Quality assured

'Primary health care of a high standard is the right of every man, woman and child in the UK. The College believes that this is best provided through general practice...It is the wide variation in general practitioner performance in the National Health Service (NHS), rather than any fundamental defect in the discipline and system of care, that is the main reason for increasing pressure for reform...'

THE Council consultation document *Towards quality in general practice*, which was circulated to all members of the College in June, marks an important stage in the development of the College and of general practice and has already attracted interest from the Government and the press. Initial comment has focussed on the issue of possible financial incentives for encouraging general practitioners to participate in performance review. This, however, is just one of a range of proposals for radical changes in the way in which general practitioners are trained and their performance is assessed. The emphasis throughout the document is on the importance of establishing standards of good care and the need to measure the general practitioner's performance in meeting these standards.

The proposals contained in the document are the practical steps that can be taken to implement a strategy for improving care in general practice. This programme has been developed by discussions within the College following the commitment given by Council in 1983, known as the Quality Initiative.[1,2] The College's strategy for quality is described under five main headings: professional development of doctors, practice management and team-work, quality assessment, contracts and incentives, and resource needs.

It is in the area of professional development that the College as an institution has most to offer. The discussion document takes note of the benefits that have accrued since the implementation of three-year vocational training for general practice and the case is made for a further period of less formal higher training — of perhaps two or three years duration — during which time a new entrant to general practice would have his or her work supervised and have protected time for educational activities. Experience in other countries, notably Belgium, has shown that this kind of educational activity for young entrants to general practice can be successfully implemented. It is proposed in the document that the MRCGP examination should be the criterion for entry to higher training. Assessment of progress during higher training would need to be on a continuing basis, with the emphasis on clinical performance. The *What sort of doctor?* report[3] provides some of the methodology necessary for such assessment.

The proposed changes in continuing education are no less radical than the above. First, the document reports that the Committee on Fellowship and the Membership Division will be recommending to Council this month that the criteria for fellowship of the College should incorporate a review of a member's performance and contribution to general practice in the first 10 years as a principal. Secondly, performance review is seen as the central core of continuing education for general practitioners but a process which will be widely implemented only if there is a financial incentive.

Thus the College has not been afraid to enter the general area of contracts and incentives. It does so because it wishes to be effective in improving the quality of health care provided by general practitioners and recognizes the importance of remuneration in influencing behaviour. Almost all general practitioners in the UK do most of their work within the NHS, in a system where there is no obvious link between pay and performance. This can foster mediocrity; changes are needed to create the financial incentives for improved performance. It is suggested that a new allowance be incorporated into the contract of general practitioners which would cease to be paid if the results of periodic reviews of performance were unacceptable. Experience gained in the assessment of trainers can be usefully applied to these performance reviews.

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The sections of the discussion document concerning practice management and team-work and quality assessment both identify the need for good information and for improved understanding of the way in which primary health care systems function. Already many general practitioners are taking advantage of the benefits provided by computers, both in the office and the surgery. In future, all doctors will need the skills to make the best use of the new information tools. Although the ability to operate computers will be useful, more important will be learning how to select and utilize appropriate data from the mass of information which will be available about the work of a practice. Without reliable information, identifying problems in health care is haphazard and planning impossible. Without an understanding of the complex way in which primary care teams function, implementing changes to improve health care will be slow and unnecessarily stressful.

The discussion document is dispassionate in tone and does not flinch from tackling some of the sacred cows of general practice. Its analysis of the cherished independence of general practitioners is a good example of this. Individuality is seen as having merit by creating an independent advocate for the patient and encouraging dynamism and flair within a practice. On the other hand, the individual general practitioner's freedom to administer medical care according to his or her own preferences can be a barrier to the development of a partnership as a coherent whole and impede the creation of an effective primary care team.

The set of proposals contained in *Towards quality in general practice* should be seen in the context of an international move towards implementing quality assurance in health care. This in turn is part of a general recognition that health care is expensive and resources are finite. Those who provide the financial resources for health care are increasingly demanding maximum value for the money provided. At the same time there is mounting pressure from consumers, who are questioning the quality of the services provided. The view from overseas repeated in one of the debates at the spring symposium of the College was that general practice in the UK is relatively cheap but lacking in quality. Under the twin pressures of Government and consumers, general practice is being challenged to demonstrate that it is both efficient and effective. The principles of quality assurance are universal[4] and the discussion document from the College indicates how these principles can be applied in general practice in the UK. It is a document that deserves to be read carefully by all those seriously interested in the future of general practice in this country.

References

1. Irvine D. Quality of care in general practice: our outstanding problem. *J R Coll Gen Pract* 1983; **33:** 521-523.
2. Royal College of General Practitioners. Summary of Council Meeting. *J R Coll Gen Pract* 1983; **33:** 523-524.
3. Royal College of General Practitioners; *What sort of doctor? Report from general practice 23.* Exeter: RCGP, 1985.
4. World Health Organization. *The principles of quality assurance. EURO Reports and studies 94.* Geneva: WHO, 1985.

Copies of the discussion document are available from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.