

Using financial incentives to improve quality

Rewarding results: using financial incentives to improve quality

M Marshall, P Smith

Financial incentives are soon to be introduced into UK general practice to encourage quality improvement

Policy makers like to experiment with different ways of improving quality. Educational approaches have been dominant in the past. These are usually professionally led and developmental in nature. While they will always play an important role, the evidence that traditional educational methods do not seem to deliver an acceptable level of performance change¹ has come as a surprise to many people. Market based approaches, which rely on the informed consumer or purchaser selectively choosing high quality providers, have also had a disappointing impact on quality.² In part this reflects the lack of real choice and the inadequacy of current sources of data to inform decision making. In a search for an alternative solution, policy makers in some countries have turned to performance management as a lever for change and, more specifically, are examining the use of financial incentives to reward measured performance.

Perhaps the most ambitious and innovative programme to encourage quality improvement is about to be implemented in general practice in the UK. Most British family doctors are not state employees but earn a large proportion of their income from capitation payments under contract with the National Health Service. This rewards general practitioners (GPs) mainly for having a large list of registered patients, but hardly at all for the quality of care that they provide for these patients. GPs were unhappy with their old contract and demanded change.³ Protracted negotiations between representatives of the profession and the government have resulted in a new contract⁴ which will be with the practice as a whole, rather than with individual doctors. This contract makes use of specific indicators to reward explicitly those practices providing a high quality of care.

The contract works in the following way. A practice will be awarded points for the level of achievement on each indicator, and these points attract payments. The number of points for each indicator is weighted to reflect the relative importance of that indicator.

There are a total of 136 indicators and a maximum of 1050 points that could be gained by the practice. Seventy six of the indicators, representing 70% of the total number of points available, relate to clinical care for common primary care conditions such as coronary heart disease, diabetes mellitus, and asthma. Fifty six of the indicators, representing about 18% of the total points, relate to organisational issues such as infrastructure, staff management, and professional development. Four indicators, representing about 10% of the total points, relate to patient views of care, assessed using standardised patient experience surveys. The remainder of the points relate to the provision of so called "additional services" such as minor surgery, child health surveillance, and maternity care.

It appears that British GPs are willing to accept the idea of performance related pay; 70% of family doctors took part in a recent ballot and 79% of these voted in favour of its implementation in April 2004. Economic theory and evaluations of incentive schemes in other countries give us some insight into the potential impact of the new contract for patients and professionals in the UK. Firstly, we can be confident that practices will respond. Financial incentives have been shown to be an effective way of influencing professional and organisational behaviour in a wide range of countries and health systems.⁵⁻⁷ This is particularly true when the incentives are aligned to professional values, targeted on areas that are deemed to be important⁸ and represent a sufficiently high proportion of total income.⁹ The new GP contract seems to satisfy these criteria. Much of the content addresses areas that clinicians want to improve and the top performing practices have the potential to increase their income by more than one third. Not all of this money will go into doctors' pockets. Some will need to be spent on better systems to improve the delivery of care. In addition, individual GPs will be able to choose whether they want to work harder and earn more, or use the new

income coming into their practices to employ new clinical and administrative staff.

"It appears that British GPs are willing to accept the idea of performance related pay"

Moreover, there is every chance that within a few years the contract will result in a significant improvement in health outcomes in the UK. General practice is responsible for most of the routine care for the common chronic conditions with a high morbidity and mortality. The clinical indicators in the contract are largely evidence based and it is possible to estimate the health outcome benefits of achieving the level of care determined by the indicators.¹⁰ These improvements are likely to be secured through changes in the structure of general practice—the contract targets will be more easily attained by large practices with clinical staff specialising in specific disease areas, and by those practices supported by more nurses and administrative staff.¹¹

However, alongside these benefits, the incentives are likely to change behaviour in ways that may have a negative impact on the service.¹² We know that an undue emphasis on external rewards can damage internal professional motivation¹³ and that the level of incentives may have to be maintained or even increased in order to sustain desired performance. Incentives can also focus attention on short term reporting or payment cycles to the detriment of long term strategic planning. We also know that any form of performance management can result in gaming, misrepresentation of data, and sometimes downright fraud. There must be doubts about whether the managerial capacity and data quality in primary care are adequate to monitor and deal with these unintended consequences.

Finally, there are very real concerns that the areas of practice in which it is more difficult to introduce incentives will be downgraded or ignored as primary care teams concentrate their attention on the high priority areas—particularly chronic disease management since this will attract most of the payments. This is less likely to be a problem for the clinical conditions for which there are no incentives; indeed, it is possible that the "halo effect" produced by improved practice systems will result in improvements in all clinical areas. Of greater concern are the more subjective elements which lie at the core of high quality general practice—continuity of care, effective communication, empathy, the promotion of patient

autonomy, and the coordination and advocacy roles of the family doctor. These patient centred values are generally regarded as the greatest strength of British general practice¹⁴ and it would be a tragedy if, in an attempt to improve health outcomes, this baby is thrown out with the bath water.

The use of financial incentives to improve performance is not a new phenomenon, but they have never previously been designed in such a sophisticated way nor used on the scale planned in the UK. We do not know whether the very real benefits that will come out of this massive policy experiment will outweigh the risks. In particular, it is unclear whether improvements in population health will come at the expense of patient centred care. There are plans to monitor progress as the contract is implemented and to evaluate its impact on patients and on the service. The results will be awaited with interest.

