New Zealand's independent practitioner associations: a working model of clinical governance in primary care?

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Clinical governance has achieved "band wagon" status in recent months in the United Kingdom.[1–3] Yet there remains considerable confusion and uncertainty about its scope and purpose. Since 1991-2, the NHS has invested in the development of clinical audit, but this has rarely been related to the parallel development of various forms of devolved budget holding, both within hospitals and in primary care. However, we believe the integration of clinical and financial accountability is essential for the development of effective clinical governance. Over the past five years, New Zealand's independent practitioner associations have been developing a working model of such clinical governance in primary care.[4 5] We think this is relevant to clinical governance in budget holding primary care groups in England and local health groups in Wales. Although Scotland's local health care cooperatives do not hold budgets or commission services, they too will need to make arrangements for clinical governance.

Summary points

- The scope and application of clinical governance in the United Kingdom remain unclear
- New Zealand's independent practitioner associations are implementing a working model of clinical governance in primary care
- This is achieved through an elected board, accountable to the purchasing authority for large and increasing amounts of public funding
- Associations have a well established infrastructure, including staff, information systems, clinical guidelines, peer discussion groups, and personalised feedback on clinical performance
- Associations have used budget holding to make savings to develop new and better services

Clinical governance in the NHS

From April 1999, the chief executive of each NHS trust (including new primary care trusts) became responsible not only for the financial health of the organisation but also for the quality of its clinical services. The key elements identified by the NHS to enable this to happen are clinical audit, clinical risk management, quality assurance, clinical effectiveness, and staff and organisational development.[6] The consultation document *A First Class Service* defined clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."[3] This definition does not refer to the collective management of resources. This may be intentional, given the reluctance of clinicians to accept a role in priority setting. But it is plain that managers (and clinicians) cannot ignore the financial dimension of their new twin responsibilities.

Thus the emerging NHS view of governance seems to be much more restricted than the general use of the term. Donaldson, a key NHS promoter of the concept, stated, early in the debate, that "the term clinical governance resonates with that of corporate governance, a set of financial duties, accountablities, and rules of conduct."[1] Yet a recent paper on clinical governance did not mention management of resources.[7]

Should clinical governance by primary care groups be implemented simply as an extension and formalisation of current initiatives to monitor and audit performance, promote quality, and maximise clinical effectiveness through guidelines and evidence based practice? Or is it mechanism through which teams of clinicians improve the quality of care while sharing the management of scarce resources? And what is the role of clinical governance at the corporate level? New Zealand's experience of independent practitioner associations may help answer these questions.

New Zealand's independent practitioner associations

New Zealand's associations began in 1992-3 as a response by general practitioners to the perceived threats posed by health reforms.[4-11] They are similar in many respects to primary care groups but are owned and controlled independently by the general practitioners themselves.[4 5] Unlike British general practitioners, 80% of New Zealand's general practitioners are still paid for general medical services by "fee for service." Typically, they derive only about a third of their income from the public purse, mainly for subsidised visits by

Comparison of features of independent practitioner associations in New Zealand and primary care groups in England relevant to clinical governance[8]

Feature	New Zealand: independent practitioner associations	England: primary care groups
Type of organisation	Mostly private companies	An integral part of NHS structure, evolving to become primary care trusts
Professional membership	Practitioners choose to join one association with no geographical boundaries	Compulsory membership based on geographical boundaries
Purchasing of services	Only laboratory tests and drugs at this stage. Remainder bought by national purchaser	Will eventually purchase all services in collaboration with local providers
Governance	Elected boards including non-general practitioners in some cases	Moving to formal trust status with joint practitioner-purchaser board membership
Community/consumer participation	A wide range, including community advisory committees	Required to consult with communities
Infrastructure development	Well advanced, with corporate organisation, management structures, and merged practice registers	Still resolving the respective roles of practice and corporate management
Accountability for quality and cost	Collective professional leadership and accountability at corporate level with involvement of member practices	Still largely at the practice level with uncertain role at corporate level

children and people on low incomes. However, there is increasing interest, particularly among association leaders, in payment by capitation for general medical services.

There are now over 30 associations, ranging from 7 to 340 members (mean 74) and representing over 75% of general practitioners.[5] Associations are governed by boards of management elected by members. Some have extended board membership to community representatives and a quarter include members other than general practitioners.[4 5] The purchasing authority is not represented and remains at arm's length in a contractual relationship. Majeed and Malcolm discussed the contrasts between England's primary care groups and New Zealand's associations,[8] and the table shows the features relevant to clinical governance.

