the lowest incomes. If it were prescribable the current exemption categories from prescription charges would effectively target nicotine replacement therapy at the most socioeconomically disadvantaged groups.

Helping people to stop smoking is not a panacea. Socioeconomic differentials in health are due to many factors, of which smoking is only one.[11] After stopping smoking the risks of different diseases fall at different rates. Ex-smokers remain at greater risk for some diseases than people who have never smoked, even many years after stopping.[12] Reducing the numbers of people who take up smoking in the first place thus remains the most important aim of health policy on tobacco. Nevertheless, making nicotine replacement therapy available on prescription would be an effective way of working towards the aims of *Our Healthier Nation*.

Liam Smeeth *General practitioner*

Department of Primary Care and Population Sciences, Royal Free Hospital and University College London Medical Schools, London NW3 2PF (l.smeeth@ucl.ac.uk)

Godfrey Fowler *Emeritus professor of general practice*

Division of Public Health and Primary Care, Institute of Health Sciences, University of Oxford, Oxford OX3 7LF (godfrey.fowler@balliol.ox.ac.uk)

GF has chaired an expert panel on smoking cessation, calling for a more effective UK policy on smoking cessation and the use of nicotine replacement, which was supported by Novartis.

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Time for organisational development in healthcare organisations

Improving quality for patients means changing the organisation

A copy of the *Quality in Health Care* supplement appears on www.bmj.com and www.qualityhealthcare.com

conference

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The supplement to *Quality in Health Care* complements a conference on 10 November 1998 in London. Inquiries to Jane Lewis (0171 383 6605, JLewis@bma.org.uk)

The discussion on quality of care has come a long way: from the efforts and research of visionaries such as Ernest Codman and Avedis Donabedian in the 1970s to the introduction of quality management and continuous quality improvement; from assessing quality from the perspective of a single profession to a more integrated and process oriented view; from control to improvement. Most of this development has been driven by pioneers with an outstanding vision, such as Don Berwick, who felt that we could do better for our patients and must improve. However, numerous publications, countless conferences, and broad discussions have not yet produced sufficient improvements of actual quality. This week the journal *Quality in Health Care* adds to this debate with a supplement on *Organisational Change: The Key to Quality Improvement* that reviews current thinking (and achievements) in the NHS in particular and health care in general (see www.bmj.com or www.qualityhealthcare.com). It provides yet another sign that what has been achieved cannot yet satisfy patients, payers, and professionals. So why is it so hard to get real improvement and change?

Over the past century health care has also come a long way—from the doctor in a solo practice, a generalist able to master all the relevant medical knowledge and apply it to the treatment of his patients, to the network of highly specialised consultants, who depend on each other for complementary expertise; from the asylum, where the interaction of nurses and doctors could guarantee optimal treatment, to today's hospital, where personnel clustered in over a thousand job categories have to run a highly complex and interactive system.[1] As different as inpatient and outpatient settings are, both have one aspect in common: the mere size and complexity have made it impossible for any single individual to control and guide the operation, and no single profession can claim to be able to guarantee high quality care. As the British Nobel Prize winning economist Ronald Coase has taught us, organisations develop because, with increasing scope and size of an operation, transaction costs defined as the costs of obtaining additional resources and information, increase to a point where it is worth while creating formal organisations.[2] Health care has, under increasing cost pressure, finally come to realise an important implication of Coase's theory: if care is to be of higher quality and lower cost the key to improvement lies in better organisational structures and processes The *Quality in Health Care* supplement collects together a series of valuable papers that aim to help our understanding of what it means for health care to organise for high quality performance.

As Leatherman, Sutherland, and Buchan point out, much of the success of quality improvement efforts will depend on clarifying roles and responsibilities and on the availability of data, appropriate incentives, and performance indicators.[3 4] One of their main lessons is that quality will improve only if healthcare systems demand and support it. However, this is, as other

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contributors emphasise, only part of the story. The other important part of the picture deals with the organisational performance of real health care. Studies and experience from numerous consulting projects indicate that there is much room for improvement.

