Influencing physician prescribing in an international context
Sturm, Heidrun Beate

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Document Version
Publisher's PDF, also known as Version of record

Publication date:
2007

Citation for published version (APA):
Pharmaceutical policies: effects of policies for prescribers using financial incentives*

*Vernby A, *Kösters JP.

*Department of Health Services Research, Norwegian Knowledge Centre for Health Services, Oslo
*Nordic Cochrane Centre, Copenhagen, Denmark
†Health Services Research Unit, University of Aberdeen, Scotland
‡University Medical Centre Groningen (UMCG), Department of Clinical Pharmacology, The Netherlands
§Karolinska Institute, Stockholm, Department of Public Health Sciences (IHCAR), Sweden

*This is an earlier version of the published Cochrane review.
**Dates**

**Contact reviewer**
Heidrun Sturm
Researcher
Department of Clinical Pharmacology
University Medical Centre Groningen
Antonius Deusinglaan 1
9713 AV Groningen
NETHERLANDS
Telephone 1: +31-50-3632820
Facsimile: +31-50-3632812
E-mail: h.sturm@med.umcg.nl, heidrunsturm@web.de

**Contribution of reviewers**
MOA, AA and ADO prepared the protocol. JPK and HS commented on protocol drafts. HS, AA, MOA, and JPK applied the inclusion criteria, assessed the quality and extracted the data for the included studies. CR further developed quality criteria (based on the EPOC criteria) for interrupted time series (ITS) and repeated measures studies. CR and AV conducted statistical reanalyses for the ITS studies. HS prepared the first draft of the report. The others commented on and contributed to subsequent iterations.

**Internal sources of support**
Norwegian Knowledge Centre for the Health Services, NORWAY
Dutch Health Insurance Board, The Netherlands

**External sources of support**
None

**Synopsis**
Pharmaceutical expenditure consumes a growing part of total health care costs. This increases the pressure to control them. One policy option of governments, non-government agencies and health insurance companies to try to control drug expenditures is to influence prescribers through financial incentives.

Budgetary policies were the only such intervention directed at prescribers of which evaluations could be included. Ten studies evaluated fundholding in private practices in the UK, one evaluated the Irish indicative drug target savings scheme (IDTSS) and two evaluated German drug budgets for physicians in private practice. The review did not find any rigorous studies that evaluated other policies of that category, such as performance-based payment.
Budgets are funds that are allocated by payers to a group or individual physicians, thereby giving them financial responsibility for the management of their own budget (Wilton 1998). Drug budgets are intended to encourage economic drug use and aim at decreasing prescribing costs. This review found that drug expenditure (per item and per patient) and prescribed drug volume decreased under budgets in all three countries, while generic drug use increased. No clear evidence was found on effects on health and health care utilization. Due to limitations of included studies, overall evidence is weak.

Abstract

Background: Pharmaceuticals, while central to medical therapy, pose a significant burden to health care budgets. Therefore regulations to control prescribing costs and improve quality of care are implemented increasingly. These include the use of financial incentives for prescribers. Financial incentives for prescribers are of two general types: increased financial accountability using budgets and performance based payments.

Objectives: To determine the effects on drug use, healthcare utilisation, health outcomes and costs (expenditures) of policies, that intend to affect prescribers by means of financial incentives.

Search strategy: We searched the following databases and web sites: ISI Web of Science (28/04/06), JOLIS (19/01/06), Global Jolis (19/01/06), WHOLIS (19/01/06), MEDLINE Ovid, 1966 to October Week 1 2005 (16/10/05) EMBASE Ovid, 1980 to 2005 Week 42 (16/10/05), OECD Publications & Documents (30/08/05), SourceOECD (30/08/05), WHO (World Health Organisation) (25/08/05), World Bank Documents & Reports (30/08/05), World Bank e-Library (04/05/05), IPA (22/04/04), PAIS International (23/03/04, NTIS (03/03/04), PubMed (25/02/04), NHS EED (20/02/04), International Political Science Abstracts (09/01/04), INRUD (21/11/03), SIGLE (12/11/03, EconLit (23/10/03), CSA Worldwide Political Science Abstracts (21/10/03), Effective Practice and Organisation of Care Group Register (22/08/03), Cochrane Central Register of Controlled Trials (15/10/03)

Selection criteria: Policies in this review were defined as laws, rules, financial and administrative orders made by governments, non-government organisations or private insurers. To be included a study had to include an objective measure of at least one of the following outcomes: drug use, healthcare utilisation, health outcomes, and costs (expenditures); the
study must be a randomised controlled trial, non-randomised controlled trial, interrupted time
series analysis, repeated measures study or controlled before-after study evaluating financial
incentives for prescribers introduced for a large jurisdiction or healthcare system.

Data collection & analysis: Two reviewers independently extracted data and assessed
study limitations. Quantitative analysis of time series data, for studies with sufficient data, and
qualitative analyses were undertaken.

Main results: We found thirteen evaluations (in 16 papers) of budgetary policies that met
our inclusion criteria, and none of performance based payments. Ten studies evaluated
fundholding in private practices in the UK, one evaluated the Irish indicative drug target
savings scheme (IDTSS) and two evaluated German drug budgets for physicians in private
practice. The included interrupted time series analyses had some limitations, whereas all the
controlled before-after studies (all from the UK) had serious limitations.

Drug expenditure (per item and per patient) and prescribed drug volume decreased with
budgets in all three countries. We found evidence of increased use of generic drugs in the UK
and Ireland, and inconclusive evidence of effects on the use of new and expensive drugs. We
found no clear evidence of increased health care utilisation and no studies reporting effects
on health.

Reviewers' conclusions: Based on the evidence in this review coming from three European
countries, drug budgets for physicians in private practice can limit drug expenditure, decrease
the volume of prescribed drugs and increase the use of generic drugs. We found no evidence
of adverse effects on health and no clear evidence of increased health care utilisation.
Administration costs were not reported. We did not find any evaluations of the effects of
performance-based payments that met our inclusion criteria. However, since the majority of
the studies included in this review were found to have serious limitations, these results should
be interpreted with care.

Background

(Abbreviations used in this review are listed in Additional Table 1.)

The proportion of total health care expenditure spent on drugs has continued to grow
in numerous countries over the last decades (Willison 2002, Okunade 2005, Reinhardt
For instance in the UK prescription costs were the largest element of the Family Health Services budget already in the 1990’s (Bradlow 1993), and in Spain drug costs in primary care consume over 50% of total primary care expenditure (Antonanzas 2003). Therefore policy makers are pressured to control pharmaceutical expenditures without adversely affecting the quality of care. Unexplained variation in prescribing between individual physicians, settings and countries (Sturm 2005) and the fact that evidence as reflected in clinical practice guidelines is often not adequately put into practice (Feely 1999), are just some reasons, that regulatory measures targeted at prescribers also aim to improve the quality of prescribing.

While policymakers’ need for evidence grows, rigorous evaluations of regulatory measures are sparse. This review is part of a series of Cochrane reviews of pharmaceutical policies (Aaserud 20014), investigating the effects of prescribing policies on drug and health care utilisation, costs and health outcomes. This (sub)-review focuses on financial policies targeted at prescribers. Policies targeted at prescribers that use educational interventions are addressed in a separate review.

The general trend to introduce market elements in health care during the last decades has been accompanied by decentralizing decision-making (Saltman2002, Bligh 1992). For physicians, this has led to an increased accountability for their use of resources (Wilton 1998), including prescribing. Budgetary arrangements for drugs are one prominent example. Regulations also aim to counterbalance market failure and focus on the quality of treatment. Quality-based payments are another type of financial incentive, which are being used increasingly (e.g. in the UK) (Giuffrida 2000).

Other monetary regulations, such as the remuneration of physicians, can also impact prescribing. However these do not specifically target prescribing and are generally not considered pharmaceutical policies. The restriction of reimbursement for patients might also be considered as a physician centred measure since they affect prescribing by physicians (Kanavos 1999). These policies, however, are considered in other sub-reviews (Aaserud 2004). Pharmaceutical policies for prescribers that use financial incentives, which are included in this review are therefore limited to drug budgets and quality based payments.

**Drug budgets**

Budgets are funds that are allocated by payers to a group or individual physicians, thereby giving them financial responsibility for the management of their own budget (Wilton 1998),
Budgets therefore encourage economic behaviour and offer incentives for savings. Drug budgets in particular aim at decreasing prescribing costs.

Budgets vary with respect to the level where the budget is set (individual practice or collective budgets), the range of services covered, and the intensity of the incentives (rewards or risks). Additional Table 2 provides a scheme of theoretical models including these three variables.

In general, individual providers or physician representatives and the payer negotiate budgets, depending on whether the budget is on a practice, group or regional/national level. Payers are represented either by a (regional) health authority (UK), a social health insurance (Germany) or as in the US, a managed care organization. The budgets are usually set based on previous spending, adjusted to patient mix or a defined target (e.g. the average spending of comparable practices, or a 1% reduction of overall health care spending, as in Italy). Most budgetary interventions were introduced in the early to mid 1990s and adapted or abolished over time.

Budgets provide incentives to prescribe fewer and less expensive drugs. Physicians can modify drug volume by changing the dosage or duration of treatment. Costs per item can be limited by increasing the use of generics or other less expensive drugs with equivalent effects. Theoretically this can also slow down the uptake of expensive new drugs with marginal benefits.

The intensity of the incentive is modified by several factors. Firstly, there is the magnitude of financial risk involved. This can be potential fines (Germany, France), savings to be used for improvement of medical services (UK), or salary bonuses as in Spain (Antonanzas 2003). Incentives are more direct and stronger if applied on an individual level than at a group level and depend on how much the budget level (target) is adapted to provider specific circumstances. For instance in the UK high cost patients and in Germany specific drug classes are exempt (Wilton 1998). The amount, type and timing of prescribing information available to budget holders are important to enable prescribers to react (Schreyoegg 2005). Lack of useful information can also be an impediment in effective contracting (Wilton 1998). Low perceived financial risk will decrease the strength of the incentive and depends on the likelihood that fines are actually executed or the ability to influence the results personally versus being dependent on a whole group.
Quality based payments

Quality based payment systems come in a variety of forms. They are most often directed at all physician services and not at prescribing singularly. Targets for these policies include administrative goals, waiting time, patient satisfaction, diagnostic and treatment goals. Prescribing policies include pay for performance and other policies offering bonuses or penalties to encourage improvement of prescribing. Based on set performance standards physicians are awarded or punished for their prescribing (McNamara 2005).


Other identified reviews focusing on effects of various financial incentives on general medical practice only rarely address prescribing or report drug related outcomes. Chaix-Couturier in her literature review of financial incentives, besides looking at methodological issues, summarized trial results according to remuneration of physicians and - overlapping - by regulations related to managed care (Chaix-Couturier 2000). Effects of interventions on drug-use were reported from only two settings: British fundholding and US managed-care. In the latter prescribing was measured as a proxy for quality of care. Reviews investigating the effect of different remuneration systems for physicians (Chaix-Couturier 2000; Bloor 1996; Maynard, 2003; Gosden 2001; Giuffrida 2000; Gosden, 1999) included only one study of a total of 25 that reported effects on drug utilisation or related costs (excluding immunization): the renewal of prescriptions. Quality-based-payments are a relatively new approach and evaluations are scarce (Giuffrida, 2000; Rosenthal 2004; McNamara 2005; Roland 2004).

The aim of this review is to support informed decisions about pharmaceutical policies and to guide future evaluations by preparing an up-to-date, comprehensive summary of what is known from well-designed research about the effects of financial incentives targeted at prescribing on drug use, healthcare utilisation, health outcomes and cost (expenditures). Complementary reviews of other pharmaceutical policies are in progress (Aaserud 2006).
Objectives

To determine the effects of prescribing policies using financial incentives on drug use, healthcare utilisation, health outcomes and costs (expenditures).

Criteria for considering studies for this review

**Types of studies**
Randomised controlled trials (RCTs), non-randomised controlled trials (CCTs), repeated measures (RM) studies, interrupted time series (ITS) analyses, and controlled before-after (CBA) studies.

**Types of participants**
Health care consumers and providers within a large jurisdiction or system of care. Jurisdictions can be regional, national or international. Studies within organisations, such as health maintenance organisations, are included if the organisation is multi-sited and serves a large population.

**Types of interventions**
Prescribing policies (financial incentives): Policies that intend to affect prescribing by means of financial incentives. Included in this category are management of drug budgets by prescribers, indicative prescribing schemes, other financial policies for prescribers such as pay-for-performance, if they are specifically targeted at prescribing or drug utilisation. Policies in this review are defined as laws, rules, financial and administrative orders made by governments, non-government organisations or private insurers. Interventions at the level of a single facility were excluded.

**Types of outcome measures**
To be included a study had to include an objective measure of at least one of the following outcomes:

- Drug use (prescribed, dispensed or actually used)
- Healthcare utilisation
- Health outcomes
- Costs (expenditures), including drug costs and prices, other health care costs and policy administration costs
Search strategy for identification of studies

The search to identify studies for this review was initially done as a part of a much broader review, Pharmaceutical policies: effects on rational drug use (Aaserud 2006), dealing with the effects of all pharmaceutical policies. The broad review has been split into several subreviews, including this review.

Initial broad search for studies of pharmaceutical policies
We developed the search strategy without language restrictions. The following databases were searched:

Effective Practice and Organisation of Care Group Register,
Idealist database searched 22/08/03
MEDLINE Ovid, 1966 to June Week 1 2003, searched 18/06/03
EMBASE Ovid, 1980 to 2003 Week 23, searched 18/06/03
ISI Web of Science, searched 08/09/05 for cited key references
CENTRAL, The Cochrane Central Register of Controlled Trials, Ovid, searched 15/10/03
CSA Worldwide Political Science Abstracts from 1975-present, searched 21/10/03
EconLit WebSPIRS from 1969-present, searched 23/10/03
SIGLE, System for Information on Grey Literature in Europe, WebSPIRS from 1980-2003/06, searched 12/11/03
INRUD, International Network for Rational Use of Drugs, searched 21/11/03
International Political Science Abstracts, WebSPIRS from 1989-2003/12, searched 09/01/04
NHS EED, National Health Services Economic Evaluation Database, CRD, searched 20/02/04
PubMed searched 25/02/04 for relevant journals not indexed in MEDLINE
NTIS, National Technical Information service from 1964-present, searched 03/03/04

The Health Management Information Consortium (HMIC) database was tested and found not to be useful for this review.

