exercise programme tailored to individual needs initiate long term changes in exercise behaviour? If so, among whom will such changes be most effectively maintained? Does investing resources in the promotion of healthy exercise in this way affect morbidity or the use of health services? As with many other initiatives promoting health, there is a danger that effort and resources may be misspent in promoting exercise to those who would have taken it up anyway, the "worried well." This group is likely to be younger and already more fit and active than average.

Many barriers exist to increasing physical activity, particularly through formal exercise programmes, which may be perceived as competitive and intimidating.⁷ Other obstacles to participation include boredom with exercises, lack of knowledge of how to get involved in exercise programmes, difficulties with transport to exercise sessions, lack of self discipline, and concerns about exercise exacerbating existing medical problems.¹

Developing an exercise programme for those most likely to benefit requires further study of the factors that influence uptake and adherence and of how to tailor programmes to match people's changing needs. Work on brief interventions in medical settings suggests that practitioners should use a menu of strategies, selecting one that matches the patient's readiness to change. "Prescribing" behavioural change may lead to resistance; giving patients more freedom of choice is likely to lead to better outcomes.⁸ A leisure centre should not be the only choice on offer.

Biddle and Mutrie have identified four problems that need to be addressed when exercise programmes are designed: getting started; keeping going with regular exercise; avoiding the start-stop syndrome; and improving knowledge about fitness.⁹ General practitioners or practice nurses may use these as starting points to construct and evaluate exercise programmes. We need to learn more about the successes and failures of pioneering projects; anecdotal data will not do. Any future prescription for

exercise programmes should be carefully evaluated; the results will help in the design of a definitive multicentre trial. Unevaluated initiatives may be of no more value than prescribing coloured water.

While we await the results of careful evaluation, primary health care teams should look closely before they leap into prescribing exercise. There may be many far more effective ways for them to use their resources to increase the fitness of their practice populations.

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Locally determined performance related pay

Better levers exist for improving performance in a health service with disparate values

At the end of August doctors from around Britain will meet in London to pursue their battle against the introduction of locally determined performance related pay within the NHS. According to the BMA no other issue since the start of the reforms has aroused such a consistent and united response from ordinary doctors working in hospitals and community trusts. Why the anger, and what are the principles at stake?

The move towards performance related pay was heralded in the Citizen's Charter, which promised that public sector workers' pay would be more closely related to performance. Earlier this year the Department of Health suggested amending the terms of service of all NHS staff to allow an element of pay to be determined locally on the basis of individual performance. Since then negotiations have continued, but the government has asked the Doctors and Dentists Review Body to make only a minimum award next year, to leave room for local supplementation; and it has told all NHS employers to establish mechanisms for local pay bargaining by next spring.

Doctors' concerns are twofold. Firstly, they fear the threat that local pay bargaining poses to a national health service. Secondly, they question the benefits of systems that tie pay rises to a formal appraisal of how an individual has met certain performance criteria. Their concerns cover both matters of principle and the practicalities of measuring performance. But they also reflect the underlying rift in the NHS between political-managerial priorities and clinical ones.

Firstly, doctors dispute that performance related pay schemes improve performance. Evidence suggests that at best such schemes produce only marginal improvements and at worst demotivate and divide.¹² The reasons for this are complex. Demming, one of the founders of the quality movement, criticised performance related reward systems for creating perverse incentives.³ In most cases, he argued, individual workers are doing their best; what prevents them from doing better is the system they work in, and the solution is not to set individuals in competition with one another but to organise their work so that collaboratively

they can improve the system. A report from the Institute of Manpower Studies points to the quality of the relationship between employees and their line managers as crucial to the success of performance related pay schemes¹; if this is not right the scheme will fail. But if the relationship is right then that itself may improve employees' performance because good managers know how to motivate through developing and supporting their staff. The report also cites research showing that the level of trust in an organisation, the degree of participative management, and managerial competence are crucial to the success of performance related pay schemes. These factors are desperately lacking in the reformed NHS, and if the government wants to improve performance and get better value for money this is where it should put its efforts.

Secondly, the introduction of locally determined performance related pay spells the end of nationally consistent pay scales for doctors and the end of the review body. Unfashionable as the review body model now is, it has proved cheap to administer and has met well its original aims of preventing pay disputes between doctors and their employer while reassuring doctors that their earnings would not be suppressed for arbitrary political reasons and the taxpayer that doctors were not earning too much.⁴ An important factor behind the NHS's success in raising the quality of specialist services throughout Britain has been that doctors have been paid broadly the same whether they worked in big cities or small towns. The fear is that local pay bargaining, combined with market forces, will lead back to the bad old days of unpopular parts of the country and sink specialties.

Thirdly, and perhaps most persuasively, the BMA argues that locally determined performance related pay will shift the emphasis in the NHS from clinical criteria to managerial criteria. Part of the problem is the difficulty of measuring the outcomes that matter: how, for example, do you measure the performance of a child psychiatrist (and who, if the psychiatrist is the sole consultant, will do the measuring)? It is not necessary to postulate aggressive managers with values different from those of doctors. It is enough that managers end up having to use measures that produce perverse incentives—such as length of stay, finished consultant episodes, waiting times—simply because they are available and measurable (and politically favoured), in a way that more complex contributions to the quality of care are not. The police pointed out the dangers when they were confronted with the possibility of performance related pay: an emphasis on easy arrests for trivial offences at the expense of complex detection and the subtle fostering of order in a community. The police won their case: the arguments are very similar in health care.

Finally, doctors believe that the effect of locally determined performance related pay will be to curb pay increases. Many trusts are in financial trouble and may not be able to afford a performance related payment. Both the review body and the Industrial Society have said that schemes designed mainly to control pay are difficult to make succeed.^{2 5} The Industrial Society report also suggests that the disparity between theory and practice in performance related systems may also be just too great. In a survey of over 1000 organisations from all sectors it found that 48% of organisations tied some pay increases to performance, and 51% of personnel directors were in favour

of it, yet only 31% thought that their organisation had got the link between pay and performance right.

Together these problems add up to a powerful set of reasons why the NHS is not yet ready for performance related pay. As a paper in this week's journal makes clear (p 528),⁶ consultants are not refusing to contemplate other sorts of contract. Indeed, a contract more closely related to the amount of work consultants do would pay them more. Nor are they against rewarding performance under the right circumstances. After all merit awards have provided a nationally consistent and broadly acceptable way of rewarding high performance.^{7 8} And in some trusts rewards for high performing teams have proved acceptable. What doctors do want is both a form of contract and any mechanism for rewarding high performance that will be uniform throughout the entire NHS and between specialties.

The real question for the government is whether performance related pay, determined locally, is a crucial lever for getting better performance out of doctors and other staff in the NHS. All managerial schemes are a trade off between the effort of implementing them and the benefits to be gained. Is the government sure that the benefits will outweigh the disadvantages? The disadvantages at the moment are great: further alienation of a core group of professional staff, the likelihood of perverse incentives, and the sheer effort at a time when NHS managers have plenty of other things to do. And have managers really no better levers to encourage the performance of NHS staff? The evidence of the past 46 years suggests that NHS staff—from consultants to porters—are committed to the NHS and its original ideals. There is more to be gained now from putting managerial effort into nurturing that commitment, ensuring that doctors and managers share the same values, and working together to establish and improve the meaning of good performance.

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Correction

Toxocara canis and human health

An editorial error occurred in this editorial by M G Kerr-Muir (2 July, pp 5-6). The publisher of reference 8, Lewis and Maizels's *Toxocara and toxocarosis. Clinical, epidemiological and molecular perspectives*, is the Institute of Biology, London SW7 2DZ. (Birkbeck were the printers.)