

Editorial

Creating a quality healthcare system for the 21st century

A Niroshan Siriwardena MMedSci PhD FRCGP
Foundation Professor of Primary Care, School of Health and Social Care, University of Lincoln, UK

In the 60th anniversary of the National Health Service (NHS), the final report of the next stage review, *High Quality Care for All*, puts quality and quality improvement at the centre stage of the NHS.[1] As Lord Darzi puts it, 'The common theme of these new measures for patients is improving quality. It must be the basis of everything we do in the NHS.'

If high-quality care means the extent to which health services are consistent with best evidence and improve outcomes in striving for health care that is safe (no needless harm), effective (evidence-based), patient centred (no feelings of helplessness and in accordance with patients reasonable expressed wishes), timely (no needless delay), efficient (no waste and with realistic outcomes) and equitable (fair to all patients)[2] then, to some extent, the review focuses on all these areas.

Whatever the quality of care we provide or receive it can be improved; and to create the highest quality service we need to be constantly thinking about how to improve care. Don Berwick, Chief Executive of the Institute for Health Improvement in the United States and Professor of Health Management at Harvard described, in his keynote lecture at the International Forum on Quality and Safety in Health Care 2008 in Paris, the four prevailing theories of quality improvement: set goals and targets; create better markets; increase resources to the current system; redesign the system for better performance. Berwick went on to describe how the first three of these methods have failed.

Targets have produced some spectacular failures due to perverse incentives and gaming which produces distorted systems or distorted figures.[3] We all remember the issue of GP waiting times highlighted in the last election. Here is a quote from John Hutton expounding the advantages ... 'Patients want to see their GP as quickly as possible. The target has helped ensure that this happens ... the longer a patient has to wait to see a GP, the more anxious they are likely to become'. But the rhetoric is very different from the reality that patients and staff experience. The new 48-hour access target to see a GP actually led to difficulties for patients booking appointments in advance, blocked practice phone lines each morning and the bizarre practice of receptionists telling patients to phone the next morning for an appointment. As Deming observed almost three decades ago 'management by numerical goal is an attempt to manage without knowledge of what to do'.[4]

Markets and increasing resources have not fared much better. Robert Kuttner in a damning indictment of the US healthcare system which costs 16% GDP and where the outcomes of care are amongst the worst in the developed world explained how the market system had failed due to a reliance on high tech care, fragmentation of services, passing on costs to patients and restricting treatments; he describes a market system that pushes people to make profits at the expense of less time with patients and this seems to be true in not-for-profit organisations in the US as well as those with shareholders.[5]

Although these obsolete strategies remain a legacy of previous polices, thankfully these are not a large part of the vision for the new quality focused NHS. 'No new targets' is an important mantra of the new regime. The goal is system redesign. How the system is redesigned will of course determine whether the quality improvement and transformational change that the new vision aspires to will occur.

The next stage review report focuses on positive action for change but what is the evidence that it will produce the transformation in the quality of health care that the vision espouses? This, when previous initiatives such as clinical audit have arguably had limited impact,[6] because we have been measuring the wrong things,[7] conducting the process ineffectively[8] or not implementing change.[9]

The report has a number of specific recommendations to consolidate and develop existing services: promoting comprehensive wellbeing by strengthening primary prevention through existing programmes such as the Quality and Outcomes Framework and new work-related initiatives to improve cardiovascular risk assessment and reduce risk; tackling specific key health issues such as obesity, smoking, alcohol and drug misuse, sexual health and mental health; and addressing long-term conditions.

The structural mechanisms for improvement focus on a number of themes: choice, access to and personalisation of primary care and other services informed by public available data; personalisation of long-term care with funding through personal budgets; collaboration through voluntary coalitions between Government, private and third sector organisations to deliver improved health outcomes.

The quality improvement methods advocated include a number of carrots and sticks: quality and quality improvement will be commissioned for; financial incentives such as funding for quality through best practice tariffs focused on areas of improvement, innovation funds and prizes; professional sharing of best practice through 'Quality Observatories'; increased public availability of quality information through 'Quality accounts'; increased assessment quality indicators and accreditation schemes greater regulation through the new 'Care Quality Commission'. Expert advice to ministers will be provided through a 'National Quality Board' which will set independent quality standards and also set priorities for development of clinical quality standards to be defined by National Institute of Health and Clinical Excellence (NICE).

What is less evident is a coherent framework for implementing improvement. If the aim is to put quality improvement at the heart of the health service there needs to be clarity of method and evidence about how this might be achieved for patients and staff to believe that the vision is achievable.

For example, emphasis is placed on the Quality and Outcomes Framework, but published evidence suggests that it has had limited impact,[10] which is partly because a number of the systems improvements that led to improvement were introduced before the Quality and Outcomes Framework came in. We need to remember that the framework only addresses 25% of morbidity seen in general practice[11] and because of the way the system works, with its emphasis on achieving targets, pay for performance, the lack of focus on improvement and the failure to involve stakeholders, is likely to produce incremental rather than dramatic changes.[12]

The public feel uninformed by currently available health performance data because they do not know how to access or interpret information and when they are able to it is too vague to be useful in making choice.[13] Both public and professionals are sceptical about the information and its use for encouraging competition.[14] Moreover, the effect of publishing data on improving quality is uncertain[15] and there is little evidence that allowing patient choice actually helps drive quality improvement.