In addition the following web sites and databases were searched:
OECD (Organisation for Economic Co-operation and Development) Publications & Documents, searched 30/08/05
The MEDLINE search strategy was mainly developed using reviews cited in the background section of the protocol and their references. The strategy includes terms for the following categories of interventions:

- Regulation and classification (licensing) policies
- Patent and profit policies
- Marketing policies
- Policies that regulate the provision of drug insurance
- Policies that determine which drugs are reimbursed
- Restrictions on reimbursed drugs
- Prescribing policies
- Pricing and purchasing policies
- Regulation of sales
- Co-payment and caps
- Patient information

We used a modified version of the EPPOC search strategy methodology filter to limit the MEDLINE strategy to randomized trials, controlled trials, time series analyses and controlled before-after studies. Search strategies for most of the other databases were developed on the basis of the MEDLINE strategy.

We screened the reference lists of all of the relevant reports that we retrieved. We searched the Science Citation Index for articles citing key references. Authors of relevant papers, relevant organizations, and discussion lists were contacted to identify additional studies, including unpublished and ongoing studies.
**Further specific search strategies for studies of pharmaceutical pricing and purchasing policies**

We performed a subsequent search for studies of financial incentives, and educational and quality improvement interventions aimed at prescribing, the latter being addressed in a separate review. Search strategies were developed for MEDLINE and EMBASE, based on relevant parts and yields of the initial broad search strategy.

**MEDLINE** Ovid, 1966 to October Week 1 2005, searched 16/10/05; **EMBASE** Ovid, 1980 to 2005 Week 42, searched 16/10/05; MEDLINE Ovid

Search fields: A combination of MeSH terms and text words

The methods of the review

Two authors (of HS, AA, JPK and MOA) independently reviewed all of the search results, abstracts and reference lists of relevant reports. The full text of potentially relevant reports was retrieved (if one or both authors thought it was potentially relevant) and two (of the above) authors independently assessed the relevance of those studies and the limitations of included studies. The lead author (HS) extracted data from included studies in collaboration with one other author (AA, JPK or MOA). For all the steps in the above process disagreements were resolved by discussion, when necessary including another author (ADO).

Included study limitations

We used the standard criteria recommended by EPOC to assess the methodological limitations of studies (risk of bias) included in EPOC reviews (EPOC 2002).

The criteria for RCTs and CCTs were:

- Concealment of allocation
- Baseline measurement of outcomes
- Follow-up of professionals
- Follow-up of patients
- Intention-to-treat analysis
Blinded assessment of primary outcomes
Reliable primary outcomes measures
Other risk of bias

The criteria for CBA studies were:
Baseline measurement of outcomes
Baseline characteristics of studies using second site as control
Follow-up of professionals
Follow-up of patients
Reliable primary outcomes measures
Blinded assessment of primary outcomes
Protection against contamination
Other risk of bias

We used the EPOC definition of RCT, CCT, CBA and ITS studies. For ITS studies the definition is: “The study must have a clearly defined time of intervention AND must have at least three data points before and three data points after the intervention.” We also considered designs where there was a control ITS group. Control ITS designs are conceptually similar to CBA design but the addition of multiple time points pre and post intervention decreases the likelihood of secular change bias. ITS studies usually have only one data item at each point in time (e.g. number of hospitalised cases). However, in this review there were studies that had ITS data for many individual patients (i.e. each individual contributed data to every point in time). Such designs usually produce a higher level of evidence than a simple ITS because between patient variability can be modelled as well as within patient variability, resulting in a study with substantially more power than a simple ITS. The criteria for protection against bias are the same as for a simple ITS except that the appropriate methods of analysis differ (e.g. repeated measures anova, generalised estimating equations or random effects models). We have called these studies repeated measures (RM) studies. As with an ITS study with a control group, RM studies can also have a control group consisting of control patients repeatedly observed over time.

Based on experience with two previous systematic reviews (Davey 2005; Grilli 2002), the statistical editor of EPOC, who is also a co-author of this review (CR), suggested minor revisions to the EPOC criteria for ITS (and RM studies). These consisted of defining reanalysed studies as meeting the ‘analysed appropriately’ criteria and allowing studies that had at least 12 monthly data points pre and post to meet the ‘reason for number of data points’ criteria.
These criteria more accurately reflected the chance of bias in the study effect sizes. We therefore used the following criteria:

- The intervention was independent of other changes (protection against secular changes). This was “MET” if there were compelling arguments that the intervention occurred independently of other changes over time and the outcome was not influenced by other confounding variables/historic events during study period.
- Data were analysed appropriately. This was “MET” if autoregressive integrated moving average (ARIMA) models were used OR time series regression models were used to analyse the data and serial correlation was adjusted/tested for OR reanalysis performed.
- Reasons for number of data points were given. This was “MET” if data for 12 months (or more) pre- and post-intervention was used OR reason for the number and spacing of data points is given OR sample size calculation performed.
- Shape of the intervention effect was pre-specified. This was “MET” if point of analysis was the point of intervention OR a rational explanation for the shape of intervention effect was given by the author(s). Where appropriate, this should include an explanation if the point of analysis was NOT the point of intervention.
- Intervention unlikely to affect data collection (protection against detection bias). This was “MET” if it is reported that intervention itself was unlikely to affect data collection (for example, sources and methods of data collection were the same before and after the intervention).
- Blinded assessment of primary outcome(s). This was evaluated as protection against detection bias. This was “MET” if the authors stated explicitly that the primary outcome variables were assessed blindly OR the outcome variables were objective, e.g. length of hospital stay, drug levels as assessed by a standardised test.
- Completeness of data set. This was “MET” if the data set covered 80-100% of total number of participants or episodes of care in the study.
- Reliable primary outcome measure(s). This was “MET” if two or more raters with at least 90% agreement or kappa greater than or equal to 0.8 OR the outcome was obtained from some automated system e.g. length of hospital stay, drug levels as assessed by a standardised test.
- Other risk of bias.
For CITS (controlled ITS) and CRM (controlled RM) studies, the time series part of the studies were assessed independently from the control part, using the above described criteria for ITS and RM studies. The control series part of the study was assessed using the CBA criteria above. If the control part had serious limitations, it was not included and the study was classified as ITS or RM, otherwise the control data were used as a control in the review.

Overall limitations for each main outcome within each study was assessed by each of the data extractors using the following guidelines:

- No serious limitations = low risk of bias = all criteria scored as ‘met’
- Some limitations = moderate risk of bias = one or two criteria scored as ‘not clear’ or ‘not met’
- Serious limitations = high risk of bias = more than two criteria scored as ‘not clear’ or ‘not met’
- Fatally flawed = study results that we believed to be untrustworthy based on an overall judgment of the risk of bias in the study, based on all of the criteria used to assess the risk of bias.

Some setting dependent judgment (i.e. judgment dependent on knowledge of the setting in which a study was done) was used when assessing overall limitations. Where setting dependent judgment has been used, the explanations are provided in Additional Table 03.

DATA EXTRACTION

The following additional information was extracted from included studies using a standardised data extraction form:

- Type of study (randomised trial, non-randomised trial, repeated measures study, interrupted time series, controlled before-after)
- Study setting (country, key features of the healthcare system and concurrent pharmaceutical policies)
- The sponsors of the study
- Characteristics of the participants (consumers, physicians, practices, hospitals, etc.)
- Characteristics of the policies
Main outcome measures and study duration
The results for the main outcome measures

If the study presented results for more than one outcome in each of the four outcome groups (drug use, health, health care utilisation and costs), we chose what we considered the most important outcome in each group, either as specified by the author or based on discussions among the reviewers. We aimed to be parsimonious. However, in cases where additional outcomes might lead to different conclusions, we also included them. Otherwise, decisions about which outcomes to include were not based on the direction or size of effect, or whether a finding was statistically significant or not.

Tables were prepared for each sub-category of intervention including the following information: study identification, characteristics of the intervention, drug use, healthcare utilisation, health outcomes, and costs. These tables form the basis for the primary qualitative analyses. We also described potential mechanisms through which the policies were intended to affect drug use and costs and postulated mechanisms for other effects, both intended and unintended. In addition we briefly listed and described important policy options for which no evaluations were found.

We attempted to identify important factors that might be taken into consideration by anyone contemplating implementing any of the policy alternatives, including: possible trade-offs (of the expected benefits versus harms and costs), different effects of varying policy conditions and background situations, short versus long term effects, limitations of the available evidence and other important factors that might affect the translation of the available evidence into practice in specific settings.

Our confidence in the available estimates of effects was graded using a modification of the approach recommended by the GRADE Working Group (GRADE 2004). When grading the quality of evidence, we started out grading ITS and RM studies as “Moderate” quality, and CBA studies as “Low” quality. This reflects our impression that the results of ITS and RM studies were more compelling (more likely to be correct) than those of CBA studies. The GRADE quality scores are High, Moderate, Low, and Very low.
There were an insufficient number of comparisons for similar outcomes across studies to allow for meaningful exploration of heterogeneity. The following potential explanatory factors were considered: differences in the characteristics of the policies, differences in the settings and differences in study limitations.

**CBA studies**

For CBA studies we reported relative effects. For continuous variables we have reported, if possible, the relative change, adjusted for baseline differences in the outcome measures; i.e.

\[
\left(\text{the absolute post-intervention difference between the intervention and control groups} - \text{the absolute pre-intervention difference between the intervention and control groups}\right) / \text{the post-intervention level in the control group}
\]

In the case of UK fundholding results were analysed separately for short-term (usually one year pre to one year post) and long-term (two to up to four years) effects.

**ITS and CITS studies**

The preferred analysis method for ITS (and RM) studies was either a regression analysis with time trends before and after the intervention, which adjusted for autocorrelation and any periodic changes, or ARIMA analysis. The results for the outcomes should be presented as changes along two dimensions: Change in level and change in slope. Change in level is the immediate effect of the policy and is measured as the difference between the fitted values for the first post-intervention data point (one month after the intervention) minus the predicted outcome one month after the intervention based on the pre-intervention slope only. The relative change in level was calculated by dividing the change in level by the predicted outcome one month after the intervention based on the pre-intervention slope only and multiplying by 100%.

Change in slope is the change in the trend from pre to post intervention that reflects the “long” term effect of the intervention. Since the interpretation of change in slope could be difficult, we chose to present the long-term effects similar to the way we calculated and present the relative immediate effects. We presented the effects after half a year as the difference between the fitted value for the sixth month post-intervention data point (half a year after the intervention) minus the predicted outcome six months after the intervention based on the pre-intervention slope only and dividing by the predicted outcome six months after the intervention based on the pre-intervention slope only and multiplying by 100%. The effects after one year, two year etc were measured similarly. For drug expenditures we also calculated the savings after a
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half year, one year etc. as the area between the predicted expenditures curves and the actual expenditures.

Given that policy changes are often announced some months prior to official implementation, a transition phase is often defined as the six months from official announcement. If applied, all results excluded the transition phase data. However, if studies provided only few data points, if the data itself did not suggest a transition phase, and most importantly, if the authors did not state a transition phase, it was not applied. Transition phase was used in one study of this review (Harris 1996).

If papers with ITS design did not provide an appropriate analysis or reporting of results, but presented the data points in a scannable graph or in a table, we (CR, AV) reanalysed the data using methods described in Ramsay 2003. The following segmented time series regression model was specified: \( Y(t) = B0 + B1 \times \text{Pre-slope} + B2 \times \text{Post-slope} + B3 \times \text{Intervention} + e(t) \)

where \( Y(t) \) is the outcome in month \( t \). Pre-slope is a continuous variable indicating time from the start of the study up to the last point in the pre-intervention phase and coded constant thereafter. Post-slope is coded 0 up to and including the first point post intervention and coded sequentially from 1 thereafter. Intervention is coded 0 for pre-intervention time points and 1 for post-intervention time points. In this model, \( B1 \) estimates the slope of the pre-intervention data, \( B2 \) estimates the slope of the post-intervention data and \( B3 \) estimates the change in level of outcome as the difference between the estimated first point post intervention and the extrapolated first point post intervention if the pre-intervention line was continued into the post-intervention phase. The difference in slope is calculated by \( B2 - B1 \). The error term \( e(t) \) was assumed to be first order autoregressive. For CITS studies, the difference between the relative changes of the intervention and the control groups are presented. Confidence intervals (95%) were calculated for all effect measures.

For studies that were analysed as CBA by the authors and reanalysed as CITS by the reviewers, results were presented for both methods, however for grading the quality of evidence, only the ITS analyses were used.

Description of studies

The main literature search (for all pharmaceutical policies, not only pricing policies) using electronic databases and web sites resulted in 17,000 references to sift. The updated search
for prescribing policies, including MEDLINE, EMBASE and Science Citation Index, resulted in 3521 additional references, including reference lists from relevant studies and reports. Roughly estimated we sifted 20,000-21,000 references in total. We identified and retrieved in full text a total of 189 papers that were potentially relevant for this review. Papers retrieved covered the following interventions: budgetary policies, remuneration of physicians (capitation, fee for service), and pay for performance (including target payments). If the study intervention qualified as a pharmaceutical policy and specifically targeted prescribing behaviour, many still were excluded because they did not meet the study design inclusion criterion. They were primarily reviews, editorials, modelling studies, cross-sectional studies, and before and after studies without a control group. The excluded studies table provides reasons for exclusion of those studies for which it is plausible to expect that a reader would question why the study was not included, studies that are well known but do not meet all of the inclusion criteria, and ITS studies that meet all the inclusion criteria except that there were too few data points.

