# Experimentation: the next step

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*SUMMARY. General practice has entered a period of accelerating change, and those responsible for planning its development now put forward a variety of promising proposals. Unless provision is made for large scale experimentation and scientific evaluation, the direction of future change will be determined not by evidence but by rhetoric. A framework for creating and evaluating a substantial programme of experimentation is suggested. The programme is the logical next step in the process of change which was given impetus by the publication of the government green paper. It should be seen as a professional, moral and political priority.*

## Introduction

THE Government's discussion document on primary health care[1] lists a number of key objectives: to enhance the quality of care; to promote health and prevention; to be responsive to the consumer and to achieve better value for money. The major innovation, and the one which has resulted in the greatest controversy, concerns incentives for better care. The suggestion of a good practice allowance, linking the income of the doctor or the practice to the achievement of negotiated health care targets, has been rejected in the General Medical Services Committee's response to the Government. While stopping short of uncritical support for the good practice allowance, the College in its response[2] reaffirms its policy[3] on a performance sensitive contract.

In one of a series of articles on the general practitioner's contract, Gray, Marinker and Maynard[4] described a model for the good practice allowance, and argued that although the contract might be imperfect in almost every aspect, it would be a marked improvement on the present one. Much of the debate, however, has been emotive. Comparisons have been made with the system of distinction awards for hospital consultants, and predictably but regrettably the good faith of almost everyone concerned has been called into question. One thing seems certain. Some framework must be agreed between the profession and society for the continued development and improvement of primary health care.

For the past few years the College has been experimenting with peer group performance review as a method of continuing education.[5] It is the possibility of linking this essentially educational activity with the provision of the rewards and resources for general practice that currently causes alarm. Although much of the debate has sounded raucous and unreasonable, there have in fact been a number of serious objections raised to the creation of a performance sensitive contract. The following is not an exhaustive list:

- There is almost always conflicting evidence and opinion about the desired content of specified clinical standards.
- No generally agreed clinical standard can apply to the needs of the unique individual patient.
- The most important aspects of care cannot be quantified, and therefore cannot be monitored.
- Most clinical standards describe structures and processes of medical care: there is rarely a strong link between structures, processes and outcomes.
- It is impossible to apply national standards to very different localities: practices in socially deprived areas will be severely disadvantaged.
- To enhance the quality of general practice we will have to create countless standards, over the whole range of ages, diseases, and situations.
- The task of monitoring such a large number of changing standards is unrealistic: the cost in terms of time, money and stress will not be commensurate with improvements in the quality of care.
- Negotiations about standards with partners may threaten or rupture fragile partnership relationships.
- Negotiations with other members of the primary health care team are impossible because of the nursing hierarchy, or because the team is often dysfunctional.
- Any attempt to reward good practice and to penalize poor practice will widen, not narrow, the gap between the best and the worst.

If these objections were sustained we would create for general practitioners, their colleagues and their patients a most uncertain prospect for reform. Most are answerable, and many remain only empty assertions. It is the evidence which is missing.

The truth of the matter is that many of the proposals in the Government's green paper on primary health care,[1] the Cumberlege report on community nursing[6] and the College's policy statement *Quality in general practice*,[3] are based on good intentions, intelligent extrapolations and benign value judgements. Few of them are based on experimental evidence because most of the experiments have not yet been devised and carried out. The time is therefore ripe to shift the debate by however modest a distance from rhetoric to reason.

## Experimentation

Yesterday's success may carry within it the seeds of tomorrow's failure. The relative lack of competitive edge in this country's manufacturing industry since the second world war has often been attributed to the fact that we were in the vanguard of the industrial revolution. Other countries which for one reason or another were able to start without the inheritance of earlier success — antiquated plant and old fashioned styles of management — were better placed to exploit the new technologies and the new markets. By the same token the past successes of the National Health Service may now be impeding progress.

A market system provides its own motivation for effectiveness and efficiency. It is in the self interest of the providers to seek quality, value for money and the development of the service. Of course there are also disadvantages in an unbridled market. Services provided for patients may be attractive — good premises, ease of assessibility, plenty of time and courtesy — but the technical quality of health care may remain uncertain. Even in the USA, often depicted as an example of a free market in health care, there is massive investment of government funds and a proliferation of regulations. The market cannot rely on entrepreneurial flair alone, there is a need for the setting and

monitoring of agreed professional standards.[7] Finally, the market cannot achieve social equity of care.