It is not clear that professional accreditation schemes or setting minimum standards of care will drive up quality[16] or inspire aspiration to high standards. Multiprofessional education and training for future clinicians, although theoretically attractive, also has little evidence for effectiveness, perhaps because we do not understand when and where to use it to best effect.[17]

Clinical and opinion leadership are also emphasised and these factors are an important precondition for transformation because professionals need to believe in and understand changes that they carry forward[18] but also because they need champions to help bring about change; the evidence for how this could or should happen to improve outcomes is unclear.[19]

What is becoming clearer is that the health system is complex and multidimensional; the external environment has a key effect on internal dynamics of the health system. The evidence we produce and outcomes we achieve are specific to the context of practitioners and service users and the beliefs of professionals and patients about evidence and health outcomes fundamentally affect behaviour. Organisational interactions lead to unpredictable responses to interventions but they can also lead to learning and change. Professionalised organisations are complex and knowledge based organisations where 'knowledge is power' to carry forward or subvert change. Interaction makes the system respond more unpredictably but, if harnessed in the right way also encourages learning and transformational change.[20]

The challenge of creating real quality is that we need to embrace the complexity of the system we are working in, enable the different parts of the health system pulled apart by competition to join up and work together and with front line staff and service users to create genuine quality that everyone can understand and feel. In order to be able to do this the government needs to reduce the vicissitudes of policy and reorganisation, build real capacity for quality improvement through education, help to break down organisational barriers and adopt a systems approach.[21] An educational approach rather than a carrot and stick approach is, I believe, what will lead to real and lasting improvements to health care ... an approach which sees doctors, nurses, allied health professionals and other parts of the health and social care system work together with service users to get real improvements in health. The new emphasis on quality offers a tremendous starting point.

ACKNOWLEDGEMENT

This editorial is partly based on an inaugural lecture, 'Creating a quality primary healthcare system for the 21st century' given on 13 May 2008 at EMMTEC, Brayford Campus, University of Lincoln.

REFERENCES

1 Darzi of Denham AD. High Quality Care for All: NHS Next Stage Review Final Report. London: Stationery Office, 2008.
2 Institute of Medicine. *Crossing the Quality Chasm: a new health system for the 21st century*. Washington DC: National Academy Press, 2001.
3 Seddon J. Systems Thinking in the Public Sector: the failure to reform regime and a manifesto for a better way Axminster: Triarchy Press, 2008.
4 Deming WS. *Out of the Crisis*. Cambridge: MIT, 1962.
5 Kuttner R. Market-based failure – a second opinion on US health care costs. *New England Journal of Medicine* 2008;358:549–51.
6 Holden JD. Systematic review of published multi-practice audits from British general practice. *Journal of Evaluation in Clinical Practice* 2004;10:247–72.
7 Hearnshaw HM, Harker RM, Cheater FM, Baker RH and Grimshaw GM. Are audits wasting resources by measuring the wrong things? A survey of methods used to select audit review criteria. *Quality and Safety in Health Care* 2003;12:24–8.
8 McKay J, Bowie P and Lough M. Variations in the ability of general medical practitioners to apply two methods of clinical audit: a five-year study of assessment by peer review. *Journal of Evaluation in Clinical Practice* 2006; 12:622–9.
9 Foy R, Eccles MP, Jamtvedt G, Young J, Grimshaw JM and Baker R. What do we know about how to do audit and feedback? Pitfalls in applying evidence from a systematic review. *BMC Health Service Research* 2005; 5:50.
10 Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B and Roland M. Quality of primary care in England with the introduction of pay for performance. *New England Journal of Medicine* 2007;357:181–90.
11 Heath I, Hippisley-Cox J and Smeeth L. Measuring performance and missing the point? *BMJ* 2007;335: 1075–6.
12 Freeman T. Using performance indicators to improve health care quality in the public sector: a review of the literature. *Health Service Management Research* 2002; 15:126–37.
13 Magee H, Davis LJ and Coulter A. Public views on healthcare performance indicators and patient choice. *Journal of the Royal Society of Medicine* 2003;96:338–42.
14 Marshall MN, Hiscock J and Sibbald B. Attitudes to the public release of comparative information on the quality of general practice care: qualitative study. *BMJ* 2002; 325:1278.
15 Fung CH, Lim YW, Mattke S, Damberg C and Shekelle PG. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of Internal Medicine* 2008;148:111–23.
16 Greenfield D and Braithwaite J. Health sector accreditation research: a systematic review. *International Journal of Quality in Health Care* 2008;20:172–83.
17 Reeves S, Zwarenstein M, Goldman J *et al.* Interprofessional education: effects on professional practice and health care outcomes. *Cochrane Database Systems Review* 2008:CD002213.
18 Ham C. Improving the performance of health services: the role of clinical leadership. *The Lancet* 2003;361: 1978–80.
19 Thomson O'Brien MA, Oxman AD, Haynes RB, Davis DA, Freemantle N and Harvey EL. Local opinion leaders: effects on professional practice and health care outcomes. *Cochrane Database Systems Review* 2000:CD000125.
20 Siriwardena AN. A voice for quality. *Quality in Primary Care* 2005;13:179–81.
21 Fitzgerald L, Lilley C, Ferlie E, Addicott R, McGivern G and Buchanan D. *Managing Change and Role Enactment in the Professionalised Organization*. Final Report for the NHS NCCSDO, 2006. Leicester De Montfort University and Royal Holloway, University of London.

ADDRESS FOR CORRESPONDENCE

A Niroshan Siriwardena, School of Health and Social Care, University of Lincoln, Lincoln LN6 7BG, UK. Tel: +44 (0) 1522 886939; fax: + 44 (0) 1522 837058; email: nsiriwardena@lincoln.ac.uk