Qual Saf Health Care 2003;12:397–398

.....
Authors' affiliations

M N Marshall, National Primary Care Research and Development Centre, University of Manchester, UK
P Smith, Centre for Health Economics, University of York, UK

Correspondence to: Professor Martin Marshall, The University of Manchester, National Primary Care Research & Development Centre, 5th Floor Williamson Building, Oxford Road, Manchester M13 9PL, UK; martin.marshall@man.ac.uk

The National Primary Care Research and Development Centre and the Centre for Health Economics are both core funded by the UK Department of Health. Professor Smith is funded by ESRC fellowship R000271253. The views expressed in this editorial are those of the authors and not necessarily those of the funding bodies.

REFERENCES

- 1 **Davis DA**, Thomson MA, Oxman AD, *et al*. Changing physician performance: a systematic review of the effect of continuing medical education strategies. *JAMA* 1995;274:700–5.
- 2 **Marshall MN**, Shekelle PG, Davies HT, *et al*. Public reporting on quality in the United States and the United Kingdom. *Health Aff* 2003;22:134–48.

- 3 **Smith R**. Why are doctors so unhappy? *BMJ* 2001;322:1073–4.
- 4 **British Medical Association**. *New GMS contract*. London: British Medical Association, 2003.
- 5 **Scott A**. Eliciting GPs' preferences for pecuniary and non-pecuniary job characteristics. *J Health Econ* 2001;20:329–47.
- 6 **Robinson J**. Theory and practice in the design of physician payment incentives. *Milbank Q* 1999;79:149–77.
- 7 **Le Grand J**. Knights, knaves or pawns? Human behaviour and social policy. *J Social Policy* 2002;26:149–69.
- 8 **Spooner A**, Chapple A, Roland M. What makes British general practitioners take part in a quality improvement scheme? *J Health Serv Res Policy* 2001;6:145–50.
- 9 **Gaynor M**, Rebitzer J, Taylor L. *Incentives in HMOs*. 2001.
- 10 **Mant J**, Hicks N. Detecting differences in quality of care: the sensitivity of measures of process and outcome in treating acute myocardial infarction. *BMJ* 1995;311:793–6.
- 11 **Marshall M**, Roland M. The new contract: renaissance or requiem for general practice? *Br J Gen Pract* 2002;52:531–2.
- 12 **Smith P**. On the unintended consequences of publishing performance data in the public sector. *Int J Public Adm* 1995;18:277–310.
- 13 **Davies HTO**, Lampel J. Trust in performance indicators? *Qual Health Care* 1998;7:159–62.
- 14 **DeMaeseneer J**, Hjortdahl P, Starfield B. Fix what's wrong, not what's right, with general practice in Britain. *BMJ* 2000;320:1616–7.

A "tipping point" crisis

.....

A crisis in maternity services: the courage to be wrong

R Youngson, T Wimbrow, T Stacey

.....

The response to a crisis experienced in the maternity unit at Waitakere Hospital, New Zealand resulted in profound improvements in care

Waitakere Hospital in urban West Auckland has a busy maternity unit. Most of our mothers receive care from independent midwives working within the hospital's birthing facilities. Complications during labour are referred to the duty obstetrician. Natural anxiety about coping with emergencies during labour and childbirth is exacerbated by the unit's isolation from other acute services. In 2001 multiprofessional dissatisfaction provoked a breakdown in relationships between obstetricians and midwives.

In some aspects of obstetric care we were not alone. Caesarian section rates in New Zealand between 2001 and 2002 increased from 20.8% to 22.1%,¹ but when our caesarian section rate hit 27% the sense of crisis was ours. Professional

relationships fractured in a series of "tipping point" events (box 1). The symptoms of a breakdown rapidly multiplied: nine major patient complaints in 3 months; enquiry into neonatal deaths; an obstetrician suspended for competency review; and independent midwives refusing to attend hospital policy review meetings at which clinicians questioned midwifery practice. The viability of on call rosters was threatened as morale plummeted and staff resigned.

A way forward with better, safer working practices seemed impossible. It was clear that resolution would only come through a process that focused on interprofessional relationships, however obvious the practical solutions to our problems of poor quality care might seem. A joint letter from 27 independent

midwives gave us the opportunity to re-engage, although not before the Minister of Health became embroiled in the dispute. Midwives wrote of serious concerns about their professional autonomy, women's rights, and poor relationship with obstetricians. A series of meetings exposed the high levels of anxiety, anger and blame on all sides. We responded with a process specifically designed to rebuild trust and focus on common goals.

A "DRAMATIC" INTERVENTION

Known thereafter as the "Big Day Out", a crucial 1 day workshop led by an outside facilitator was convened, attended by 65 people comprising all the main contributors to obstetric care—obstetricians, anaesthetists, paediatricians, midwives, and consumer advocates. To ensure maximum attendance, clinics and routine operating lists were cancelled and locums provided cover for urgent patient care.

The workshop was unusual. Planned but unscripted, it was based on role play. For most, this was an unfamiliar approach to learning and many were fearful. Participants role played labour room crises, slowing down time to allow exploration of interactions, behaviours, beliefs, and difficulties in communication. At first roles were represented by moving furniture. Gradually people volunteered to play their own roles,