Reviewer's report

Title: Differences in quality of primary medical care across the NHS: Evidence from the Quality and Outcomes Framework

Version: 1 Date: 12 March 2007
Reviewer: Martin Roland

Reviewer's report:

General

Using the QOF as a quality benchmark to compare policy in the four countries is an interesting approach, and of value in its own right. The broader conclusions about the different health care systems need to be treated (and presented) with some caution as they are somewhat speculative. However, there are few papers which have chosen to look at the four countries in the UK in terms of their different approaches to health reform, so the paper is welcome.

More detailed points.

The term ‘payment quality’ used by the authors is analogous to our ‘reported achievement’, and ‘delivered quality’ is analogous to ‘population achievement’ in work which we have published Doran et al NEJM 2006; 355:375-384. It would be helpful if academics could agree on these terms!

The idea that areas with higher prevalence lose out on a per-patient basis is an extrapolation of their arguments in their previous paper. It is usefully applied at country level.

The separation of types of outcome into four categories is sensible, but I have a few queries:
- Why have they left out CHD2 (referral for exercise testing), apart from the fact that it doesn’t sit neatly in any of their categories?
- Why have they left out DM2 (BMI recorded) and DM13 (micro-albuminuria testing)?
- Exception reporting for intermediate outcomes has to be calculated in a different way from the other indicators. The authors haven’t provide details of how they’ve calculated the indicators, so it’s difficult to comment on whether they’ve done this correctly, but they certainly haven’t noted in the methods that they’ve treated intermediate outcomes indicators any differently. The method for secondary indicators is to use the denominator from a relevant primary indicator as the basis for calculating exceptions, rather than the register size for the disease in question. They rather imply that they have done the latter (page 6, line 7)

A few comments on the results for the countries:

Wales: It appears that Welsh GPs have to deal with a greater burden of disease, in a more deprived population (although they don’t comment on the latter point), but nevertheless achieve comparable levels of quality to their English counterparts for those indicators over which they have most control. Where they fall down is on indicators that may require the cooperation of outside agencies.

Northern Ireland: NI has a relatively young population profile compare to the UK as a whole, and the slightly odd reported prevalence rates (high for CHD & stroke, low for HT and diabetes). Both these factors may affect achievement rates. There’s not much the authors can do to address this problem, but they should at least acknowledge it.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

None
Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Responding to query on method of calculating exception reporting rates for intermediate outcomes.

Clarifying why certain indicators have been left out.

Discretionary Revisions (which the author can choose to ignore)

Other comments under ‘general’ above

What next?: Accept after minor essential revisions

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I am active in the same research field.