We identified four studies (Dusheiko 2003; Houghton 1998; Etter 1997; Elhayany 2001) that possibly meet our inclusion criteria, but could not be retrieved and assessed before submission of the review. The studies are listed amongst “studies awaiting assessment” in the reference list.

Sixteen papers, reporting 13 studies, met the inclusion criteria. In 10 studies the effects of British fundholding were analysed (Baines 1997; Bradlow 1993; Burr 1992; Corney 1997; Harris 1996; Kammerling 1996; Rafferty 1997; Whynes 1997; Wilson 1995; Wilson 1999). One study analysed effects of the indicative prescribing scheme in Ireland (Walley 2000). Two studies reported on drug expenditure budgets in Germany (Güther 1995, Schoeffski 1997). Three studies were reported in more than one paper (Bradlow 1993; Schoeffski 1997; Wilson 1995). See the Included Studies Table for details.

**Study designs**

None of the studies were RCTs or CCTs or RM studies. We included three CITS analyses (Harris 1996, Rafferty 1997; Wilson 1995), three ITS (Walley 2000; Güther 2003; Schoeffski 1997) and nine CBA studies (Baines 1997; Bradlow 1993; Burr 1992; Corney 1997; Harris 1996; Kammerling 1996; Rafferty 1997; Wilson 1995; Wilson 1999). Three of those are presented as CBA and CITS studies (Harris 1996, Rafferty 1997; Wilson 1995). All time series results were re-analysed by the review-team (AV, CR). See Included Studies Table.
Characteristics of the setting and interventions of included studies

Although budgetary policies were applied in at least seven countries (see Additional Table 17), evaluations could be included from only three (UK, Ireland and Germany) (see Additional Table 03).

UK fundholding

Fundholding for general practitioners (GPs) in England and Scotland was introduced with the first wave of voluntary practices in April 1991 and in Wales and Northern Ireland in April 1993. Each year practices with initially at least 11,000 registered patients could join the fundholding scheme in “waves”, until in 1997 health care-trusts were introduced. With each wave, regulations on requisites for joining practices were relaxed. The aim of fundholding was to increase efficiency of care by giving GPs financial control over some of their provided services (Wilson, 1997; Audit Commission, 1996; Glynn, 1992; Glennerster, 1996; Weiner 1991). Besides costs of prescribed drugs, practice staff and a range of secondary care such as specialist services and elective surgical services were covered by separate budgets, with the drug budget offering the greatest savings potential (Harris, 1996). Overspending in one budget had to be covered by funds from another budget, savings could be used in other areas of patient care (Coulter 1993). Budgets were set based on previous expenditure and at the discretion of the local health authority medical advisor. Therefore budgets varied substantially from practice to practice (Day 1991). Concurrently all practices, fundholders and non-fundholders alike were exposed to practice level feedback with their own performance in comparison with others (benchmarking), as well as to regular visits of pharmaceutical advisors. Additionally initiatives to reduce costs of individual prescriptions such as limited lists and the promotion of generics were launched (Baines 1997).

UK Indicative prescribing scheme

Introduced at the same time as fundholding (Wilson 1995) (Department of health 1989, Mannion 2005, Bligh 1992) and with budgets calculated in the same way, indicative budgets meant, there was no penalty for overspending and the practices could not individually retain the surplus. However, up to 50% of the savings could be used by the regional Family Health Authority for improvement of the regions’ primary care. The schemes were also referred to as indicative prescribing amounts / budgets. Indicative prescribing budgets later became an integrated element of the primary care trusts.

Indicative Drug Targeting Savings Scheme (IDTSS)
In 1993 in Ireland a comparable scheme called Indicative Drug Targeting Savings Scheme (IDTSS) was introduced (Walley 2000). GPs individual indicative or hypothetical budgets covered prescribing and associated costs and were calculated based on previous spending and the national average (Walley 2000b). Savings were split between the GP and the local health authority to be used for the development of services. There were no penalties for overspending.

**German drug budget**

Collective budgets for drug expenditures for physicians in private practice in Germany were in use from 1993 to 2002 with the stated goal to maximize effectiveness by using less costly and more effective drugs. It was expected that while generic use would increase use of drugs with disputed effect would decrease (Schreyoegg, 2004, Busse 1996, Schwermann 2003, Henke 1994, Gross 1994, Schwartz 1996). While spending caps were regionally negotiated or nationally set each year and made all physicians in private practice in one region collectively liable, target volumes for each individual practice were only theoretically established. From 2002 budgets were abolished and replaced by practice level target volumes (negotiated between the physician association (KV) and insurers). No studies evaluating this regulation were included. Parallel to the budgets, reference pricing, changing levels of co-payment and price cuts for pharmaceuticals were introduced.

**Characteristics of outcomes**

Prescribing data in the UK in all studies was obtained from PACT (Prescribing analysis and cost) data, which records costs and numbers of all dispensed NHS prescriptions of general practitioner practices (Majeed 1997). Volume and costs were measured per patient or per adjusted patient unit (PU). PU accounts for increased drug requirements in older patients; Astro-PU additionally corrects for sex and temporary residents (see abbreviation list). Changes in costs are also presented per item. An item is defined as each preparation on the prescription.

In Germany included studies are based on data from regional databases providing information of computerized general practitioners and internists in private practice. Data collected were referrals to specialists and hospitals as well as total number of prescriptions.

The Irish data were derived from a regional health authority’s GMS (General Medical Services) payments database. Prescribing data, related to individual physicians, was reported quarterly for groups of doctors.
Results are presented with short-term and long-term effects (when available) in Additional Tables 04 to 12, and summary of findings can be found in Additional Tables 13 and 14.

**Methodological quality of included studies**

The quality of included studies is presented in Additional Table 03. For British fundholding drug use was assessed in six CBA studies (Bradlow 1993, Burr 1992, Rafferty 1997, Whynes 1997, Wilson 1995, Wilson 1999), two ITS (Harris 1996, Wilson 1995), and one CITS study (Rafferty 1997). Drug expenditure was assessed by nine CBA studies (Baines 1997, Bradlow 1993, Burr 1992, Corney 1997, Harris 1996, Rafferty 1997, Wilson 1995, Whynes 1997, Wilson 1999), and the same two ITS and one CITS studies. One CBA study that assessed referrals was included (Kammerling 1996). We reanalyzed all time series data.

All British CBA studies were assessed to have serious limitations due to marked differences between the experimental and control groups (selection bias). Most importantly fundholding was voluntary and requirements to join the scheme especially in the first years made it likely, that fundholders were a selected group with respect to practice size, affluence, location and pre-fundholding levels of prescribing (Moon 2002, Coulter 1993, Gosden 1997). Additionally numerous simultaneous interventions were introduced in both settings, which could not be accounted for in a CBA design. All ITS studies were recalculated based on graphs provided in the publications, therefore of those studies (Wilson 1995, Harris 1996, Rafferty 1997) both CBA and (C)ITS results are provided. Three studies (Rafferty 1997, Wilson 1995, Harris 1996) were assessed as having some limitations.

One ITS study assessed volume and drug costs of the Irish Indicative Drug Targeting Savings Scheme (IDTSS). The quality was rated as having some limitations. We included two ITS studies that evaluated German drug budgets. Drug volume was assessed by one (Guether 1995) and referrals by two (Guether 1995, Schoeffski 1997). The quality of these data was rated as having some limitations since data were quarterly rather then monthly and timeseries had too few datapoints (Guether 1995), or due to limitations of the data completeness (Schoeffski 1997). In Guether 1995 data was reported with a “quasi control group” (prescriptions for privately insured patients not subject to budgets as opposed to socially insured), but the groups were found to be too different to be used as reliable comparisons, and therefore only the ITS data of the intervention group was used in the analysis.
Results

Ten studies reported in 12 papers on British fundholding, one study in one paper reported on Irish IDTSS and two studies in 3 papers of German drug budgets met inclusion criteria. Of all included studies data on drug use was provided by 12 studies of which generic prescribing was reported in six studies, data on drug expenditures based on dispensing by 10 studies and health care utilisation (referrals) by three studies. Detailed results for the included studies are provided in the Tables 4 to 12, and the summary of evidence can be found in tables 13 and 14. Confidence intervals (CI) could only be calculated for (C) ITS results. For CBA results there were not enough data to calculate CIs.

BRITISH FUNDHOLDING

Drug expenditure (Additional Table 04 and 05)
Eight studies provided data or information to calculate estimates of the one-year and two-year effect on drug expenditure of fundholders relative to non-fundholders.

--drug expenditures per item
Mean costs for dispensed drugs per item in British fundholding were reported in four CBA studies of which CITS results were obtained for two studies. All measured outcomes showed that the real expenditure level of fundholders relative to the expected level dropped more post intervention than those of non-fundholders.

Relative changes in levels of fundholders compared to controls for the two CITS studies ranged from -49,17% to -6,18% to at one year follow up (Wilson 1995, Rafferty 1997), and showed mostly a statistically significant, slight increase for longer follow-up periods. Relative effects in CBA studies reporting results at one-year follow-up (Bradlow 1993, Rafferty 1997) ranged from -5,3% to -6,3% for all waves.

--drug expenditures per patient
Almost all available effects on costs per patient (reported in 8 CBA and three CITS studies), across different waves and follow-up periods, consistently showed a bigger relative reduction in expenditure levels in fundholders. Relative level changes of fundholders compared to controls for CITS studies ranged from -79,7% to 66,8% with a median of -2,8% at one year follow up (Wilson 1995, Harris 1996, Rafferty 1997). While most confidence intervals were
insignificant, some turn significant in long-term follow-up and mostly effects are continuously increasing over time. The effect appears somewhat smaller in later waves. CBA results of the same studies were in line with these findings with a median of –4.2% and a range between –9.5% and 0.5% after 12 months (Burr 1992, Bradlow 1993, Wilson 1995, Harris 1996, Rafferty 1997, Baines 1997, Whynes 1997, Corney 1997).

--total prescribing cost
The only study reporting changes in total prescribing costs (Harris 1996) found reductions for most follow-up periods and waves (range at 12 months follow-up: -27.3% to -69.6%), though only third wave results were significant at 12 months.

Drug use (Additional Table 06 and 07)
Seven studies provided data or information to calculate estimates of the one-year and two-year effect on drug expenditure of fundholders relative to non-fundholders, and 6 studies reported on generic prescribing

--overall drug use
Four studies reported effects in 1st wave FH in GB (Burr 1992, Rafferty 1997, Bradlow 1993, Wilson 1995,); three reported of later waves (Rafferty 1997, Wilson 1995, Wilson 1999). In CITS (median -1.5%; range -28.8% to -1.5%) as well as in CBA studies (median: -1.2% (-5.7% to +1.8%) a relative reduction of prescribed drugs in fundholders compared to controls was seen. The effect seemed to decrease with later waves.

--generic drug use
The effect on generic drug use was the most consistent across waves and follow-up periods: all results reported in two CITS studies and 5 CBA studies uniformly showed a greater increase in increase of generic use in fundholders, although effects of CITS were not statistically significant (Wilson 1995, Rafferty 1997: median at 12 months: +15.0% (range -43.7% to 190.5%); at 24 months: +18.3% (13.6% to 23.0%)). Effects of CBA studies ranged between 8.8% and 13.4% (median: 11.1%) at 12 months (Bradlow 1993, Rafferty 1997), and between 4.0% and 17.2% at 24 months (Bradlow 1993, Wilson 1995, Baines 1997, Rafferty 1997,Wilson 1999): (median: 10.6%).

--use of specific drug subgroups
One included CBA study (Wilson 1999) reported the effect on the use of newer or more expensive drugs for gastric ulcer and depression. In both cases the use of newer drugs was
relatively lower in fundholders, however this was more pronounced for proton-pump inhibitors (adjusted relative change: -7.9%) than for selective serotonin-reuptake inhibitors (SSRIs) (relative change: -0.8%).

**Health**
No study reported effects on health.

**Health care utilisation** (Additional Table 08)
One CBA study (Kammerling 1996) found a decreased relative referral rate to NHS outpatient care for fundholders over long-term follow-up (-15.3%).

**IRISH INDICATIVE DRUG TARGET SAVINGS SCHEME (IDTSS):**

**Drug expenditures** (Additional Table 09)
One ITS study evaluated the effects of IDTSS (Walley 2000). While the change in costs per item over time was statistically non-significant (relative change in level at 12 months: 0.6%), overall prescribing costs had decreased absolutely. Compared with the expected level without the policy change, the level was reduced at 12 months (-18.0%) and at 24 months (-21.7%) after the introduction of indicative budgets. However these results were also statistically non-significant.

**Drug use** (Additional Table 10)
A relative reduction in number of prescribed items over a follow-up period of one year (-8.2%) and two years (-10.1%) was found (Walley 2000).

**German Drug Budget:**
Two German studies were included (Guether 1995, Schoeffski 1997) and reanalysed as ITS with some limitations.

**Drug expenditures**
No evaluations of cost effects of the German drug budget met our inclusion criteria.

**Drug use** (Additional Table 11)
One (ITS-) study (Guether 1995) provided results on the overall number of prescriptions.
The measured level relative to the expected level decreased from –11.2% at three months to –13.4% at 12 months. All results were statistically non-significant.

Health care utilisation (Additional Table 12)
Referral rates of socially insured patients to outpatient specialists were reported in two studies (Guether 1995, Schoeffski 1997) and were inconclusive (relative effects: -15.42% to 13.18% at 12 months). One study (Schoeffski 1997) reported results on referrals to hospital with a relative immediate effect at 3 months of 13.30%, and 13.31% at 12 months.

UK INDICATIVE PRESCRIBING SCHEME

Only one study was identified (Bateman 1996), but did not meet our inclusion criteria. The study indicated that the prescribing behaviour of the general practitioners in the study was similar to that of the fundholding practitioners, and that the incentive scheme did not seem to reduce the quality of prescribing.

