatly reduced risk?

1. How much of what they are explicitly paid to do should GPs do anyway as competent professionals?

2. Does this spending in general practice represent good value for money – compared to other things that could be done in primary care and compared to things outside primary care or the NHS? If I may say, these interventions look easy to deliver and rather unimaginative.

3. What impact on smoking would there be if doctors were incentivised to recommend vaping and provide some basic advice – or even hook up with a vape store? Would this be better value for money than what they are asked to do and paid for by the NHS? Has the obsession with medicalising vaping and

classing it as smoking cessation treatment (NICE guidance) meant a more radical and fundamental opportunity is being squandered?

4. Does it help to explain why the BMA, the doctor's trade union, doesn't like vaping very much? If 'patients' redefine themselves as 'consumers' and decide to take a non-medical route to deal with their smoking, don't BMA members have £88 million at stake? Is there a huge unsurfaced conflict of interest at work here, as the medical model competes with the consumer model of tobacco harm reduction, with millions of pounds on the table?

Simon Stevens, new Chief Executive of the NHS, wants to be radical with the NHS and its finances and to 'get serious on prevention', and I believe him (see this). Jeremy Hunt, Secretary of State for Health, says he wants to end smoking in Britain. 'Excellent' says ASH. They are happy to will the ends, but are they *really* prepared to will the means?

More detail for those interested follows…

What activity does the QOF pay out for?

On smoking, here is what it will pay out for in 2014-15 (from the guidance on the GP contract page 137) – in this case there are payments for recording smoking status (SMOK002), providing stop-smoking info and advice in the surgery (SMOK003), referring smokers to some form of smoking cessation treatment (SMOK004), and a focus on patients particularly at risk (SMOK005). I'll explain the system below, but each practice scores how well it does in reaching its population with these interventions, and can accumulate up to all the points available for the intervention (e.g. 25 for SMOK002). Each point they score receives a payment…

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months *NICE 2011 menu ID: NM38*	25	50–90%
Ongoing management		
SMOK003. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2	
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months *Based on NICE 2011 menu ID: NM40*	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months *NICE 2011 menu ID: NM39*	25	56–96%

Guidance to Quality and Outcomes Framework 2014-15

Note that these are not actually payments for 'outcomes', but for *activity*. This is a long-standing criticism of this system – it isn't payment for better health, but based providing one link in a chain of reasoning that will in theory lead to better health. So a GP's advice will have an impact on the patient's behaviour; they will be referred to an appropriate service and will attend; that service will meet that individual smoker's needs; and that the success rate will be that achieved for the self-selecting sample that does actually use these services. You can criticise every link in that chain. In fact, the government itself admits it doesn't really know what is achieved in General Practice. In its September 2014 evidence to the NHS pay review body, it states at 5.14:

> *Transparency*
>
> *5.14 There is currently limited information on outcomes and quality in primary medical care. Without this kind of information, it can be unclear what expenditure on general practice is delivering.*

How much money is involved in QOF payments?

I can't provide an estimate for 2014-15, but there are data available for 2012-13. The indicators were different at the time – see below.

Smoking

Indicator	Points	Payment stages
Ongoing management		
SMOKING 5. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months *NICE 2011 menu ID: NM38*	25	50–90%
SMOKING 6. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months *NICE 2011 menu ID: NM39*	25	50–90%
SMOKING 7. The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months	11	50-90%
SMOKING 8. The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months *NICE 2011 menu ID: NM40*	12	40-90%

Guidance to Quality and Outcomes Framework 2012-13

A body called the Health and Social Care Information Centre provides statistics on how the QOF is working. I downloaded both England-level and practice-level data from here. The value of each point in 2012-13 was £133.76 (see guidelines).

QOF smoking indicator 2012-13	Sum of points awarded to all practices	
SMOK05	200,089.7	
SMOK06	195,486.4	
SMOK07	79,519.6	
SMOK08	78,751.8	

Total	553,847.4	
QOF payment per point (England 2012-13)	£133.76	
Cost without population adjustment	£74,082,634	
Population adjustment		
Average practice size used for population index calculation	5,891	
Population registered at GPs April 2013 (England)	56,043,609	
Actual average practice size	6,988	
National average contractor population index	1.19	
Total earnings from smoking related QOF	£87,877,788	
Average per practice based on 8,020 practices	£10,957.33	
Average per adult (46.6m adults > 15 years)	£1.89	
Average per smoker (9.2m smokers > 15)	£9.56	

The English national data give an idea of how much the smoking part of the QOF is work to GPs.You can view and download my Google spreadsheet for this data here and view in simple HTML format here.

Annex – how QOF works

The QOF system for achievement points works broadly as follows. A fuller explanation from the BMA – download.

An area for intervention is identified – like persuading a smoker to attend a stop smoking clinic. A maximum number of QOF 'points' is allocated to each intervention – the points attract payments under the QOF part of the GP contract. A calculation is made of how many of the maximum points the practice qualifies

for – in summary it is rewarded for reaching a high proportion of the people eligible for the intervention on its list.

1. The number of people on the practice list who would qualify for the intervention is calculated.

2. The number who actually get the intervention in the year is measured and the *proportion* of the eligible people participating is calculated

3. That proportion is used to calculate how well the practice is doing by seeing where it falls between a lower and upper expectation defined in the QOF guidance (typically between 50% and 90%)

4. The guidance will allocate a maximum number of points to the intervention – say 25. If the practice achieves the upper expectation it receives the full points.

5. The surgery earns points for how well it is doing in the range set in the QOF – a practice achieving 80% participation where the range is expected range is 50-90% would receive 60% of the maximum points (80 is 60% of the way between 50 and 90). If the achievement is above or below the range, the practice gets the maximum or zero points respectively.

6. The points scored attract a payment (£133.76 in 2012-13, £156.92 in 2014-15)

7. An adjustment is made for the size of the practice relative to the average (the English practice average of 5,891 was used in 2012-13, but that has now been recalibrated to 7,052). So a practice with 10,000 would have its points uplifted by 10,000/7,052 = 41.8% in 2014-15.

I have given an example of how it works using figures for a GP surgery not far from where I live in London. You can view and download the full Google spreadsheet for this data here and view in simple HTML format here.

Inequality in this system

As so often happens with funding formulae there is something nasty buried in this one. It favours better off GP practice areas at the expenses of poorer areas. The reason is that the 'achievement' is defined by the *proportion* of eligible eligible people receiving the intervention. This quantity (the proportion) is independent of the size of the registered population, or actual number of smokers. Obviously,

bigger practices have to do more work and see more people. So a correction is made (7 above) to uplift by the size of the practice population relative to the average (7,052). We know that smoking prevalence has a strong 'socio-economic gradient' (it rises with poverty). But consider how this plays out in two practices each of 10,000, but one in a wealthy area with a smaller number of smokers (eg. 15%) and one in a poorer area with 30%. Both would get the same points for reaching 90% of their smokers, both would get the same population uplift, but the first one will have to have dealt with twice as many people. The system creates a distribution of NHS resources in favour of better off areas!

How to address this (updated): the the contractor population index for each indicator should be constructed from the number of people eligible for the intervention in each practice (eg. number of smokers), not the total number of people on the practice list. This would require a CPI for each indicator, but it would be much fairer and a better way to address health inequalities.

Disclaimer and corrections

I should state that I have done my best to understand and model the the QOF from the available documentation and to check this against actual results – however the documentation and available statistics are not that easy to follow or designed to let a critical citizen to 'follow the money'. It is possible therefore I have missed or muddled something. I'm open to criticism and will correct any blunders.

Correction 1: Population adjustment. The first version did not recognise that the actual average GP registered population is larger than the registered population used for the calculation that corrects for practice size. In fact, the real England average practice size is 19% larger than assumed in the calculation (6,988 rather than 5,891 so on average). After 2012-13 the calculation has been rebased with more accurate (i.e. higher) numbers assumed as the average, but the value of each point has been increased to keep the cost approximately neutral. The effect is to raise my estimate of the amount spent through the QOF in 2012 by 19% – or £88 million rather than £74 million. Apologies.