Up to this point a student of management and organisation theory could only be stunned by how little the efforts to improve quality have learnt from current thinking in management theory and from the experience of other industries. In a groundbreaking study of quality departments in the air conditioning industry David Garvin found that those firms that use their quality departments to facilitate improvement by work teams do measurably better than those who rely on audit.[5] Although these findings are not unique and are supported by theory, some health systems still rely on external control and audit. This lack of openness to the experience of others may in part be due to the belief of most doctors that health care is fundamentally different and has therefore little to learn from other disciplines.

The right way to organise for a given task depends on the demands of the environment of the organisation and more specifically on the tasks, the technology used, and the economic and institutional environment.[6 7] The more complex, changeable, and unpredictable an organisation's environment, the more it is forced to differentiate and specialise. Most healthcare organisations master this part of the challenge, adding to the complexity of today's hospital and provider network. But differentiation and specialisation are only one side of the coin. To provide high quality care efficiently the organisation has to integrate its organisational functions, professional groups, and specialist workers into one coherent effort. This is the part where most healthcare organisations fail miserably. Although modern health care calls for extensive team work, most organisations have difficulties in bridging the gaps between the professions and expert groups. The need to take teamwork seriously makes the paper by Firth-Cozens an important contribution.[8]

Again, the lack of teamwork cannot be attributed to lack of knowledge. The management literature offers valuable advice on how to facilitate work teams. In his model of group effectiveness Richard Hackman offers a comprehensive analytical and prescriptive model of what helps a group successfully to fulfil its tasks.[9] The model identifies the organisational context, the design of the team, and the process of group work as crucial factors. Managers might usefully take Hackman's model and use it to analyse a their organisation and identify areas for change.

Changing an organisation is a complex task: the more complex the organisation, the more complex the change process. Change processes often fail because actors look at only one part of a process and follow a simple cause and effect logic. But organisations have to be viewed as systems, with interrelated parts, which will not follow commands like a simple machine and where an apparently logical change in one part of the process may have unforeseen consequences if the system is not viewed as a whole. Therefore, changing organisations is a process that will involve a series of learning cycles; this makes long range planning futile and demands a continuous reassessment of changes and intermediate results. The goal for any organisation in a complex environment is to become a learning organisation, able to adapt to the changing demands of the environment.[10]

Such an organisation is, among other things, characterised by trust of and empowerment of individuals. Ever since McGregor's groundbreaking work we have known how much the assumptions of the organisation's leadership about the nature of human beings influences the performance of its workers.[11] However, only a very few healthcare organisations have dropped bureaucratic routines, which rely on control and distrust.

All these changes require leadership. And here again health care has much to learn. The "machine bureaucracy" model often influences current thinking in hospitals. This assumes that all knowledge, responsibility, authority, and power is vested at the top of the organisation, from where it is delegated to lower levels. Leading therefore means controlling all processes and decisions. Current thinking in management theory, however, as argued by people like Heifetz, assumes leading to be equivalent to moderating and managing the adaptive and change processes.[12] On Heifetz's reasoning, managing the status quo does not qualify a manager to be a leader, and issuing orders or executing commands will not support the developmental—that is, adaptive—qualities of the organisation.

The literature on organisational behaviour and management is full of valuable insights on how to run complex organisations. Most healthcare delivery systems could benefit from looking at these accounts, but only a few have dared to do so. One plausible hypothesis is that a comprehensive analysis of current healthcare organisations would almost certainly reveal a tremendous need for organisational change—and doctors and others probably fear the change in power distribution that this would inevitably entail. But really to improve the quality of care for patients does depend on changing current organisational settings. Without such effort, health professionals will be left to struggle against the inertia of rigid organisational structures and processes unfit for the task.

Christian Koeck *Professor of health policy and management, University of Witten-Herdecke*

Koeck, Ebner and Partner Inc, Alserstrasse 4, A 1090 Vienna, Austria (ckoeck@csi.com)

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