Discussion

Although prescribing policies based on financial incentives are applied in various countries (see Additional Table 17), studies that met the inclusion criteria for this review came from only three countries and evaluated only budgetary policies. Cross-sectional studies evaluating modifying factors such as practice characteristics did not meet our study design criterion for inclusion (see Excluded Studies Table), but provide relevant information (Wilson 1996) that is considered in the discussion below.

Additional Table 13 and 14 provide summaries of the main findings. The evidence about the effects of budgetary policies is strongest in British fundholding, although also there the quality of the evidence is graded very low. Drug expenditures (per item and per patient) and the amount prescribed decreased under budgets in all three settings. There is evidence about increased use of generic drugs from the UK and Ireland, while the effect on newer and expensive drugs is inconclusive and the evidence is weak. There is only weak and inconclusive evidence available about the effects of drug budgets on referrals.

Drug budgets - Effects on drug expenditure
Firstly it was assessed, whether drug budgets would limit drug expenditure as intended.
Included studies reporting effects on costs were from the UK and Ireland. British fundholders consistently had slower increases in the cost per item than non-fundholders. This effect was found in first wave fundholders (five studies, including 2 CITS) as well as in later waves (two (CITS) studies) and persisted during longer follow-up (three studies, including one CITS). Costs per patient reported in eleven UK studies also increased at a slower rate in fundholder practices and the effect persisted with longer follow-up. The only included evaluation of indicative budgets (IDTSS) indicated a decrease in the growth rate of overall drug expenditures while maintaining constant costs per item over time (Walley 2000). Decrease in drug expenditure was reported also by other, not included studies from the UK (Mannion 2005), (Burr 1992) as well as from Germany, a different health care system with vastly different budgetary arrangements (Schreyoegg 2005).

**Drug budgets – Effects on drug utilisation**

Lower costs per item indicate use of generic drugs or other less costly drugs. In eight included studies from the UK and Ireland generic drug use consistently increased faster with budget holding. It was expected that this effect would decrease over time, since a switch to generics can only happen once per patient (Walley 2004). Our results did not support that: the effects for long-term follow-up were comparable (in CBA studies) or even increasing with time (Rafferty 1997).

Evidence from included studies about substitution with other drugs is less strong. It was anticipated, that the proportion of expensive, newer drugs for the same indications would decrease under budgetary arrangements. Only one British study met our inclusion criteria (Wilson 1999) and results showed indeed that overall drug costs and overall number of drugs per patient grew slower in fundholders for two indications (anti-ulcer medication and anti-depressant use). While the proportion of the more expensive prescribed proton-pump inhibitors (PPI) grew slower in fundholders, the proportion of SSRI’s for depression developed equally rapidly.

Lower costs per patient can be achieved by reducing the amount or duration of prescribed drugs. Ranges and the majority of individual outcomes of included British studies on dispensed items per patient point to a slower increase of the number of dispensed drugs with fundholding. Also the result from the evaluation of Irish IDTSS (Walley 2000) showed a non-significantly slower growth of drug use over time. Similarly, evidence from the included German study with some limitations showed that prescriptions for patients subject to budgetary constraints
decreased while effects for privately insured patients were smaller. Thus drug budgets appear to have decreased prescribing volume in all three settings.

**Drug budgets – Effects on health care utilisation**

Referrals, the only health care utilisation outcome reported, were measured as an indicator of cost shifting rather than as a surrogate measure of effects on health, and it is important to note that these effects are likely due to a budget for referrals rather than to a drug budget. In the UK it was expected, that referrals within the NHS might decrease since those were subject to the budget and their reduction would offer potential savings to be used for service improvement. To compensate for that, it was expected that physicians would increase referrals to private specialists, not included under the budget (Coulter 1993) and by this create better care structures for their patients (“two-tear system”) (Moon 2002). Results of studies that did not meet the inclusion criteria did not support these claims (Surender 1995) (Maxwell 1993, Gosden 1997, Coulter 1993, Howie 1995) found neither lower referrals to NHS specialists in fundholding practices nor a change in referrals outside the NHS. However these studies have to be considered with care as control or intervention practices were partly in the preparatory phase for fundholding. Croxson (Croxson 2001) suggested that the apparent lack of effect could also be due to pre-fundholding inflation of referrals. This is supported by a study of prospective fundholders (before and after negotiating budget setting), who assessed referrals in old-age psychiatry (Fear 1994). Only one study reporting referrals met our inclusion criteria (Kammerling 1996) and it found that fundholders indeed slowed down referrals to NHS orthopedic specialist outpatient care as compared to non-fundholders.

In Germany by contrast, referring patients to a higher level of care would save physicians prescribing costs billed to their budgets, so an increase was expected for socially insured patients, but not for privately insured patients without budgetary constraints.

This was not clearly supported by the evidence included in our review. The two results for socially insured patients both found a statistically non-significant increase in referrals, but at one-year follow-up the results were contradictory (Güther 1995, Schöffski 1997). The absolute effects for privately insured patients assessed by Güther (Güther 1995) were smaller but paralleled the overall development. These findings are supported by descriptive data reported by Schöffski 1997.
Quality of care and modifying factors

Effects on quality of care
No studies reported effects on health outcomes or the quality of prescribing. The effect on treatment quality can therefore only be estimated indirectly. In theory, quality might suffer if necessary treatment were withheld or postponed. The reduction found in prescriptions in all settings could indicate a potential quality problem. In Germany however, descriptive nationwide data indicate that the overall decrease of prescriptions after the introduction of the budgets was mainly contributed to a reduced use of drugs with disputed effectiveness, such as expectorant drugs, medication against dementia and medication to treat neuropathies (Schreyoegg 2005).

Evidence about the use of expensive new drugs in all settings is inconclusive. Evidence is clearest for the increased use of generic drugs, which is generally considered to be "quality neutral" (Walley 2004); i.e. would not be expected to have an impact on the quality of care or health outcomes.

Changes in referrals to other sectors might be the result of under treatment. At the same time, however, quality might increase by the involvement of specialist care (Schreyoegg 2005). With UK fundholding the change in referral patterns (Walley 2004; Ess 2003; Narine 1997; Willison 2002) might have induced additional local health care capacities (Glynn 1992; Coulter 1995), thus possibly having a positive effect on quality, although the creation of a two-ear system was feared. Several excluded studies reported newly created clinics at health centres and reduced waiting times, making organisation of care more effective (Kammerling 1996, Bain 1993, Jones 1993, Croxson 2001). However, again, this likely was not attributable to drug budgets, but to fundholding for referrals.

In general, it appears that drug budgets did not impact on the quality of care or health outcomes (Jones 1993), although we did not find strong evidence to support this assertion.

Savings
We did not find direct evidence about generated savings. The slower increase in drug expenditure with budget holding, at least over the first year of follow-up, potentially generated savings. Wilson for instance, based on regional British results, calculated hypothetical national savings over the first three years of fundholding to be £72 million (Wilson 1997). However this effect of fundholding was perceived as minor relative to the continuing absolute increase in
spending (Steward-Brown 1995, see Bradlow 1993). National drug expenditures still grew more than the government’s forecast during the first two years of the policy (Jones 1993). Sustainability has also been questioned based on the results of an excluded study (Steward-Brown 1995; Rietveld 2002). The results of this review, however, do not indicate a decrease in effect for longer follow-up periods.

In Germany national trends in sales or turnover are difficult to interpret due to German reunification. However, sickness fund expenditures decreased markedly after the introduction of the budgets in 1992 for drugs with disputed effects, while expenditures for drugs with undisputed effects continued to rise (Schreyoegg 2005). On the other hand the demonstrated increase of referrals could offset generated savings as indicated by Schöffski (Schöffski 1997).

**Modifying factors**

Different factors may modify the effects, but studies of modifying factors are generally cross-sectional and did not meet our inclusion criteria. The magnitude of the financial risk, which can be postulated to be a key-modifying factor, is dependent on the absolute budget level, the directness of potential savings, costs or losses involved, and the range of services covered under the budget.

Since budgets usually are set based on previous levels of prescribing, an anticipatory increase of prescribing was feared but could not be clearly confirmed by evidence from the UK (Stewart-Brown 1995, Coulter 1995, Healy 1994, (Croxson 2001) or Germany. Some authors have concluded that irrespective of changes in prescribing, UK fundholders were more often able to keep within their budgets (Jones 1993). However since the strictness of negotiated budgets was very inconsistent and fundholding budgets generally considered generous (Glynn 1992), this evidence is weak (Robinson 1996). In Germany Guether 1995 associated the increase in prescriptions in the three fall months before the start of the policy as anticipatory hoarding by patients, while seasonal variation cannot be excluded by the presented data.

Other modifying factors include the health care setting and other concurrent policy changes. In the UK, for instance, benchmark information along with virtual budgets was also introduced for non-fundholding practices, while in Germany this information was unavailable. In the UK regular visits by pharmaceutical advisors were introduced and Health Promotion Clinics (DMP) were included in the 1991 GP contract (Stewart-Brown 1995). Pharmaceutical detailing
activities might be different in the two countries. In Germany patients could change their GP if the expected medication was not prescribed (Schwermann 2003), while in the UK GPs act as gatekeepers. In Germany co-payments of drugs were changed repeatedly (Schwermann 2003). Other modifying factors include reference-pricing (Schwermann 2003), practice characteristics and marketing effects (Stewart-Brown 1995) (see Additional Table 16).

From the available evidence it is not possible to distinguish the impact of any of these interventions (Coulter 1995). Therefore there is substantial uncertainty concerning the transferability of results to other settings.

Methodological issues/limitations

Comparability of the presented results, even from within one country, is limited due to the following aspects: Studies from the UK used different units (e.g. per prescribing units (PU) and per patient, median or mean). Prescribing volume is mostly measured in dispensed items per patient, where a change in the true volume (for example, shorter prescriptions or lower dosage) cannot be detected. However, a systematic change in item size between fundholders and non-fundholders during the study periods would not expected (Wilson 1995).

In the UK, selection bias was likely because of specific practice characteristics of fundholders such as practice size (Dixon 1994, Moon 2002). Other relevant characteristics mentioned were training status, deprivation score (Whynes 1995) and the possibility to dispense (Morten-Jones, Rafferty 1997). The risk of selection bias for all CBA results of fundholding might lead to an overestimation of the effect. The same was true for the study populations of the included German studies, where only computerized practices were included.

Where possible, CBA studies were reanalysed as ITS studies, since this design is considered better quality. However effect sizes cannot be directly compared. Still the consistence of the effect direction also over time strengthens the evidence.

Evidence from this review is largely in accordance with common interpretations of fundholding effects in the UK. While overall drug expenditure continued to grow, fundholders seemed to be able to contain prescribing costs slightly better (Narine 1997, Ess 2003), Bloor 1996, Walley 2004, Mannion 2005, Wilson 1995). This effect seems to be partly the result of switching to generics or other less expensive drugs (Gosden 1997, Ess 2003, Bloor 1996, Narine 1997,
Walley 2004), and partly due to decreased prescribing volume (Narine 1997, Rietveld 2002, Gosden 1997, Walley 2004). The effects might decrease over time (Rietveld 2002; Bloor 1996), however here the evidence is less clear.

Results of the review also support conclusions from narrative reviews (Bloor 1996, Walley 2004, Schwermann 2003) about the German collective budget. Overall prescriptions decreased immediately after introduction of the spending caps. No German data on cost and generic use met our inclusion criteria. Commonly the decrease in drug expenditure along with increased generic use (Bloor 1996, Walley 2004) was at least partly attributed to the drug budgets, despite other concomitant interventions such as price cuts, co-payments, etc. (Walley 2004). No studies with long-term follow-up met our inclusion criteria. The effects of budgetary policies in New Zealand have been interpreted similarly (Bloor 1996).

REVIEWERS’ CONCLUSIONS

Implications for practice

Although financial incentives are considered to be an important element of strategies to change prescribing patterns (Rutledge 1996, Grol 2000) we could only find studies on budgetary policies from three countries that met our inclusion criteria: British fundholding, Irish IDTSS and German drug budgets. They all had some methodological limitations, generating weak overall evidence. The findings of our review support the conclusion that drug budgets can decrease prescribed drug volume and limit drug expenditure. Evidence was strongest for an increased use of generic drugs or other less expensive drugs. The few includable results on health care utilisation were inconclusive. While we did not find evidence of undesirable impacts on the quality of care, we did not find strong evidence to rule these out. Administration costs were not reported at all in the studies included in our review.

Implications for research

Our review found few well-designed evaluations of pharmaceutical prescribing policies. Although we performed an extensive literature search, there could be more studies in the grey literature, such as working papers or internal government reports that we have not identified. Updates of this review will include further efforts to identify studies in the grey literature.
Compared to budgetary policies elsewhere, British fundholding has been relatively well evaluated. Some of the studies included in this review could be recalculated as ITS (with controls in the UK setting), but authors mostly presented controlled before after designs for drug use, drug costs and health care utilisation outcomes. Such observational designs have serious limitations. Due to the nature of the implementation of the policies no randomised trials were conducted. However well done studies, including trials could be applied to evaluate drug policy interventions if planned in advance. They might be done more quickly and efficiently than observational studies, and could reduce the risk of bias (Schneeweiss 2004).

Evaluations in the majority of included studies focus on relatively short term outcomes. Long-term analyses would provide important supplementary evidence, but the risk for bias related to other confounding interventions would increase with the length of the observation period.

Because pharmaceutical policies have uncertain effects and they might cause harm as well as benefits, it is important that they are properly evaluated. Evaluations should be planned ahead of introducing the policies and should be a routine part of the policy process.