A state welfare system such as our own has to create some other engine for change than that which might be provided by market forces. With hindsight it is astonishing that those who designed the NHS made such scant provision for critical appraisal, experiment, evaluation and change.

The advent of the acquired immune deficiency syndrome will certainly enforce some radical rethinking about medical care. Other forces for change, less dramatic but perhaps as powerful, reside in the accelerating changes in technology, in social mores and in the skills and ambitions of a growing number of health care professions. A monopolistic national health service, unchallenged by a programme of radical experiment, will simply not be able to adapt.

## Making judgements

The arguments in favour of a programme of experimentation in primary health care may seem at first to be self evident. There will be opposition from those who would claim that experiments may put patients at risk and that they may compromise the present service and jeopardize its future development. The counter-argument, that patients are put at risk by receiving unevaluated services, is less frequently put.

It is therefore necessary to create a framework which will minimize the risks, and answer these objections. Such a framework should not predict the nature of particular experiments, but should set broad aims. These aims would allow us to choose between experiments, and to make judgements about the results achieved. Further, by applying this framework to a wide variety of experiments, it would be possible to make comparative value judgements between the results of different experiments. This could provide some basis for choosing priorities in health care planning.

As a way of beginning to build such a framework, I suggest the following. Any experiment should attempt to advance one or more of the following aims, and to contradict none of them:

- The achievement of social and geographical equity in the availability and quality of health care.
- A shift of health care tasks and resources from hospital to general practice, and the community.
- An increase in appropriate self care and care by informal carers.
- An improvement in measurable indices of health.
- A more effective and efficient use of current resources.
- A containment of, or an actual saving in, the combined cost of primary and secondary care.
- An increase in available health care choices.
- Enhanced job satisfaction for health care workers.

## Values

Of course the wording of these aims begs many questions. Who will define social and geographical equity, or appropriate self care? These aims express certain values, and are themselves likely to be controversial. An aim concerned with achieving greater equity in health care may seem in conflict with the aim of achieving excellence. Some would argue that excellence must always take priority over equity: that to achieve an equitable distribution of indifferent care is scarcely a worthwhile endeavour. Others would argue that to neglect equity is to undermine a fundamental ethic of medicine and society.

At first glance, it might appear perfectly reasonable to aim at a containment of cost. But others would argue persuasively that in a service which appears to be so inexpensive in comparison with those in other developed nations, experiments should only be carried out on the deployment of additional resources. Proponents of this view might regard it as unethical to experiment in containing costs, at a time when there is 'self evident' need for greater investment in general practice.

By the same token, exception may be taken to the aim concerned with enhancing self care and support for informal carers. Such support is seen by some as a device by a male dominated establishment, to place on defenceless and guilt-ridden women the burden of care which properly should be supported from public funds.

Even an aim so seemingly benign as an increase in patient choice, may be seen by some to conflict with such well entrenched general practice values as continuity of care, and preventive medicine based on a stable and known population.

I give these examples not in order to determine the rights and wrongs of the debate. I wish only to stress the need for widespread discussion, elucidation and modification of the framework outlined above. What seems to me to be indisputable is the need for such a framework.

## Five areas of experimentation

A number of (overlapping) areas of experimentation suggest themselves. These might be presented in the form of tenders invited from a variety of applicants: general practices willing to innovate; family practitioner committees; district general managers; local authorities; health insurance companies; and any group competent to adapt, create and deliver a comprehensive primary health care service.

At the same time tenders would be invited for the evaluation of these experiments from university departments and research institutes. It is essential that the funding for each experiment should be matched by funding for its evaluation. This evaluation must be scientifically sound, but could be formative rather than summative, allowing the evaluators to modify and enhance the experiment which they are observing. Each experiment and its evaluation should be carried out by an independent organization.

The major impediments to health services experimentation are to be found in the professional customs, codes of practice, organizational structures, terms and conditions of service, and indeed the legislative structure of the NHS itself.

Many of these obstacles might be removed by the exercise of good will and sensitive negotiation. But some will be immovable without special dispensation from professional organizations, and others will require a change in the regulations. Three years ago the author proposed that a solution might be found by setting up NHS 'enterprise zones'.[8] This may have been too fanciful a suggestion, but solutions can be found, if there is a will to find them.

