Improving quality in British primary care: seeking the right balance

For many people involved in primary care in continental Europe and the United States, Britain has historically served as a beacon. For years, we have borrowed ideas about clinical audit, teamwork, skill-mix, fundholding, continuity, and patient-centred care. Now, with quality of care as a prominent international concern and yet more organisational innovation in the United Kingdom (UK), British general practice is once again the focus of attention. In fact the vitality, perhaps even the survival, of the NHS rests on whether general practitioners (GPs) will rise to meet the pressing challenges facing their health system. Delivering on these high expectations will require an artful balance of government involvement and professional leadership.

It is necessary to see all quality improvement reforms within the historical, economic, and cultural context of a country. To put it more directly, countries are likely to get the quality improvement systems that they deserve. For over 50 years, the centrally planned Beveridge model of health care, based on a low level of funding in comparison with most other countries, has led to systems for assuring and improving good quality that are dominated by politicians and centralised planning. Seen from the outside — from countries where the power in health care is much more located outside the government (The Netherlands — with the professionals and care-providing institutions, Germany — with the insurers, the United States — with private enterprise) — the British primary care environment seems to have both some advantages and some real problems.

From our perspective outside the UK, a major accomplishment is the recently implemented comprehensive infrastructure for quality, with discrete but interrelated organisations (the National Institute for Clinical Excellence, the Commission for Health Improvement, and the Modernisation Agency) and initiatives (clinical governance, National Service Frameworks, National Performance Assessment Framework), requiring integrated activities at national, regional and local levels. Most other countries lack this essential central infrastructure, which is often fragmented because of conflicts of interests between stakeholders, and have failed to develop a coherent leadership. Also positive are the very concrete targets for improving patient care, which range from making resources available for employing more GPs and other primary care professionals, to structural considerations, such as modernisation of premises and plans for a new quality-based contract. Patient needs are explicitly at the centre of this plan and many of the ideas are innovative and ambitious. The UK is the first country in the world to have a national plan and specific targets to improve quality across the whole of its health system. It would appear, at least from the outside, that the UK government is seriously committed to creating systemic and sustained change. This compares with many other countries, where real changes are stuck in political rhetoric and debate, or, as in the US, made impossibly complicated by decentralisation manifest by the numerous and disparate healthcare systems.

Balanced against this positive view, we observe some serious vulnerabilities and formidable pitfalls in what the UK is attempting. The constant emergence of new policies and plans with frequent public articulation of new priorities is inevitably resulting in the widespread phenomenon of ‘reform fatigue’. For example, before the potential of Primary Care Groups has been realised, already a change into even larger and more autonomous Primary Care Trusts is taking place. For the ordinary practitioner this must be very difficult to understand and it is hardly surprising that it leads to feelings of cynicism and inertia. Although there is a comprehensive policy, with different organisations and initiatives responsible for setting standards, delivering improvements and monitoring change, they all seem to work rather independently, not yet showing an integrated approach to the difficult problem of improving patient care at the front line. Much needed tools for implementing quality improvement are still not widely available, such as reliable and standardised clinical data systems, agreed measures of quality, and vehicles for valid comparative reporting and benchmarking. Finally, some of the developments in the UK seem to be driven more by politics and by horrendous but idiosyncratic disasters, such as the murderous Shipman, rather than by evidence-based policy.

So, we have ambivalent feelings as we look at what is happening in the UK. On the one hand — particularly for a person from The Netherlands, where professionals have taken the lead in improving practice and activities are mainly driven by consensus among self-regulating GPs — the UK model sometimes looks overly controlling. We would be anxious about the implications of disempowering individual health professionals working on the front line. Even the latest plans to shift power to a more local level look contrived; there is risk that providers will have great responsibility but not the authority to go with it. On the other hand, however — particularly when seen from a US perspective — the potential to align centralised policy directives with allocation of resources is enviable. The likelihood of being able to drive predictable and explicit performance improvements seems to be significantly enhanced in a context such as that which exists in Britain, where accountabilities for performance are subject to a system-wide monitoring and reporting, as well as reinforced by performance-based contracts.

Delivering on the quality agenda in the NHS now requires less of a focus on the policy issues and greater focus on the frontline interactions between patients and their care-givers. New policies for clinical governance, practice assessment, patient empowerment, periodic revalidation, and public performance reporting have all been put in place. Indeed, society has a right to know whether general practice is doing a good and safe job for its citizens. But what do these copious changes mean for the ordinary GP and practice team? Can they meet the increasing demands, or will they feel as overwhelmed and demoralised as their colleagues in other countries? We must acknowledge that, in the end, the very best tool for assuring quality of care may be the professional values of individual clinicians, together with a collective professional ethos. The challenge is to find the right balance between the bottom-up and top-down approaches to improvement.
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