Acknowledgements

We gratefully acknowledge:

- Marit Johansen conducted the literature searches.
- Sue Hill, Malcolm MacLure and Carolyn J. Green helped sift references and abstracts from the broad literature search for pharmaceutical policies and commented on drafts of the data collection form.
- Doris Tove Kristoffersen provided statistical advice.
- Curt D. Furberg, Mark Gibson, Roberto Grilli, David A. Henry, Bob Nakagawa, Dennis Ross-Degnan, Gail Shearer, Stephen B. Soumerai, Luke Vale, Lisa Bero, Kirby Lee, Merrick Zwarenstein and Alain Mayhew provided helpful comments on drafts of the protocol or the review, or both.
- Morten Bjerklund, Matthew Oxman, Kjetil Olsen and the Library of the Norwegian Directorate for Health and Social Affairs helped retrieve copy and register papers.
Potential conflict of interest

☐ MA has previously carried out short-term pharmacoeconomic projects for the National Insurance Service and the Norwegian Medicines Agency. From 1997-99 he worked for a private company, Brevreklame, doing market research for pharmaceutical firms in Norway.

☐ HS was supported by the Dutch Health Care Insurance Board (CVZ).

☐ JPK has previously worked one year each for the Danish Medicines Agency and Lundbeck A/S as part of a residency in clinical pharmacology and is currently employed five hours a week at the Danish Medicines Agency (Licensing Division).
### Tables

**Characteristics of included studies**

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<td>Setting: UK, District Health Authority in South West England FH (2nd and 3rd wave): 10</td>
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<td>Method</td>
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<td>ITS</td>
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<td>GPs</td>
<td>Drug use (items) Cost: (per item, per patient)</td>
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<td>Whynes 1997</td>
<td>CBA</td>
<td>UK, Lincolnshire FH (4th wave): 23 Non-FH: 63</td>
<td>Practice</td>
<td>Drug use: (items, generics) Costs: (per patient)</td>
<td>Wave 1-3 (aggregated) not included in analysis because no adequate baseline/ intervention period</td>
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<td>UK, 5 health Authorities in NW-Region</td>
<td>Practice</td>
<td>Drug use: (DDD, drug subgroups) Cost: (per patient, per DDD)</td>
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*Net Ingredient Cost
**Prescribing Unit
***All long term results measured 2 year post, expect Baines 1997 and Stewart-Brown 1995 which are measured 3 years post
## Characteristics of excluded studies

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<th>Study</th>
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<td>Bateman 1996</td>
<td>Observational study/ no control group</td>
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<tr>
<td>Chernew 2000</td>
<td>No baseline/ no control group</td>
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<tr>
<td>Baines 1997b</td>
<td>No baseline data</td>
</tr>
<tr>
<td>Coulter 1993</td>
<td>Not adequate control group</td>
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<tr>
<td>Danzon 1997</td>
<td>Multiple interventions measured simultaneously, effects of drug budgets can not be extracted separately</td>
</tr>
<tr>
<td>Edgar 1999</td>
<td>No baseline data</td>
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<tr>
<td>Fear 1994</td>
<td>Evaluated only a pre-fundholding pilot project, with no real incentives</td>
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<tr>
<td>Hoopmann 1995</td>
<td>Cross sectional</td>
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<td>Howie 1995</td>
<td>Evaluates a “shadow fundholding” project, pre-fundholding. Overlaps with the start of real fundholding</td>
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<td>Jünger 2000</td>
<td>No control group</td>
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<td>Maxwell 1993</td>
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<td>Newton 1993</td>
<td>No control group</td>
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<tr>
<td>Schreyögg 2004</td>
<td>Untrustworthy data because of time series strongly influenced by historical event (Germany reunification)</td>
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<tr>
<td>Whynes 1995</td>
<td>Untrustworthy results, intervention groups are at different stages of fundholding</td>
</tr>
<tr>
<td>Whynes 1997b</td>
<td>No control group</td>
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## References to studies

### References to included studies (*indicates the primary reference for the study)

- **Baines 1997c (published data only)**

- **Bradlow 1993 (published data only)**

- **Burr 1992 (published data only)**

- **Corney 1997 (published data only)**

- **Guether 1995 (published data only)**

- **Harris 1996 (published data only)**
Chapter 7


Kammerling 1996 (published data only)

Rafferty 1997 (published data only)

Schöffski 1997 (published data only)


Walley 2000 (published data only)

Whynes 1997 (published data only)

Wilson 1995 (published data only)


Wilson 1999 (published data only)

References to excluded studies

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Baines 1997 (published data only)

Baines 1997b (published data only)

Bateman 1996 (published data only)

Chernew 2000 (published data only)

Coulter 1993 (published data only)


Danzon 1997 (published data only)

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Pharmaceutical policies: effects of policies for prescribers using financial incentives


* Indicates the primary reference for the study

Additional references


Christianson 1992 Christianson, JB, FAU; Manning, W, FAU; Lurie, N, FAU; Stoner, Tj, FAU; Gray, Dz, FAU; Popkin, M, FAU; Marriott, S, Christianson, JB, FAU; Manning, W, FAU; Lurie, N, FAU; Stoner, Tj, FAU; Gray, Dz, FAU; Popkin, M, FAU; Marriott, S, Utah’s Prepaid Mental Health Plan: the first year.


Grilli 2002 Grilli R, Ramsay CR, Minozzi S. Mass media interventions: effects on health services utilisation. In: The


Schneeweiss 2004 Schneeweiss S, Maclure M, Carleton B, Glynn RJ, Avorn J. Clinical and economic consequences of

**Schwermann 2003** Schwermann T, Greiner W, Schulenburg JM: Using disease management and market reforms to address the adverse economic effects of drug budgets and price and reimbursement regulations in Germany. Value Health 2003;6 Suppl 1:S20-S30.


### References to studies awaiting assessment


### 01 Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>CBA</td>
<td>Controlled before and after</td>
</tr>
<tr>
<td>CCT</td>
<td>Controlled clinical trial</td>
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<tr>
<td>CI</td>
<td>Confidence interval</td>
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<td>CITS</td>
<td>Controlled interrupted time series</td>
</tr>
<tr>
<td>CRM</td>
<td>Controlled repeated measures</td>
</tr>
<tr>
<td>DMP</td>
<td>Disease management program</td>
</tr>
<tr>
<td>EPOC</td>
<td>Effective Practice and Organisation of Care</td>
</tr>
<tr>
<td>FH</td>
<td>Fundholding (fundholders)</td>
</tr>
<tr>
<td>H2RA</td>
<td>Histamine-2 receptor antagonist</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>Item</td>
<td>is defined as each preparation on the prescription.</td>
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<tr>
<td>ITS</td>
<td>Interrupted time series</td>
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<tr>
<td>IDTSS</td>
<td>Indicative Drug Target savings scheme (Ireland)</td>
</tr>
<tr>
<td>NIC</td>
<td>net ingredient costs</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PACT</td>
<td>Prescribing analysis and cost (data used in British fundholding)</td>
</tr>
<tr>
<td>PPI</td>
<td>Proton pump inhibitors</td>
</tr>
<tr>
<td>PU</td>
<td>Prescribing unit, allows for demographic differences between practices. Patients under 65 are counted as one prescribing unit, while those aged 65 and over count as three. AstroPU in addition corrects for age, sex and temporary residency.</td>
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<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
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<td>RM</td>
<td>Repeated measures</td>
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<tr>
<td>RR (adj)</td>
<td>Risk ratio (adjusted for pre intervention differences) = ( \frac{RR \text{ post intervention}}{RR \text{ pre intervention}} )</td>
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<tr>
<td>SSRI</td>
<td>selective serotonin reuptake inhibitors</td>
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## 02 Description of interventions of included studies

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<th>COUNTRY</th>
<th>POLICY/ TIME PERIOD</th>
<th>MOTIVATION</th>
<th>SETTING OF BUDGET</th>
<th>PHYSICIAN INCENTIVES</th>
<th>PHYSICIAN DISINCENTIVES</th>
<th>THEORETICAL EFFECTS</th>
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</thead>
<tbody>
<tr>
<td>Germany</td>
<td>Collective drug budget “spending caps” (Health Care Reform Act) 1993-2002 (Formally abolished in 2001)</td>
<td>Control prescription drug cost</td>
<td>Based on previous regional spending. From 1998: regional net budget: gross budget minus co-payments and rebates from industry nationally set 1993, then regionally Negotiated between physician associations and statutory health insurance</td>
<td>None (savings will not be available to physicians)</td>
<td>Regional physician associations are responsible for overspending (max 5% of total budget). Can decline to pay for excess spending and can request it from individual practice.</td>
<td>Reduction of drugs with disputed effect, savings can facilitate use of more expensive drugs. Improve quality of prescribing. Increase referrals to save (drug budget is independent of other care)</td>
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<tr>
<td>Germany</td>
<td>Individual practice caps “Target volumes” 2002-</td>
<td>Control prescription drug cost</td>
<td>Of gross budgets a target expenditure per patient is calculated and extrapolated to a practice level (adjusted for instance for specialty and patient age) Negotiated by physician associations and statutory health insurance</td>
<td>None</td>
<td>Excessive spending will have to be paid back (individual practice monitoring)</td>
<td>Reduction of drugs with disputed effect, savings can facilitate use of more expensive drugs. Improve quality of prescribing. Increase referrals to save (drug budget is independent of other care)</td>
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<tr>
<td>UK</td>
<td>Indicative prescribing scheme 1991-1997</td>
<td>Control prescription drug cost</td>
<td>Based on previous spending practice Negotiated by local medical advisors and statutory health insurance</td>
<td>Savings to be used within health authority and equally divided by all GPs to improve services</td>
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<td>Ireland</td>
<td>IDTSS (Indicative Drug target savings scheme) 1993-</td>
<td>Control prescription drug cost</td>
<td>Individual practice budget based on previous spending and national average Negotiated by local medical advisor and practice</td>
<td>Savings were divided between GP and health authority</td>
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<td>UK</td>
<td>Fundholding GB + Scotland: April 1991-1997 (announced in 1990) Wales + Northern Ireland 1993-1997</td>
<td>Control prescription drug cost</td>
<td>Based on previous spending of practice adjusted for patient mix and spending of comparators. Negotiated by local health authority and practice</td>
<td>Savings can be invested by each fundholder to improve services in other budgets, or in the following year following year’s drug budget</td>
<td>Responsible for overspending up to a limit of 500£. Overspending can be covered by other budgets</td>
<td>Decrease prescribed drug volume and cost per item. Improve quality of prescribing. Referrals are postponed, since those are also part of a budget.</td>
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## 03 Assessment of limitations in included studies

**POLICY: UK FUNDHOLDING**

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<th>Appropriate data analysis</th>
<th>Reason for number and spacing of data-points</th>
<th>Shape of Intervention effect pre-specified</th>
<th>Intervention unlikely to affect data collection</th>
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<th>Data set complete / reliable primary outcome measure(s)</th>
<th>Other risk of bias</th>
<th>Overall assessment of limitations / study design</th>
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### POLICY: UK FUNDHOLDING

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Outcome: DRUG USE (Generics)
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#### Outcome: DRUG USE (volume)

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### STUDY ID Baseline measure-ments Baseline character-istics Follow-up of profession-als Follow-up of patients Reliable primary outcome measure(s) Blinded assess-ment of primary outcome(s) Protection against contamination Other risk of bias Overall assessment of limitations / study design notes

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**04 Effects on drug expenditures: UK Fundholding, CITS studies**

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<td>RELATIVE CHANGE (95% CI)</td>
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<td>-0.41 (-0.83 to 0.01)</td>
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Pharmaceutical policies: effects of policies for prescribers using financial incentives
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* Costs of drugs dispensed from UK PACT data
** If not otherwise noted, price year not specified in paper
*** All Rafferty outcomes: difference of mean (cost per item results for year 3 were not reanalyzable), all Harris outcomes percentage of non-fundholders, all Wilson outcomes difference of median
05 Effects on drug expenditures: UK Fundholding, CBA studies

<table>
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<td>Cost 2</td>
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**COST PER PATIENT ALL ANTI-ULCER DRUGS**

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<thead>
<tr>
<th>Study</th>
<th>Wave</th>
<th>Cost 1</th>
<th>Cost 2</th>
<th>Cost 3</th>
<th>Cost 4</th>
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<tr>
<td>Wilson 1999</td>
<td>3/4</td>
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**COST PER PATIENT ALL ANTI-DEPRESSANT DRUGS**

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<tr>
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<td>3/4</td>
<td>-</td>
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All costs in Brit. £
* 3 year f/u
** Combined wave 4: 1 year f/u, wave 3: 2 year f/u
*** Data from Stewart Brown study
### 06 Effects on drug use: UK Fundholding, CITS studies

<table>
<thead>
<tr>
<th>ITEMS PER PATIENT</th>
<th>IMMEDIATE (3 months)</th>
<th>SHORT TERM (6 months)</th>
<th>SHORT TERM (12 months)</th>
<th>LONG TERM (24 months)</th>
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<tbody>
<tr>
<td>STUDY ID</td>
<td>SETTING</td>
<td>ABSOLUTE LEVEL EFFECT (95% CI)</td>
<td>RELATIVE CHANGE (95% CI)</td>
<td>RELATIVE CHANGE (95% CI)</td>
</tr>
<tr>
<td>Rafferty 1997</td>
<td>Wave 1</td>
<td>-63.60 (-249.33 to 122.12)</td>
<td>-2.46 (-9.78 to 4.86)</td>
<td>-1.03 (-8.82 to 6.77)</td>
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<tr>
<td>Harris 1996</td>
<td>Wave 1</td>
<td>0.36 (-1.08 to 1.8)</td>
<td>0.4 (-1.20 to 1.99)</td>
<td>0.70 (-1.30 to 2.68)</td>
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<td>Wilson 1995</td>
<td>Wave 1</td>
<td>1.39 (-6.63 to 9.4)</td>
<td>1.94 (-9.26 to 13.14)</td>
<td>-4.14 (4.26 to -4.02)</td>
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<td>Wave 1</td>
<td>-43.59 (-257.00 to 169.83)</td>
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<td>Wave 3</td>
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<td>16.84 (-17.1 to 50.8)</td>
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<td>Harris 1996</td>
<td>Wave 4</td>
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<td>0.31 (-0.44 to 1.06)</td>
<td>0.14 (-0.63 to 0.92)</td>
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<td>Harris 1996</td>
<td>Wave 5</td>
<td>-0.22 (-0.98 to 0.54)</td>
<td>-0.22 (-0.98 to 0.54)</td>
<td>-0.21 (-0.98 to 0.57)</td>
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</table>