### *In-service training*

General practice in the past decades has developed a number of innovatory methods of continuing education. These have included small group case discussions, the use of distance learning materials including video recordings, analysis of video recorded consultations, clinical standard setting and audit, and most recently peer group performance review.[5] Experiments could now be mounted to determine the effectiveness and acceptability of this performance review, and to build on the College's experience of the *What sort of doctor?* initiative,[5] in order to explore other methods.

Multiprofessional workshops in primary care could be established with a view to exploring the roles, relationships and tasks of the different professionals. We could explore new

methods of making policies, setting goals and monitoring their achievement, both in relation to the care of particular patients and families, and in relation to providing a service for the mentally handicapped, the mentally ill, the elderly and those with major chronic disease.

Workshops designed to look at the interface between primary and secondary medical care may prove to be a potent source of progress, capable of achieving many of the aims previously described. Consultants and general practitioners have already experimented with such workshops, and have begun to create specific agreed standards of clinical management and monitoring.[9] Such workshops could lead to new local patterns of training, redistribution of services and resources between general practice and the hospital, the introduction of audit and the creation of comprehensive district plans.

Doctors, nurses and others have long taken part in these and similar activities. The motivation has been professional enthusiasm and idealism. But other inducements to experiment could also be offered. These might take the form of a limited redistribution of resources to meet the needs of the experimenters. If plans are made to shift the tasks of the diabetes clinic from hospital to general practice, the general practitioner would benefit not only from the satisfaction of personal and continuing care, but from the part-time attachment of a diabetes health visitor, a chiropodist, an ophthalmic optician and a dietician. The hospital consultant would benefit because routine workload would be reduced, and there would be time available for new, complex and appropriate consultations.

Most important of all, those who take part in such educational experiments must be given the time to take part. Performance review has demonstrated that the boundaries between education, research, organization and the care of patients are artificial. Their only function is to create guilt and confusion. If there is to be a serious experiment in continuing education, as a means of reforming the service, the provision of time to learn will have to be built into the contracts of all those involved.

### *New roles*

A number of changes in the roles of primary health care workers have been suggested. There have been suggestions for the development of community nurses with specialized functions; generic nurses who would combine the tasks of district nurse, practice nurse and health visitor; and nurse practitioners with competences drawn from both nursing and medicine. Changes have been suggested in the role of general practitioners, in relation to both clinical and management skills. These and others roles need to be evaluated in terms of effectiveness, efficiency and acceptability.

### *Incentives*

Even if the profession continues to resist the suggestion of a good practice allowance it will be hard to resist the offer to experiment. It is conceivable that a number of individual practices might be prepared to accept such a challenge, and to abandon the financial security of the present allowances in the hope of winning larger rewards, if the required standards are met. Other practices may wish to change to a salaried service. General practitioners may be prepared to become salaried members of neighbourhood nursing services. Yet other practices may wish to experiment with a new form of group practice in which doctors, nurses, physiotherapists, social workers and others have all become independent contractors, and profit sharing partners. A variety of imaginative experiments may be put forward, suited to the needs of different communities.

Evaluation could be comparative, and would look at performance, cost, and acceptability to both clients and providers.

### *Primary care populations*

Both the practice list of patients[10] and the neighbourhood[6] have been advanced as the logical unit of primary health care. Each has merit. In new housing areas, in inner cities and in some rural areas, it might be possible to experiment with neighbourhood based practices. What are the advantages and disadvantages of each approach? How do they perform in relation to the agreed aims?

### *Health maintenance organizations*

There has been much speculation about the introduction of health maintenance organizations[11] on an experimental basis. Initial enthusiasm may have been dampened by some recent findings in the USA,[12] which suggest health maintenance organizations do not perform as well as competing services in the care of a number of vulnerable groups. If we import health maintenance organizations into the NHS, we may see a new partnership between private enterprise, public bodies and the profession. Such a partnership, however, would prove politically highly sensitive.

Since the essence of the argument for health maintenance organizations is that the providers must compete for the custom of the patients, any viable experiment would seem to require the setting up of two competing organizations in the same area. It may of course be argued that a health maintenance organization entirely funded by the NHS (but contracted to private enterprise) might simply compete with the surrounding and unmodified health service. Maynard[13] suggests that both public and private health care systems may run into similar problems of cost containment. He suggests that the solution to the problems of both may lie in the introduction of competition and incentives. Much of the political risk might be reduced if government were to insist that any large scale experiment be evaluated in terms of the framework described earlier.

