LETTER

Can financial incentives for improvements in healthcare quality enhance identification of COPD in primary care?

Undiagnosed chronic obstructive pulmonary disease (COPD) is a major public health issue, as it leads to patients missing out on appropriate preventive and therapeutic interventions.1–3 The ratio of diagnosed/predicted COPD prevalence differs widely between Primary Care Trusts (PCTs), suggesting that there are unacceptable variations in care.4 A National Clinical Strategy for COPD is to be launched in the UK in 2010 and there is an urgent need for evidence to support strategies to increase the identification of patients, particularly those with early disease.

In 2006 a locally enhanced service (LES) for COPD was introduced by NHS Kensington and Chelsea (K&C), giving general practitioners a small financial incentive for each individual screened and a larger payment for each patient diagnosed with COPD, where the quality items included in the LES were then documented. These included spirometry, pulse oximetry, body mass index, smoking cessation management, inhaler technique, Medical Research Council (MRC) dyspnoea score, medication review, a self-management plan, provision of a COPD rescue pack if appropriate and influenza and pneumococcal vaccination (see online for further details).

Practices received two types of payment; one for a screening test and one for the enhanced management of patients. Thus, if a patient was screened and found to have COPD, a practice would be paid both the screening fee and the enhanced management fee. Hence the incentive for screening was to locate new cases, so that they could go through the enhanced management template and attract the enhanced payment. The remuneration for the screening itself was quite small (only £10), but for the enhanced management was more significant (£30). This incentivised practices to focus screening on those patients most likely to have COPD—that is, older individuals and smokers.

Data on COPD prevalence for 31 PCTs in London from 2005 to 2009 were obtained from the national quality outcomes framework database. Individual practice data from K&C were compared with NHS Westminster, a partner PCT in an Integrated Service Improvement Programme, where the LES had not been introduced. Between 2005 and 2008 there was a linear increase in COPD prevalence in K&C (r²=0.997). If the preceding trend had continued, the predicted prevalence for 2009 would have been 0.87% (95% CI 0.84% to 0.90%), whereas following the introduction of the LES it was 0.98% (figure 1). Neither Westminster nor other London PCTs showed any variation from the preceding 4 years’ trend (data for each PCT and comparison of individual Westminster and K&C practices are available online).

In the 39 practices that participated in the LES in K&C, 963 patients were screened with spirometry, 31.5% of whom were diagnosed with COPD. The cost of the screening per diagnosis was £94, which included £1000 given to each participating practice up-front to cover set-up costs for the LES.

Our data are consistent with previous findings that financial incentives can accelerate improvements in healthcare quality.5 Incentivised targets for quality care in COPD through a LES can drive case-finding in general practice and could lead to a step change in the prevalence of COPD if adopted more widely.

Christine Falconer,1 Sarah L Elkin,2 Julia L Kelly,3 Frankie Lynch,1 Iain D Blake,1 Nicholas S Hopkinson*1

1Central London Community Healthcare, St Charles’ Hospital, London, UK; 2Respiratory Medicine, Imperial College NHS Trust, London, UK; 3Respiratory Muscle Lab, National Heart & Lung Institute, Imperial College, Royal Brompton Hospital, London, UK; 4NH Saskatchewan and Chelsea, Primary Care Directorate, St Charles’ Hospital, London, UK

Correspondence to Dr Nicholas Hopkinson, Respiratory Muscle Lab, National Heart & Lung Institute, Imperial College, Royal Brompton Hospital, Fulham Road, London SW3 6NP, UK; n.hopkinson@ic.ac.uk

Additional materials are published online only. To view these files please visit the journal online (http://thorax.bmj.com).

Funding This work was supported by the NIHR Respiratory Disease Biomedical Research Unit at the Royal Brompton and Harefield NHS Foundation Trust and Imperial College London, and by The Inner Northwest London Care Community Integrated Service Improvement Program for COPD.

Competing interests None.

Contributors The LES was developed by CF, IDB and FL. NSH, JKL and CF collected and analysed the data. NSH wrote the first draft with CF, and all authors contributed to the final draft and approved the final version. NSH is the guarantor of the paper.

Provenance and peer review Not commissioned; not externally peer reviewed.

Accepted 28 June 2010

Thorax 2010; 65: doi:10.1136/thx.2010.140913

REFERENCES


Can financial incentives for improvements in healthcare quality enhance identification of COPD in primary care?
Christine Falzon, Sarah L Elkin, Julia L Kelly, Frankie Lynch, Iain D Blake and Nicholas S Hopkinson

Thorax  published online October 14, 2010

Updated information and services can be found at:
http://thorax.bmj.com/content/early/2010/10/14/thx.2010.140913

These include:

Supplementary Material
Supplementary material can be found at:
http://thorax.bmj.com/content/suppl/2010/11/26/thx.2010.140913.DC1

References
This article cites 3 articles, 2 of which you can access for free at:
http://thorax.bmj.com/content/early/2010/10/14/thx.2010.140913#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/