### GENERIC PERCENTAGE

| Rafferty 1997 | Wave 1 | 2.79 (1.45 to 4.13) | 10.77 (5.57 to 15.97) | 12.66 (7.07 to 18.24) | 15.81 (9.44 to 22.18) | 22.99 (15.04 to 30.95) |
| Wilson 1995 | Wave 1 | 1.72 (0.76 to 2.69) | 345.7 (539.6 to 151.8) | 342.73 (341.1 to 344.4) | 190.51 (189.0 to 192.0) | - |
| Rafferty 1997 | Wave 2 | 1.32 (-0.20 to 2.85) | 5.08 (-0.93 to 11.08) | 5.89 (0.43 to 12.20) | 8.53 (1.59 to 15.47) | 13.55 (5.35 to 21.74) |
| Rafferty 1997 | Wave 3 | 0.46 (-0.95 to 1.88) | 1.76 (-3.66 to 7.38) | 5.68 (-0.13 to 11.49) | 14.24 (8.06 to 20.43) | - |
| Wilson 1995 | Wave 2 | 1.02 (-0.05 to 2.1) | 45.4 (-2.36 to 93.2) | 68.47 (66.1 to 66.8) | 68.14 (67.6 to 68.7) | - |
| Wilson 1995 | Wave 3 | 1.88 (0.8 to 2.96) | 35.5 (15.1 to 55.9) | -12.22 (-12.4 to -12.1) | -43.72 (-43.5 to -44.0) | - |
## Effects on drug use: UK Fundholding, CBA studies

<table>
<thead>
<tr>
<th>STUDY ID</th>
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<th>SHORT TERM (12 months)</th>
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<td>Wave 1</td>
<td>-461.00</td>
<td>-1.02</td>
<td>-5.17</td>
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<td>1.81</td>
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<td>3.17**/****</td>
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### GENERIC PERCENTAGE

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## Pharmaceutical policies: effects of policies for prescribers using financial incentives

### Items per Patient

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<th>Setting</th>
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<th>Adjusted Relative Change [%]</th>
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<td>-7.87***</td>
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<td>-7.86***</td>
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*Median
**3 year f/u
***Combined wave 4: 1 year f/u, wave 3: 2 year f/u
****Data from Stewart-Brown study

### Effects on health care utilization (referrals): UK Fundholding, CBA studies

#### Referrals to NHS Outpatient Care

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<th>Adjusted Absolute Change</th>
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<th>Adjusted Relative Change [%]</th>
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<td>Kammerling 1996</td>
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<td>-18.9</td>
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### Effects in Irish Indicative budgets

#### 09 Effects on drug expenditures: Ireland Indicative budgets (IDTSS), ITS studies

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<th>COST PER ITEM*</th>
<th>IMMEDIATE (3 months)</th>
<th>SHORT TERM (6 months)</th>
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<tr>
<td><strong>STUDY ID</strong></td>
<td><strong>SETTING</strong></td>
<td><strong>ABOSULUTE LEVEL EFFECT (95% CI)</strong></td>
<td><strong>RELATIVE CHANGE (95% CI)</strong></td>
<td><strong>RELATIVE CHANGE (95% CI)</strong></td>
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<td>Walley 2000</td>
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<td><strong>TOTAL PRESCRIBING COST</strong></td>
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*If not otherwise noted, price year not specified in paper

#### 10 Effects on drug use: Ireland Indicative budgets (IDTSS), ITS studies

<table>
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<tr>
<th>ITEMS PER PATIENT</th>
<th>IMMEDIATE (3 months)</th>
<th>SHORT TERM (6 months)</th>
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<tr>
<td><strong>STUDY ID</strong></td>
<td><strong>SETTING</strong></td>
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<td><strong>RELATIVE CHANGE (95% CI)</strong></td>
<td><strong>RELATIVE CHANGE (95% CI)</strong></td>
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<td>-0.81 (-1.42 to -0.19)</td>
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Effects in German drug budgets

### 11 Effects on drug use: German drug budget, ITS studies

<table>
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<th>ITEMs PER PATIENT</th>
<th>IMMEDIATE (3 months)</th>
<th>SHORT TERM (6 months)</th>
<th>SHORT TERM (12 months)</th>
<th>LONG TERM (24 months)</th>
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<tbody>
<tr>
<td>STUDY ID</td>
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<td>RELATIVE CHANGE (95% CI)</td>
<td>RELATIVE CHANGE (95% CI)</td>
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<td>Guether 1995</td>
<td>Social insurance</td>
<td>-34552 (-9896 to 30791)</td>
<td>-11.2 (-32.3 to 10.0)</td>
<td>-12.06 (-37.84 to 13.72)</td>
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### 12 Effects on health care utilization (referrals): German drug budget, ITS studies

<table>
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<tr>
<th>REFERALS TO OUTPATIENT SPECIALISTS</th>
<th>IMMEDIATE (3 months)</th>
<th>SHORT TERM (6 months)</th>
<th>SHORT TERM (12 months)</th>
<th>LONG TERM (24 months)</th>
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</thead>
<tbody>
<tr>
<td>STUDY ID</td>
<td>SETTING</td>
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<td>RELATIVE CHANGE (95% CI)</td>
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<tr>
<td>Guether 1995</td>
<td>Social insurance</td>
<td>1543.03 (-509,64 to 8181.70)</td>
<td>3.40 (-11.30 to 18.10)</td>
<td>3.48 (-21.87 to 14.92)</td>
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<tr>
<td>Schoeffski 1997</td>
<td>Social insurance</td>
<td>7.51 (-1.99 to 17.00)</td>
<td>22.80 (-6.01 to 51.61)</td>
<td>8.41 (-25.02 to 41.84)</td>
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</table>

<table>
<thead>
<tr>
<th>REFERALS HOSPITALS</th>
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<tr>
<td>Schoeffski 1997</td>
<td>Social insurance</td>
<td>0.12 (0.01 to 0.23)</td>
<td>13.30 (1.15 to 25.45)</td>
<td>10.78 (-3.12 to 24.67)</td>
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</table>
### 13 Summary of findings. Effects of UK Fundholding (UK)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No of studies</th>
<th>Median relative effect at 12 months post (Range)</th>
<th>Quality</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Drug use (number of drugs prescribed per patient)</td>
<td>3&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Relative change: -1.58 % (-28.85 to 1.52)</td>
<td>4</td>
<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Use of generics</td>
<td>2&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Relative change: 15 % (-43.72 to 190.51)</td>
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<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
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<tr>
<td>Cost per item</td>
<td>2&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Relative change: -44.26 % (-49.17 to -6.18)</td>
<td>4</td>
<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Cost per patient</td>
<td>3&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Relative change: -2.67 % (-79.74 to 66.77)</td>
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<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Total prescribing cost</td>
<td>1&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Relative change: -50.59 % (-69.61 to -27.26)</td>
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<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
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<td>Inpatient referrals</td>
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<td>-</td>
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<tr>
<td>Outpatient referrals</td>
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<td>Adjusted relative change: -15.30 %&lt;sup&gt;4&lt;/sup&gt;</td>
<td>4</td>
<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
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### 14 Summary of findings. Effects of German drug budget

<table>
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<th>Median relative effect at 12 months post (Range)</th>
<th>Quality</th>
<th>Comments</th>
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</tr>
<tr>
<td>Outpatient referrals</td>
<td>2&lt;sup&gt;2,2&lt;/sup&gt;</td>
<td>Relative change: 13.18 % to -15.42 %</td>
<td>4</td>
<td>Very low&lt;sup&gt;2,3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Footnotes:
1. There were 3 controlled interrupted time series (ITS) analyses and 5 controlled before-after (CBA) studies. Only the controlled ITS analyses are included here. The 3 controlled ITS include 3 comparisons from wave 1, and 7 comparisons from later waves.
2. Fundholding practices were all self-selected and there is uncertainty about how comparable they are to practices that chose not to participate in fundholding.
3. There is uncertainty about how direct the evidence, which all comes from the UK National Health Service, is for other health care systems.
4. There were 2 controlled interrupted time series (ITS) analyses and 5 controlled before-after (CBA) studies. Only the controlled ITS analyses are included here. The 2 controlled ITS analyses include 2 comparisons from the first wave and 4 from later waves.
There were 2 controlled interrupted time series (ITS) analyses and 3 controlled before-after (CBA) studies. Only the controlled ITS analyses are included here. The 2 controlled ITS analyses include 2 comparisons from the first wave and 3 from later waves.

There were 3 controlled interrupted time series (ITS) analyses and 6 controlled before-after (CBA) studies. Only the controlled ITS analyses are included here. The 3 controlled ITS analyses include 3 comparisons from the first wave and 7 from later waves.

The time series had too few data points, and the intervention was not independent of other changes since other drug policies were introduced in the same period.

There is uncertainty about how direct the evidence, which all comes from Germany, is for other health care systems.

### 15 Overview mechanisms of budgetary policies

<table>
<thead>
<tr>
<th>Policy</th>
<th>Positive Incentive</th>
<th>Negative Incentive</th>
<th>Additional elements</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtual budgets</td>
<td>None</td>
<td>None</td>
<td>Budget agreement</td>
<td>Overall agreement between state and industry (France, Spain[24])</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Budgets/targets set by state (Greece, Italy, Portugal [24])</td>
</tr>
<tr>
<td>Collective budgets (not for individual practices)</td>
<td>Collective savings</td>
<td>None</td>
<td>Benchmarking, feedback</td>
<td>UK: Indicative prescribing scheme and primary care trusts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(overspending is covered)</td>
<td></td>
<td>Italy: “budget agreements”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spain: regional prescribing targets</td>
</tr>
<tr>
<td>Individual (practice) budgets</td>
<td>Savings can be used within practice, or personal income</td>
<td>Individual liability with practice finance or income, sometimes buffers are applied</td>
<td>Individual practice feedback</td>
<td>UK fundholding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>US: HMOs withhold funds, which are paid depending on financial performance [28], US: capitation for prescribing (Chernew)</td>
</tr>
<tr>
<td>Individual punishment</td>
<td>None</td>
<td>Individual liability with or without buffers*, fines</td>
<td>Individual practice monitoring</td>
<td>Germany: collective drug budgets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>France: adherence to Guidelines (RMO)</td>
</tr>
<tr>
<td>Targets</td>
<td>Collective savings</td>
<td>Loss of income or licence</td>
<td>Feedback</td>
<td>UK pay for performance</td>
</tr>
</tbody>
</table>
### Factors that could modify the effects of drug budgets

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>DESCRIPTION</th>
<th>POTENTIAL EFFECTS OF CONDITIONS NOT FULFILLED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget (target) level</td>
<td>Level of set budget should offer room for improvement but be reachable.</td>
<td>If too high or too low: Drug use: Less shift towards cheaper drugs Drug expenditure: Less decrease Health care utilisation: Setting dependent Patient drug expenditures: Setting dependent</td>
</tr>
<tr>
<td>Budget strictness / directness</td>
<td>- Virtual budgets / agreement without consequences - Collective budgets - Individual budgets</td>
<td>The more direct the effect for the individual prescriber, the stronger the effects</td>
</tr>
<tr>
<td>Incentives / disincentives</td>
<td>- Only savings can be achieved - only punishments - both</td>
<td>Drug use: Decrease Referrals: Increase if not covered in budget Health: Decrease if care is delayed, increased if more specialist care or shorter waiting time Health care utilisation: Increase</td>
</tr>
<tr>
<td>Services covered under the budget</td>
<td>If only prescribing costs are subject to a budget, costs might be shifted to other sectors of care</td>
<td>Drug use: Decrease Referrals: Increase if not covered in budget Health: Decrease if care is delayed, increased if more specialist care or shorter waiting time Health care utilisation: Increase</td>
</tr>
<tr>
<td>Available feedback information</td>
<td>Should be available to prescribers in order to react</td>
<td>Drug use: Less shift towards cheaper drugs or overreaction Drug expenditure: Less decrease Health: Potential for under-treatment</td>
</tr>
<tr>
<td>Concurrent policy changes:</td>
<td>Should not be introduced simultaneously if individual effects should be assessed.</td>
<td>Drug use: Unclear Health: Unclear Health care utilisation: Unclear</td>
</tr>
<tr>
<td>Co-payment changes</td>
<td>If primary care physician acts as gatekeeper and patients have a limited choice of care provider, physicians might be less dependent on patients preferences</td>
<td>Drug use: Less shift towards cheaper drugs Drug expenditure: Less decrease Health: Unclear Health care utilisation: Increase</td>
</tr>
<tr>
<td>Reference pricing</td>
<td></td>
<td>Drug use: Less shift towards cheaper drugs Drug expenditure: Less decrease Health: Unclear Health care utilisation: Increase</td>
</tr>
<tr>
<td>Negative lists etc.</td>
<td></td>
<td>Drug use: Less shift towards cheaper drugs Drug expenditure: Less decrease Health: Unclear Health care utilisation: Increase</td>
</tr>
<tr>
<td>Practice characteristics</td>
<td>- Practice size - Level of organization, efficiency - number of partners</td>
<td>Drug use: Less shift towards cheaper drugs Health: Decrease Health care utilisation: Increase Patient drug expenditures: Increased</td>
</tr>
<tr>
<td>Dispensing practices</td>
<td>Practice can dispense medicines</td>
<td>Drug use: Bigger shift towards cheaper drugs Drug expenditure: Stronger decrease</td>
</tr>
</tbody>
</table>
### 17 Description of other identified budgetary policies that did not meet the inclusion criteria

