

Health Reform

- Mainly England not UK
- 1990 Internal Market

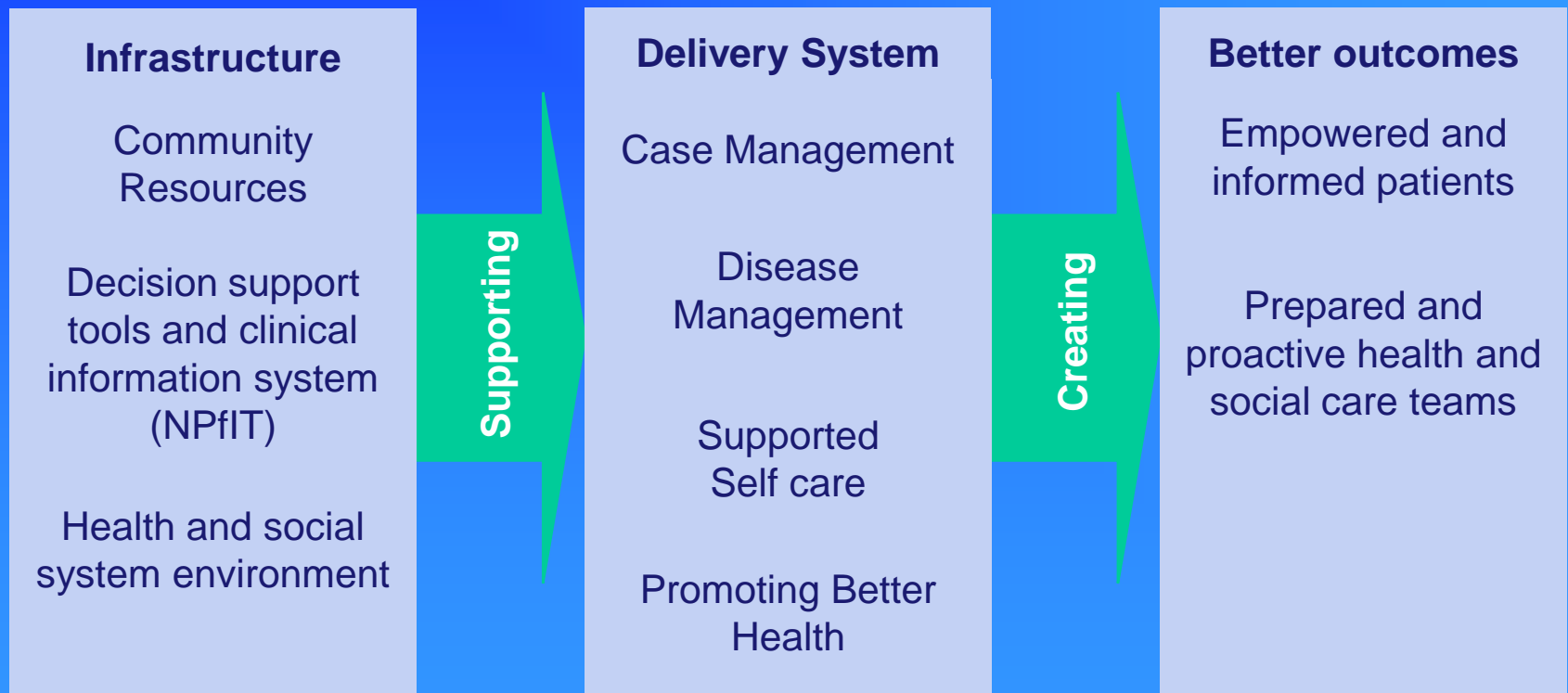
- 1997 Blair Government; Principles of reform
 - - National Framework of Standards and Accountability,
 - - Devolution to the Local Level,
 - - Improved Rewards and Conditions of Employment (Flexibility, Incentives, Rewarding Success, Shedding Bureaucracy),
 - - More Choice, More Contestability

- 2004 NHS Implementation Plan, The NHS and Social Care Chronic Disease Management Model, GP contract with pay for performance Quality and Outcomes Framework)

- 2008 Next Stage Review

- 2009 Quality and Productivity

The NHS and Social Care Chronic Disease Management Model



STRATEGY REFRESH: MANAGEMENT OF LONG TERM CONDITIONS

Proposed interventions to improve effectiveness

- ▶ We have identified a range of interventions that we believe will improve the delivery and effectiveness of long term conditions management and will address the current national variation in performance.
- ▶ Our suggested interventions are grouped at three levels, and could be delivered in the short, medium or longer term:

1. Redesign of incentives and system management

2. Improved design and targeting of clinical interventions

3. Empowering patients and supporting self-care

- ▶ There is already ample evidence about the attributes of good clinical management of long term conditions. We have focused most on creating the right environment in which providers systematically deliver excellent care and on supporting service users to take greater ownership of their health and health services.
- ▶ Our priority interventions have been distilled from the longer list of options by assessment against three criteria: likely impact on quality, likely impact on cost and ease of implementation.

The QOF was introduced into primary care in the United Kingdom (UK) in April 2004 as part of the 2003 General Medical Services (GMS) Contract. The original aims of the framework were to both improve the quality of care delivered in general practice and to reward practices for the delivery of existing high quality care. Paul Shekelle called it:

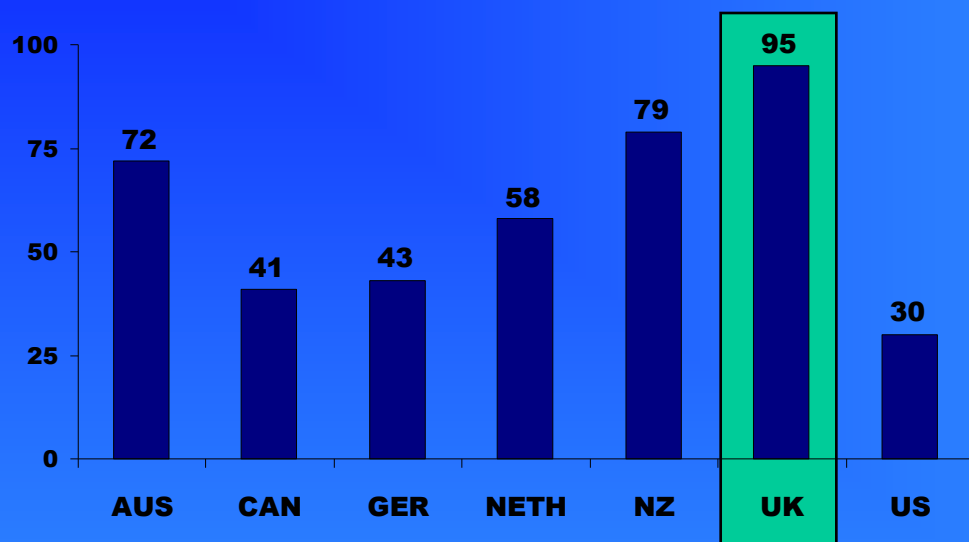
'the boldest such proposal on this scale ever attempted anywhere in the world ... with one mighty leap, the NHS vaults over anything being attempted in the United States, the previous leader in quality improvement initiatives'
(Shekelle 2004; 458).

Although it is a voluntary framework, 99.6% of practices in the UK participate.

In 2004-6, the QOF consisted of 136 indicators (1050 points each worth £75 in 2004-5 and £125 since then), covering four domains of quality. The framework was revised in 2006 to include seven new clinical areas and one new organisational area. Points were reduced to 1000. A further minor revision in 2008 has led to the removal of 7 organisational area indicators and expansion of the patient experience domain to include two new indicators on 48-hour access and advanced booking, embedded within a new national survey.

The Quality and Outcomes Framework was the first example of its kind in the world, introducing a dramatically more systematic focus on evidence-based

care.



GPs are ahead of family doctors in comparator countries in uptake of financial incentives for quality, IT use and chronic disease management

Percent receive financial incentive:	AUS	CAN	GER	NETH	NZ	UK	US
Achieving certain clinical care targets	33	10	9	6	43	92	23
High ratings for patient satisfaction	5	—	5	1	2	52	20
Managing patients with chronic disease/complex needs	62	37	24	47	68	79	8
Enhanced preventive care activities	53	13	28	18	42	72	12
Participating in quality improvement activities	35	7	21	28	47	82	19

Source:
2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.