## Organization

Such a programme of experimentation would require the allocation of substantial sums of money, over at least a decade, although no attempt is made in this paper to put a price on the programme. The Department of Health and Social Security would need to set up machinery to receive applications from various providers of health care, and to determine the likelihood of these proposals meeting the agreed aims of the programme.

In addition, an evaluation committee might be established, made up of representatives of the professions, and senior academics in general practice, community medicine, nursing and health economics. Because of the particular ethical issues raised by such experiments, the committee should include one or two leading exponents of ethical theory. Its task would be to offer each experiment for evaluation to university departments, research units and similar organizations. Proposals would be invited for each study and chosen on a competitive basis.

The evaluation committee would demand that each evaluative study should address itself to the aims devised for the whole programme. Such a framework for evaluation would permit comparative statements about the outcome of very different experiments, and would allow us to rank them in terms of costs and benefits.

## Politics

Politically it would be hard to argue against such a significant shift from rhetoric to evidence. There is however a danger in setting up such a mechanism. The need for experiment, for sound evidence about the outcome of change, must not itself be used as a brake on progress and reform. Government, the DHSS and

professional and client organizations must all be free to continue their normal dialogue and negotiations throughout the experiments, although they may draw on the experience of the experiments in determining policy.

Such a programme should prove attractive to most of those involved. The government is likely to purchase a great deal of public and professional good will. The General Medical Services Committee and the Royal College of General Practitioners may be grateful to be given the opportunity of coming into closer partnership and moving forward in a relatively safe way. Nursing organizations will be given the opportunity to develop the role and influence of nurses in primary health care more radically and more rapidly than might otherwise be the case. Client organizations may feel assured that intelligent efforts are being made to learn how best to secure better quality and better value for money.

## Conclusion

In debate about the ways to improve general practice, what begins as healthy scientific scepticism all too easily slips into cynicism and eventually a profound nihilism which permits only the boast that we are doing as well as can be expected in trying times.

Logic suggests that the enhancement of general practice can only bring benefits in the quality of health care, and savings in overall cost. General practice will continue to change rapidly in the coming decade, not least because of the pressures of technological and social changes. But the direction of this change will be uncertain, unless it is enlightened by experiment. Experimentation must not be dismissed as a side-show in the health service; a game for academics; one of many possible options. I would argue that it is an ethical requirement in the practice of medicine, and a moral imperative for those who are responsible for providing a national health service.

## References


1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771).* London, HMSO: 1986.
2. Royal College of General Practitioners. *The front line of the health service. College response to 'Primary health care: an agenda for discussion'. Report from general practice 25.* London: RCGP, 1987.
3. Royal College of General Practitioners. *Quality in general practice. Policy statement 2.* London: RCGP, 1985.
4. Marinker M, Gray DP, Maynard A. The doctor, the patient and their contract. The good practice allowance: is it feasible? *Br Med J* 1986; **292:** 1374-1376.
5. Royal College of General Practitioners. *What sort of doctor? Report from general practice 23.* London: RCGP, 1985.
6. Department of Health and Social Security. *Neighbourhood nursing — a focus for care (The Cumberlege Report).* London: HMSO, 1986.
7. Donabedian A. *Explorations in quality assessment and monitoring.* Ann Arbor: Health Administration Press, 1985.
8. Marinker M. Developments in primary health care. In: *A new NHS act for 1996?* London: Office of Health Economics, 1984.
9. Irvine D, Russell I, Hutchinson A, *et al.* Educational development and evaluative research in the Northern Region. In: Pendleton D, Schofield T, Marinker M (eds). *In pursuit of quality.* London: RCGP, 1986.
10. Royal College of General Practitioners. *Combined reports on prevention. Reports from general practice 18–21.* London: RCGP, 1984.
11. Enthoven A. *Reflection on the management of the national health service. Occasional paper 5.* London: Nuffield Provincial Hospital's Trust, 1985.
12. Ware J, Brook R, Rogers WH, *et al.* Health insurance: comparison of health outcomes at health maintenance organizations with those of fee per item of service care. *Lancet* 1986; **1:** 1017-1022.
13. Maynard A. *Financing the UK national health services. Health policy 6.* 1986: 329-340.



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