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy</th>
<th>Motivation</th>
<th>Setting of budget</th>
<th>Incentives</th>
<th>Disincentives</th>
<th>Theoretical effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>Independent practice associations (IPA): Umbrella organisation of GPs, specialists and other HC providers with different budgets for provided care 1993 - ?</td>
<td>Budgets: to increase quality of care. (IPAs: increase power of GPs towards health reforms)</td>
<td>IPA can choose to take a budget for diff. Services. Historical expenditure (change from FFS to Integrated capitation based budgets)</td>
<td>Regional health authority (or other payers) and IPA</td>
<td>Savings can be kept by associations to improve quality of care. Savings can be shifted between budgets</td>
<td>IPA's responsible for overspends, but physicians have refused to take financial responsibility GPs within association compete for patients</td>
</tr>
<tr>
<td>USA</td>
<td>Managed care withholdings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>Pharmaceutical Capitation</td>
<td>Health plans can control the growth of their own spending by controlling the capitation levels</td>
<td>Target drug spending amount for a set of patients (per member per month) based on a base rate, adjusted for case mix</td>
<td>Providers negotiate with health plan</td>
<td>Later, savings will be shared by prescribers</td>
<td>A percentage of the difference between target and actual spending (around 70%) has to be paid by the physician</td>
</tr>
</tbody>
</table>

Footnotes:
1. see Willison 2002
<table>
<thead>
<tr>
<th>Country</th>
<th>Policy</th>
<th>Motivation</th>
<th>Setting of budget</th>
<th>Incentives</th>
<th>Disincentives</th>
<th>Theoretical effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>Unified budgets for new primary care groups 1999-</td>
<td>Accountability of GPs will help solve problems</td>
<td>Budget for hospital care, community health services, prescribing, infrastructure costs</td>
<td>Funds allocated by health authority. Compulsory for all GPs</td>
<td>For staff premises and computer costs. GP salary not involved</td>
<td>Increased monitoring needed. Since GP budget grows slower than overall budget, incentive to limit spending.</td>
</tr>
<tr>
<td>Sweden</td>
<td>Regionalisation: responsibility of drug expenditure moved from federal to regional level 1998-</td>
<td>Increase the cost awareness of county councils</td>
<td>Government and county council</td>
<td>Generate savings</td>
<td>2002-2004: exceeding costs are covered by government, which compensates county council for up to 75% of overspent costs (ca. 9% of budget)</td>
<td>Development of local initiatives promoting economical prescribing (generic prescribing, drug lists etc)</td>
</tr>
<tr>
<td>Italy</td>
<td>Benchmarking 1980; virtual targets (&quot;budget agreements&quot;) 1992; guidelines</td>
<td>Contain costs, decrease growth of drug expenditure</td>
<td>Local agreement (local health enterprises responsible for drug budget)</td>
<td>GP-association and local health enterprises</td>
<td>Regional savings will be distributed in terms of money or other rewards</td>
<td>None applied</td>
</tr>
<tr>
<td>Spain</td>
<td>Regional target budgets for primary care centres and hospitals 2000-</td>
<td>To improve efficiency of care</td>
<td>Regional</td>
<td>About 2% of salary is dependent on prescribing targets (Antononaz 2002)</td>
<td>None (national drug budgets are always covered by industry. Physicians are paid by salary)</td>
<td>No abuse due to constant monitoring</td>
</tr>
</tbody>
</table>
Pharmaceutical policies: effects of policies for prescribers using financial incentives

18 Search strategies: EMBASE

EMBASE Ovid
Search fields: A combination of EMTAGS and text words
1. (regulat$ or requirement? or restrict$ or monitor$ or control$).tw.
2. (legislation? or law? or act? or policy or policies or politics or reform$ or system? or plan? or program$ or stratag$).tw. or Drug Legislation/ or Policy/ or Health Care Policy/ or Politics/ or Drug Program/
3. (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$).tw. or exp Pharmaceutics/ or exp Drug or Prescription/ or *Drug Use/ or Drug Utilization/
4. (cost Control/ and 3 and 2)
5. ((control$ or containment or curtailment or reduc$ or save or saving) adj3 cost?).tw.
6. ((cost? or expenditure? or expense?) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
7. 5 and 6 and 2
8. ((control$ or reduc$ or cut$ or regulat$ or negotiat$ or fix$) adj3 (price? or pricing)).tw.
9. ((price? or pricing) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
10. 8 and 9 and 2
11. (reference$ adj3 (price? or pricing)).tw.
12. (index$ adj3 (price? or pricing)).tw. and 3
13. ((maxim$ or minim$) adj3 (cost? or price? or pricing)).tw. and 3
14. (cost? effect$ adj3 (price? or pricing)).tw. and 3
15. (reimburs$ adj1 contract?).tw. and 3
16. *(Drug Cost/ or *Pharmacoeconomics/) and (1 or 2)
17. *(Hospital Purchasing/ and 3
18. (purchase$ adj3 (group? or join$ or hospital? or shared)).tw.
19. ((group? or join$ or hospital? or shared) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
20. 18 and 19 and 2
21. (procurement$ adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw. and 2
22. (acquisition cost? adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw. and 2
23. (rebate? adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw. and 2
24. (generic adj3 (price? or pricing or substitut$)).tw. and 3
25. ((price? or pricing) adj3 (policy or policies or regulat$ or negotiat$)).tw. and 3
26. (rate? adj1 return).tw. and 3
27. (profit$ adj3 regulat$).tw. and 3
28. 4 or 7 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27
29. Randomized Controlled Trial/
30. (randomised or randomized).tw.
31. experimen$tw.
32. (time adj series).tw.
33. (pre test or pretest or (posttest or post test)).tw.
34. evaluat$.tw.
35. Comparative Study/
36. or/29-35
37. 28 and 36
38. Nonhuman/
39. 37 not 38
19 Search strategies: Effective Practice and Organisation of Care Group Register

Effective Practice and Organisation of Care Group Register, Idealist database
Searched terms anywhere in text
drug [or] drugs [or] pharmaceutic* [or] medicines [or] medicat* [or] prescrip* [or] prescrib*

20 Search strategies: CENTRAL

CENTRAL, The Cochrane Central Register of Controlled Trials, Ovid
Search fields: A combination of MeSH terms and text words
1. (regulat$ or requirement? or restrict$ or monitor$ or control$).tw.
2. (legislation? or law? or act? or policy or policies or politics or reform$ or system? or plan$ or program$ or strateg$).tw. or Policy Making/ or Legislation, Drug/ or Public Policy/ or Health Policy/ or Politics/ or Health Care Reform/
3. (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$).tw. or exp Pharmaceutical Preparation/ or Drug Utilization/
4. (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$).tw. or exp Pharmacological Preparations/ or Drug Utilization/
5. (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$).tw. or exp Pharmaceutical Preparation/ or Prescriptions, Drug/ or Drug Utilization/
6. Drug Approval/ or (approv$ adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
7. Licensure/ and 4
8. Drug Labeling/
9. ((licens$ or registrat$ or label$) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
10. (6 or 7 or 8 or 9) and (1 or 2)
11. Classification/ and 3 and 2
12. ((classify$ or classification?) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw. and 2
13. 11 or 12
14. 10 or 13
15. Patents/ and 4
16. (profit? adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
17. ((profit$ adj3 (control$ or reduc$ or regulat$ or fix$ or restrict$)) and (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
18. (15 or 16 or 17) and (1 or 2)
19. (Marketing/ or Marketing of Health Services/ or Advertising/) and 4
20. ((advert$ or promot$ or market$) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
21. (19 or 20) and (1 or 2)
22. ((insurance, Hospitalization/ or Insurance, health, reimbursement/ or Reimbursement Mechanisms/ or Reimbursement, disproportionate share/ or Reimbursement, incentive/) and 5
23. Insurance, pharmaceutical services/
24. ((reimburse$ or insur$ or (third party adj1 pay$) or benefit plan?) adj3 (drug or drugs or pharmaceutic$ or pharmacy or pharmacies or medicines or medicament? or medicat$)).tw.
25. (22 or 23 or 24) and (1 or 2)
26. Formularies/ and 5
27. Formularies, Hospital/ and 3
28. ((formulary or formularies or positive list? or negative list?) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$ or hospital?)).tw.
29. (26 or 27 or 28) and (1 or 2)
30. Drugs, Essential/
31. (essential adj3 (drug? or pharmaceutic$ or medicine? or medicament?)).tw.
32. (drug? or pharmaceutic$ or medicine? or medicament?) adj3 list?).tw.
33. 31 and 32
34. 30 or 33
35. (prior authori#ation? or preauthorization? or prior authori#ation?) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
Pharmaceutical policies: effects of policies for prescribers using financial incentives

36. Reminder Systems/ and 5 and 2
37. (reminder? adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medication? or medica$)).tw. and 2
38. Prescriptions, Drug/
40. Education, Continuing/
41. Education, Pharmacy, Continuing/
42. (improv$ or incentive?).tw. 43. 39 or 40 or 41 or 42
44. 38 and 43 and (1 or 2)
45. (((prescrib$ or prescription?) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medication? or medica$)) and ((continu$ adj1 education) or (improv$ or incentive?)$)).tw. and (1 or 2)
46. (Guidelines/ or Practice Guidelines/ or Guideline Adherence/).tw. and 2 and 5
47. (((guideline? or recommendation?) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$))) and (disseminat$ or implement$ or complian$ or adherence)).tw. and 2
48. 46 or 47
49. (((generic$ adj3 prescrib$) or (generic$ adj3 prescription?)) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
50. (local$ or global$ adj3 budget$).tw.
51. (budget$ adj3 (general pract$ or GP? or physician? or doctor?)).tw.
52. 50 and 51
53. (fundhold$ adj3 (general pract$ or GP? or physician? or doctor?)).tw.
54. 52 or 53
55. 54 and 3
56. "Pharmacy and Therapeutics Committee/" and 2 and 5
57. ((drug? or formulary or pharmac$) adj3 committee?).tw. and 2
58. 56 or 57
59. (Drug Monitoring/ or Adverse Drug Reaction Reporting Systems/ or (safe$ adj1 (drug or drugs or pharmaceutical$ or medicines or medicament? or medicat$)).tw.) and 2
60. Product Surveillance, Postmarketing/ and 3 and 2
61. 59 or 60
62. 36 or 37 or 44 or 45 or 48 or 49 or 55 or 58 or 61
63. (Cost Control/ or Cost Savings/).tw. and 5 and 2
64. (((control$ or containment or curtailment or reduc$ or save or saving) adj3 cost?).tw.
65. (cost? adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
66. 64 and 65 and 2
67. ((control$ or reduc$ or cut$ or regulat$ or negotiat$ or fix$) adj3 (price? or pricing)).tw.
68. ((price? or pricing) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
69. 67 and 68 and 2
70. (reference$ adj3 (price? or pricing)).tw.
71. ((price? or pricing) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
72. 70 and 71
73. (index$ adj3 (price? or pricing)).tw.
74. ((price? or pricing) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
75. 73 and 74
76. (cost? effect$ adj3 (price? or pricing)).tw.
77. ((price? or pricing) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
78. 76 and 77
79. (cost? effect$ adj3 (price? or pricing)).tw.
80. ((price? or pricing) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
81. 79 and 80
82. (reimbursement contract? adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
83. (Drug Cost/ or Economics, Pharmaceutical/).tw. and (1 or 2)
84. (Purchasing, Hospital/ or Group, Purchasing/).tw.
85. (purchas$ adj3 (group? or join$ or hospital? or shared)).tw.
86. ((group? or join$ or hospital? or shared) adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw.
87. 85 and 86 and 2
88. (procurement$ adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw. and 2
89. (rebate? adj3 (drug or drugs or pharmaceutical$ or medicines or medicament? or medica$)).tw. and 2
90. 63 or 66 or 72 or 75 or 78 or 81 or 82 or 83 or 84 or 87 or 88 or 89
91. Marketing/ or Marketing of Health Services/ or Advertising/ or Licensure/ or Drug Labeling/
92. Pharmacies/ or Pharmacists/ or (pharmacy or pharmacies or pharmacist? or retailer? or wholesaler? or supplier? or dispens$).tw.
93. 91 and 92 and 3 and (1 or 2)
94. (advert$ or promot$ or market$).tw.
95. Pharmacies/ or Pharmacists/ or (pharmacy or pharmacies or pharmacist? or retailer? or wholesaler? or supplier? or dispens$).tw.
96. 94 and 95 and 3 and (1 or 2)
97. 93 or 96
98. ((control$ or reduc$ or regulat$ or fix$ or restrict$) adj3 profit?).tw.
99. (profit? adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
100. Pharmacies/ or Pharmacists/ or (pharmacy or pharmacies or pharmacist? or retailer? or wholesaler? or supplier? or dispens$).tw.
101. 98 and 99 and 100
102. (generic$ adj3 substitut$).tw.
103. (substitut$ adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
104. 102 and 103
105. (licens$ adj3 (pharmacy or pharmacies)).tw.
106. (((supply or supplies or distribut$ or sale$) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament$ or medicat$)) and (pharmacy or pharmacies or retailer? or wholesaler? or supplier? or dispens$)).tw. and (1 or 2)
107. 97 or 101 or 104 or 105 or 106
108. Cost Sharing/ and 5
109. (cost? adj3 (sharing or share)).tw.
110. ((sharing or share) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
111. 109 and 110
113. (pay$ adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
114. 112 and 113
115. ((copay$ or co pay$) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
116. ((prescrib$ or prescription?) or pharmaceutic$ or pharmacy or pharmacies or dispens$) adj3 (charg$ or fee$)).tw.
117. ((charg$ or fee$) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
118. 116 and 117
119. ((prescrib$ or prescription?) adj3 (limit$ or cap$)).tw.
120. (limit$ or cap$ adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
121. 119 and 120
122. ((coinsurance or deductible?) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament$ or medicat$)).tw.
123. “Deductibles and Coinsurance”/ and 5
124. Fees, Pharmaceutical/
125. Prescription Fees/
126. Capitation Fee/ and 5
127. 108 or 111 or 114 or 115 or 118 or 121 or 122 or 123 or 124 or 125 or 126
128. Drug Information Services/ and (patient? or consumer?).tw. and 2
129. Drug Labeling/ and (patient? or consumer?).tw. and 2
130. Patient Education/ and 3 and (1 or 2)
131. ((educat$ or inform$) adj3 (patient? or consumer?)).tw.
132. (patient? or consumer?) adj3 (drug or drugs or pharmaceutic$ or medicines or medicament? or medicat$)).tw.
133. 131 and 132 and (1 or 2)
134. 128 or 129 or 130 or 133
135. 14 or 18 or 21 or 25 or 29 or 34 or 35 or 62 or 90 or 107 or 127 or 134
Pharmaceutical policies: effects of policies for prescribers using financial incentives

