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The impact of incentives on the behaviour and performance of primary care professionals

Executive summary for the National Institute for Health Research Service Delivery and Organisation programme

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Executive Summary

Background

There has been a trend over the last 15 years to treat incentives in UK public services more explicitly. These initiatives reflect a general shift away from placing implicit trust in individuals and organisations to carry out their duties, towards actively managing their performance.

Understanding the impact of different types of incentives on professional behaviour in primary care has been recognised as an urgent need in a context where major changes to incentive structures have been introduced in recent years.

Aims

The overall aim of the project was to explore and explain the impact of incentives in primary care on professional behaviours and performance in three settings: general medical practice, community pharmacy and general dental practice.

About this study

The three year study used a combination of quantitative and qualitative methods. The former involved analysis of national (in England) performance data. The latter involved interviews with Primary Care Professionals and their staff, as well as Primary Care Trust employees and patients.

Key findings

Incentives acted as powerful levers to change behaviours, resulting in

- a contribution to high levels of attainment of quality targets and a reduction, over time, in the variation in care quality related to deprivation in general medical practice
- increasing volumes of incentivised activities in community pharmacy
- a shift towards dental treatments which pay more, relative to effort expended

We identified a range of factors (internal, organisational, community, professional and wider health system factors) impacting on the motivation of Primary Care Professionals. The presence, nature and impact of these factors were different in each of the three settings studied. There were also some differences within settings reflecting local circumstances.

In all settings there were unintended consequences. These varied between settings, but included 'tick box' care delivery, decisions taken based on remuneration rather than clinical factors and worsening relationships between Primary Care Professionals' organisations and commissioners. These appeared to be most marked in dentistry where opportunities for gaming and for exit (from NHS provision) were highest and the level of trust in professionals to perform in the absence of incentives was lowest.

In general medical practice, changes to the incentive programme impacted adversely on motivation, although over time the incentive system became increasingly embedded in organisational life. In dentistry and pharmacy, there were no major changes to the incentive structure over the study period.

There is no one perfect blend of incentives applicable to all settings, but key factors influencing responses to be considered when constructing an incentive programme are

The extent to which

- the goals of the incentives programme are mutually compatible
- the programme places trust in individuals and organisations
- the messages of incentive programmes are clear and targeted properly
- those who are targets of incentives are able to respond in the desired way
- the desired result is subject to significant influence by those who are targets of incentives
- the organisational setting provides the capacity to respond to incentives
- what is being measured is perceived as accurate
- what is being measured is perceived as fair and legitimate
- changes to incentive structures are perceived as threatening
- rewards relative to effort are perceived as fair (in absolute terms, but also in comparison to others)
- those who are targets of incentives feel that they have a voice in the incentive process (particularly when exit not an option)
- the level of 'perceived public service efficacy' amongst Primary Care Professionals concerning the benefit that their organisations provide to the public is high

- exit is an option for those on the receiving end of changes

Conclusions

Incentives are powerful levers for changing behaviour. Whilst it is desirable to align incentives with policy aims, primary health care settings are characterised by complex, multiple and competing goals, which make this process difficult. Financial incentive programmes tend to be relatively blunt instruments which are not well suited to contexts of high goal ambiguity and complexity. This can lead to prioritisation of some goals over others, as well as unintended and dysfunctional consequences. Although some consequences may be unintended they are not necessarily unpredictable. When designing changes to incentive structures, therefore, policy makers should give greater consideration to the likely impact of potential schemes in terms of the key factors outlined above. They should also clearly articulate in advance the ways in which incentives are hypothesised to impact on each of the many and varied problems they are intended to solve.

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Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk