PostScript

LETTER

Financial incentives and quality improvement

We share Marshall and Harrison's caution on over-reliance on financial incentives for improving quality of care manifested in the new UK general practice contract.[1] Financial incentives do not always result in behaviour change as intended for reasons that are not well understood. We argue that "the fascination with financial incentives" is not "based on sound empirical evidence".

In recent years at least three systematic reviews on the impact of financial incentives on provider behaviour have been published.[2–4] The reviews agree that good quality evidence is lacking and that the available research evidence provides mixed messages.[3 4] For example, a controlled before/after study of 426 Danish GPs assessed the effects of adding fee-for-service to capitation on the use of repeat prescription.[5] Contrary to expectations, fee-for-service payments were associated with a fall in repeat prescription rates. Some suggested the findings either implied that GPs did not respond to financial incentives or the fee was not sufficient to change behaviour.[6] Neither could justify the significant reduction that followed the fees.

We subjected the systematic reviews to forward citation searches in the Science and Social Science Citation Index databases (accessed via http://wok.mimas.ac.uk, February 2005). As a result, we identified only two research studies that could have met the Cochrane Effective Practice and Organisation of Care Review Group criteria for acceptable evidence in provider behaviour change.[7 8] The studies did not support the argument that financial incentives necessarily result in intended behaviour changes. Firstly, a US randomised controlled trial assessed the impact of financial incentives on provision of smoking cessation services. It concluded that financial incentives alone did not result in adherence to the performance targets linked to clinical guideline recommendations.[7] This was in line with a previous uncontrolled UK study that concluded fee-for-service payments were ineffective in increasing provision of smoking cessation advice.[9] Secondly, a controlled before/after study assessed the effects of changing GP payment from capitation plus fee-for-service to salaried arrangements. No significant change in GP behaviour occurred.[8] Others also assessed the impacts of salaried arrangements on quality of care in the UK.[10] They found evidence of effect on quality of care, but this was inconsistent and confounded.

Research evidence does not support policymakers' enthusiasm for using financial incentives for quality improvement while, as Marshall and Harrison point out, there are dangers of unintended negative effects.[1]

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BOOK REVIEWS

Clinical Practice Guidelines in Mental Health: a Guide to their Use in Improving Care

P Whitty, M Eccles, Eds. Oxford: Radcliffe Press, 2004, £24.95. ISBN 1 85775 837 4.

There is something missing from this book. As I understand the intentions of the authors, they want their book to be read by working mental health professionals, those involved in Primary Care Trusts who commission and provide mental health care, and people who use mental health services. It is strange, then, that they fail to really address the issues that have kept many of us busy for quite a while since the publication of the National Service Framework for Mental Health five years ago. It's all very well designing guidelines, protocols and care pathways, but how do you get then fully implemented? How do you persuade the doctors who didn't participate in any way in the production of your local depression protocol to get the folder out of the in-tray and read it?

Paradoxically, if you haven't succeeded in achieving this in your organisation, this book can be quite reassuring. As Steven Woolf and his colleagues in a chapter entitled "Potential benefits, limitations and harms of clinical practice guidelines" say: "*Too often advocates view guidelines as a 'magic bullet' for healthcare problems and ignore more effective solutions. Clinical practice guidelines make sense when practitioners are unclear about appropriate practice and when scientific evidence can provide an answer. They are a poor remedy in other settings*" (page 10).

Also comforting for clinicians is a quote from Sir Michaels Rawlins, Chairman of NICE: "*No guideline can cover 100 percent, because people vary. It's up to the doctor or other health professional to decide when the guideline is no longer acceptable and what to do in its place*" (page 45). This presupposes that an adequate clinical governance mechanism is in place to map the clinical process, compare existing practice against guidelines, agree where implementation is or is not appropriate, and audit the impact on clinical outcomes. Where mental health is concerned—both in specialist trusts and in primary care—these systems are still fairly rudimentary. The section by Roger Paxton and his team from Morpeth on implementation of a NICE informed schizophrenia guideline through an integrated care pathway is one of the few that offers a real practical insight into these complex matters.

More than half of the book is generic in content and of interest to anyone concerned with what has happened in the field of guidelines and protocols over the last decade. I learned about the way in which NICE works and what the National Collaborating Centres actually are. But the experts were mostly telling us what they thought we ought to know about the interesting things they had been doing rather than engaging in the sticky issues we face on the ground. The Department of Health tells us to produce local protocols, wants boxes ticked, and issues guidelines. Ultimately, I began to wonder how much this knowledge has actually informed (or not) the unseen ones who send out the instructions and who still, despite the fine words of Louis Appleby in the foreword, think that is all they need to do.

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Regulating Pharmaceuticals in Europe: Striving for Efficiency, Equity and Quality

E Mossialos, M Mrazek, T Walley, Eds. UK: Cornwall, 2004, £24.99. ISBN 0335214657

Few markets are as controlled by government as pharmaceuticals. Medicines permeate

health care, are a major source of health care, and are made by one of the world's most successful high technology industrial groups—the pharmaceutical industry. In Europe there exists both socialised healthcare systems and one of the few high tech industries in which Europe can compete with the USA and Japan. The European Union as a whole, and particularly the countries which have a thriving pharmaceutical industry, want to maintain a strong and competitive industry which provides substantial tax income and very significant export earnings in some countries. On the other hand, the countries want to achieve a healthy population in which they at least maintain equity, quality, and improve efficiency while containing costs. How. then, can this circle be squared? The answer is, not easily—and not in any simple or uniform way.

There is a sort of dynamic equilibrium between cost containment, quality, equity and efficiency—rather like a balloon half filled with water, squeeze one area and another bulges out. Squeeze costs and a problem with equity may bulge out. Health professionals, managers, policy makers, the public, the media, and sometimes the law are regularly made aware of aspects of these tensions. However, as we often see one issue at a time, it can be hard to set the policy in any sort of context. This book, part of a series from the influential European Observatory on Health Systems and Policies, is the most comprehensive book I have seen on medication policies in the EU. While keeping to the focus described in the title, it avoids a narrow perspective, including sections on prescribing, patients and medicines, ''lifestyle'' drugs, and alternative medicines.

The book consists of 21, usually multi-authored, chapters. A common problem with this sort of edited work is that it is hard to get the contributors' chapters to flow and contribute to the whole. The editors solve this problem by starting with an excellent 37 page overview that flows as a whole while contextualising the chapters. It is worth buying the book for this overview alone. The early chapters cover issues such as the politics of pharmaceuticals, EU policy, price and reimbursement control, and measuring the consequence of policy outcomes. The middle section covers good prescribing, patients and medicines, financial incentives, community and hospital pharmacy, cost sharing, and off-patent and over-the-counter markets. The future is looked to in pharmacogenetics/genomics and debate about payment for lifestyle drugs. Policy in the Central, Eastern and the old USSR countries is also reviewed. The final chapter suggests a framework for fair containment of costs.

The overall message is that this is a very complex area, and one should transfer lessons from one country to another with caution. The blurb states that the book is for students of health policy, and for managers, and policy makers; however, I think it is of use to students and professionals in professions related to medicines and, not least, to many in the pharmaceutical industry. There is no perfect solution to balancing quality, equity, efficiency and costs, but the contents of this book will contribute to wiser policy being made.

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