21 Search strategies: CSA Worldwide Political Science Abstracts

CSA Worldwide Political Science Abstracts Search field: ‘Key Words’ KW=(legislation OR law* OR act* OR policy OR policies OR politics OR reform* OR system* OR plan* OR program* OR strategy* OR regulat* OR requirement* OR restrict* OR monitor* OR control) AND KW=(drug* OR pharmaceutical* OR medicines OR medicament* OR medicat*) AND KW=(random* OR intervention* OR control* OR compar* OR evaluat* OR time OR longitud* OR repeated measure* OR pretest OR posttest OR pre test OR post test OR impact* OR chang* OR effect* OR experiment*)

22 Search strategies: EconLit

EconLit, WebSPIRS Search field: ‘Terms Anywhere’ regulat* or requirement or restrict* or monitor* or control* or legislation or law? or act? or policy or policies or politics or reform* or system? or plan* or program? or strateg*) and (drug? or pharmaceutical* or medicines or medicament? or medicat*) and (random* or intervention? or control? or compar* or evaluat* or time or pretest or posttest or pre test or post test or impact? or chang* or effect? or experiment?)

23 Search strategies: SIGLE

SIGLE, System for Information on Grey Literature in Europe, WebSPIRS Search field: ‘Terms Anywhere’ (regulat* or requirement or restrict* or monitor or control or legislation or law? or act? or policy or policies or politics or reform* or system? or plan* or program? or strateg*) and (drug? or pharmaceutical* or medicines or medicament? or medicat*) and (random* or intervention? or control? or compar* or evaluat* or time or pretest or posttest or pre test or post test or impact? or chang* or effect? or experiment?)

24 Search strategies: INRUD

INRUD, International Network for Rational Use of Drugs Search field: ‘All non-indexed fields’ (drug) or (pharmaceutic) or (medicines) or (medicament) or (medicat) AND (regulat) or (requirement) or (restrict) or (monitor) or (control) or (legislation) or (law) or (act) or (policy) or (politics) or (reform) or (system) or (plan) or (program) or (strateg) AND (random) or (intervention) or (control) or ( compar) or (evaluat) or (time) or (pretest) or (posttest) or (pre test) or (post test) or (impact) or (chang) or (effect) or (experiment)

25 Search strategies: PAIS International


1. ((explode “Drug-stores” in DE) or (explode “Pharmacists” in DE) or (explode “Prescriptions” in DE) or (explode “Drugs” in DE) or (explode “Pharmaceutical-industry” in DE) OR (((drug? or pharmaceutic* or medicines or medicament? or medicat*)) in AB ) OR (((drug? or pharmaceutic* or medicines or medicament? or medicat*)) in TI ))) AND (((random* or intervention? or control? or compar* or evaluat* or time or pretest or posttest or pre test or post test or impact? or chang* or effect? or experiment?)) in AB ) OR ( ((random* or intervention? or control? or compar* or evaluat* or time or pretest or posttest or pre test or post test or impact? or chang* or effect? or experiment?)) in TI ))

2. ( (narco* or crim* or war? or terror* or weapon? or addict* or abus* or traffi  c* or illicit*) in AB) OR ( (narco* or crim* or war? or terror* or weapon? or addict* or abus* or traffi  c* or illicit*) in TI)

3. (1 AND 2) NOT 3
Chapter 7

26 Search strategies: International Political Science Abstracts

International Political Science Abstracts, WebSPIRS Search field: ‘Terms Anywhere’ (regulat* or requirement or restrict* or monitor* or control* or legislation or law? or act? or policy or policies or politics or reform* or system? or plan* or program* or strateg*) and (drug* or pharmaceutic* or medicines or medicament? or medicat*) and (random* or intervention? or control* or compar* or evaluat* or time or pretest or posttest or pre test or post test or impact? or chang* or effect? or experiment?)

27 Search strategies: NHS EED

NHS EED, National Health Services Economic Evaluation Database, CRD
Search fields: A combination of ‘Subject Headings’ and ‘All fields’
Search done in 6 separate stages

1. drug-approval or licensure or drug-labeling or classification or patents or marketing or marketing-of-health-services or advertising/Subject Headings
   AND
   drug or pharmoc or medicin or medica or prescri/All fields
   AND
   regulat or require or restrict or monitor or control or legislation or law or act or policy or policies or politics or reform or system or plan or program or strateg/All fields

2. insurance-hospitalization or insurance-health-reimbursement or reimbursement- mechanisms or reimbursement- disproportionate-share or reimbursement-incentive or insurance-pharmaceutical-services/Subject Headings
   AND
   drug or pharmoc or medicin or medica or prescri/All fields
   AND
   regulat or require or restrict or monitor or control or legislation or law or act or policy or policies or politics or reform or system or plan or program or strateg/All fields

3. formularies or formularies-hospital or drugs-essential or reminder-systems or prescriptions-drug or education-continuing or education-pharmacy-continuing or guidelines or practice-guidelines or guideline-adherence/Subject Headings
   AND
   drug or pharmoc or medicin or medica or prescri/All fields
   AND
   regulat or require or restrict or monitor or control or legislation or law or act or policy or policies or politics or reform or system or plan or program or strateg/All fields

4. drug-monitoring or adverse-drug-reaction-reporting-systems or product-surveillance-postmarketing/Subject Headings
   AND
   drug or pharmoc or medicin or medica or prescri/All fields
   AND
   regulat or require or restrict or monitor or control or legislation or law or act or policy or policies or politics or reform or system or plan or program or strateg/All fields

5. deductibles or coinsurance or fees-pharmaceutical or prescription-fees or capitation-fee or drug-information-services or patient-education /Subject Headings
   AND
   drug or pharmoc or medicin or medica or prescri/All fields

6. cost-control or cost savings or drug-cost or economics-pharmaceutical or purchasing-hospital or group-purchasing or pharmacies or pharmacists or cost-sharing/Subject Headings
   AND
   drug or pharmoc or medicin or medica or prescri/All fields
   AND
   regulat or require or restrict or monitor or control or legislation or law or act or policy or policies or politics or reform or system or plan or program or strateg/All fields
28 Search strategies: NTIS

NTIS, National Technical Information Service Search fields: A combination of ‘Index Terms’ (KT), ‘Key Words/Phrases’ (no tag) and ‘Title’

#1. KT=PHARMACEUTICALS OR KT=DRUGS OR KT=MEDICATIONS OR KT=PRESCRIPTION DRUGS OR KT=DRUG PRESCRIPTIONS

#2. REGULAT* OR REQUIR* OR RESTRICT* OR LEGISLAT* OR LAW? OR ACT? OR POLICY OR POLICIES

#3. COMPAR* OR EVALUAT* OR EFFECT?

#4. NARCO* OR CRIM* OR WAR? OR ADDICT* OR ABUS* OR TRAFFIC* OR ILLICIT?

#5. TI=MANUAL? OR TI=CANCER OR TI=REGISTRATION FILE OR TI=RETIRED REGISTRANTS

#6. (#1 AND #2 AND #3) NOT #4

#7. #6 NOT #5

29 Search strategies: IPA


1. ((approval*) in DE) or ((licensing) in DE) or ((licensure) in DE) or ((labeling) in DE) or ((classification) in DE) or ((patent*) in DE) or ((marketing) in DE) or ((advertising) in DE) or ((insurance) in DE) or ((reimbursement) in DE) or ((formularies) in DE) or ((formulary) in DE) or ((essential) in DE) or (reminder system*) or ((Education-pharmaceutical-continuing) in DE) or ((Education-continuing) in DE) or ((Hospitals-pharmacy-and-therapeutics-committee) in DE) or ((drug) near1 monitoring) or ((Drugs-adverse-reactions-reports) in DE) or ((Reports-drugs-adverse-reactions) in DE) or ((Costs-drugs) in DE) or ((Pricing-drugs) in DE) or ((pharmacoeconomics) in DE) or ((Costs-prescription-drugs) in DE) or ((Costs-prescription-drugs) in DE) or (cost adj sharing) or ((copayment*) in DE) or (deductibles) or (coinsurance) or ((Drug information services) in DE) or (patient adj education)

2. (regulat* or restrict* or control* or legislat* or law or laws or act or acts or policy or policies or program or programs) and (control* or compar* or evaluat* or time series or impact* or effect or effects) and ((sc=20) or (sc=22))

3. (1 and 2) not sc=6

30 Search strategies: OECD

OECD (Organisation for Economic Co-operation and Development) Searched: Publications & Documents, limited to OECD Publications only drug or drugs or pharmaceutical or pharmaceuticals or medicaments or medicines or prescription or prescriptions or prescribe or prescribing

31 Search strategies: SourceOECD

SourceOECD Search fields: ‘Title’ or ‘Abstract’ drug or drugs or pharmaceutic* or medicament* or medicines or prescrip* or prescrib*

32 Search strategies: World Bank Documents & Reports

World Bank Documents & Reports Limited to sectors: Health, Nutrition and Population or Hospitals, Secondary & Tertiary or Primary health or Reform and Financing drug or drugs or pharmaceutical or pharmaceuticals or medication or medicaments or medicines or prescription or prescriptions or prescribe or prescribed or prescribing

33 Search strategies: World Bank e-Library

World Bank e-Library Search fields: ‘Title’ or ‘Abstract’ or ‘Keywords’ drug or drugs or pharmaceutical or pharmaceuticals or pharmaceutics or pharmacoeconomics or medication or medicaments or medicines or prescription or prescriptions or prescribe or prescribed or prescribing
34 Search strategies: JOLIS

JOLIS, The Library Network, serving the World Bank Group and IMF Search field: ‘Keywords Anywhere’. Search done in two separate stages
1. keywords anywhere “pric$ or cost$ or purchas$ or procur$ or profit$” AND keywords anywhere “drug or drugs or pharmaceutic$ or medicament$ or medicines or prescrip$ or prescrib$”
2. keywords anywhere “rate$” AND keywords anywhere “return” AND keywords anywhere “drug or drugs or pharmaceutic$ or medicament$ or medicines or prescrip$ or prescrib$”

35 Search strategies: Global Jolis

Global Jolis, online catalogue for the World Bank Country Office PIC/Libraries Search field: ‘Words or Phrase’. Search done in two separate stages
1. words or phrase “pric$ or cost$ or purchas$ or procur$ or profit$” AND words or phrase “drug or drugs or pharmaceutic$ or medicament$ or medicines or prescrip$ or prescrib$”
2. words or phrase “rate$” AND words or phrase “return” AND words or phrase “drug or drugs or pharmaceutic$ or medicament$ or medicines or prescrip$ or prescrib$”

36 Search strategies: WHO

WHO (World Health Organisation), browsed The Essential Drugs and Medicines web site

37 Search strategies: WHOLIS

WHOLIS, the WHO library database Search field: ‘Words or phrase’ “pric$ or cost$ or purchas$ or procur$ or profit$” AND drug or drugs or pharmaceutic$ or medicament$ or medicines or prescrip$ or prescrib$ AND regulat$ or requirement$ or restrict$ or control$ or legislation$ or law? or act or acts or policy or policies or politics or reform$ or system? or plan or plans or planning or program? or strateg$
Pharmaceutical policies: effects of policies for prescribers using financial incentives

Contact details for co-reviewers

Dr Heidrun Sturm, MPH
Researcher
Department of Clinical Pharmacology
University of Groningen
Antonius Deusinglaan 1
9713 AV Groningen, NETHERLANDS
Telephone 1: +31-50-3632820
Facsimile: +31-50-3632812
E-mail: h.sturm@med.umcg.nl, heidrunsturm@web.de

Astrid Austvoll-Dahlgren
Researcher
Norwegian Knowledge Centre for the Health Services
PO Box 7004 St Olavs Plass
Pilestredet Park 7
Oslo, NORWAY 0130
Telephone 1: +47 (46) 400 406
E-mail: astrid-austvoll-dahlgren@nokc.no

Morten Aaserud
Researcher
Department of Health Services Research
Norwegian Knowledge Centre for Health Services
PO Box 7004 St Olavs Plass
Universitetsgaten 2
Oslo, NORWAY 0130
Telephone 1: +47 23 25 51 29
Telephone 2: +47 24 16 33 49
Facsimile: +47 24 16 30 09
E-mail: Morten.Aaserud@kunnskapssenteret.no

Dr Andy D Oxman
Co-ordinating Editor, Methodology Review Group
Norwegian Knowledge Centre for Health Services
P.O. Box 7004, St. Olav’s plads
Oslo, NORWAY N-0130
Telephone 1: +47 23 25 50 94
Facsimile: Fax:+47 23 25 50 40
E-mail: oxman@online.no

Dr Craig Ramsay
Statistician
Health Services Research Unit
University of Aberdeen
Polwarth Building
Foresterhill
Aberdeen, UK
AB25 2ZD
Telephone 1: +44 1224 558994
Facsimile: +44 1224 554080
E-mail: crr@hsru.abdn.ac.uk