Almost all associations have now taken on responsibility for non-general medical services budgets for laboratory and pharmaceutical services, in addition to developing new services.[4 5 11–14] The main incentive has been the opportunity to improve the quality of clinical decision making and achieve savings to develop new services. The main sources of finance are from budget holding savings and government grants.[4 5] For the purchaser, the incentive was to minimise the risks of growing, largely uncontrolled, expenditure on laboratory and pharmaceutical services. Budgets have so far been historical, and associations have been able keep a varying proportion of their savings.[4 5 8–11]

Associations have established comprehensive information systems, computerised practice registers (now in nearly all member practices), personalised feedback on prescribing behaviour and laboratory use, and peer group discussion of guidelines.[4 5 12–14] This has identified wide variations in clinical behaviour. To build a more comprehensive primary health care service, corporate initiatives include building relationships with other primary care professionals such as nurses and midwives. Many new forms of community participation are being established. These represent the equivalent of accountability to shareholders in a firm. New service integration projects are also being developed between primary and secondary care in a system which has been notoriously fragmented in the past.[4–6]

The national purchaser recently signed a contract with the associations to move to population based equitable funding, especially of laboratory and pharmaceutical services for all general practitioners, but the timing and strategies to achieve this remain unclear. The immediate consequence for associations will be the need to address inappropriate variation in expenditure between and within associations. A related issue is how to address poor quality practice and the nature of any sanctions needed to achieve this.[5]

Is this clinical governance?

We believe that associations have succeeded in putting in place the prerequisites for clinical governance. They have established an infrastructure, appointed key staff, developed information systems, prepared clinical guidelines, and introduced personalised feedback and peer discussion groups.[4 5 12–14] Better quality prescribing is being facilitated by trained staff who visit selected practices.[12 13] Major efforts have been made to develop both internal as well as external relationships.[6]

Most importantly, general practitioners have developed collective professional responsibility for expenditure, especially for laboratory and pharmaceutical services. Evaluations have shown savings from 5% to 23% in laboratory services in just over a year.[4 5 12–14] This gives associations the opportunity to shift resources between services according to their priorities—for example, using savings to improve immunisation levels[15] and disease management programmes.[4 5]

Yet, most associations continue to reject bearing full financial risk.[4 5] This is understandable. Like the boards of public hospitals, they manage large sums of public money. Unlike such boards, they have no capital base against which to borrow to cover overexpenditure. They face political and professional risks, which make them cautious about taking on the full financial risk. Furthermore, they assert that their goals and incentives are primarily professional, not commercial. Consequently, nearly all associations reject direct personal gain, seeing it as both unprofessional and unethical.[4 5] Although the associations consist of private providers, they see themselves as "quasi-public" bodies, managing additional public money to achieve public goals. Only indirectly does this assist in improving the financial circumstances of members. This is similar to the position of the former general practitioner fundholders in Britain, who could not profit directly from their actions.

UK experience

The experience in Britain suggests, similarly, that delegating budgets to general practices can generate

What can be learnt from New Zealand's independent practitioner associations

- Clinical governance is likely to develop as a collaborative but corporate function, with clinician leaders elected by colleagues to achieve both better quality and efficiency in use of resources
- Clinical governance is likely to work best if bureaucratic control is kept to a minimum while ensuring appropriate accountability
- Corporate leadership is needed to establish the necessary infrastructure to manage clinical activity such as staffing, information systems, peer groups, clinical guidelines, quality initiatives, personalised feedback to members, and relationship building
- Professional incentives, such as the ability to use savings to develop new services are likely to be more effective in motivating practitioners than personal gain
- Clinical governance provides the leadership to build relationships in a comprehensive primary health care service, including with other health professionals and with communities

incentives for practitioners to review their use of resources, even when practices do not bear the full financial risk. Under fundholding, the prescribing budget presented a stronger, direct incentive to manage pharmaceutical costs than the indicative budget given to non-fundholders, despite the fact that the only sanction for overspending fundholders was removal from the scheme. Fundholders were able to contain the rate of increase in their drug costs more effectively than non-fundholders. This was achieved by reducing the cost of each item rather than prescribing fewer items.[16 17]

Likewise, in the pilot extension to fundholding known as total purchasing, projects which were granted greater budgetary responsibility by the parent health authority seemed to achieve more than those with indicative budgets.[18] Also, larger, multipractice pilot projects found it more difficult than single practice pilots to adjust their patterns and levels of spending to remain within budget.[19] They were far more likely than single practices to leave responsibility for reviewing expenditure against budget and for taking action to the lead general practitioner rather than making all general practitioners responsible. The reaction to financial pressures was to delay non-urgent treatment rather than attempt to influence the referral rates of individual practitioners, suggesting that clinical governance was still relatively immature.

What can be learnt from New Zealand?

The experience of the total purchasing pilots highlights the importance of effective commissioning of services and collective management of resources and clinical activity. This requires development of a strong management infrastructure capable of linking independent practices and practitioners. Independent practitioner associations in New Zealand have gone further than fundholding groups, total purchasing pilots, or the new primary care groups along this road. This has been particularly noticeable in the collection, analysis, and use of comparative information on individual practitioner performance across the associations. The information has been used to shape practice in order to make better use of resources.

By contrast, some participants in primary care groups seem to be unwilling to accept that finite budgets might require changes in practitioner behaviour.[20 21] This reluctance has been reinforced by ministers' unwillingness publicly to restrict the freedom of general practitioners to prescribe and refer as they see fit.[22] At this stage, there is still much uncertainty about what this will mean in practice and, particularly, how budgets might be set.[21 23] On the other hand, the current commissioning pilots in England, which manage a collective, cash limited pharmaceutical budget, like the primary care groups, have shown that volunteer practices are willing and able to use a range of techniques to shape the quality and cost of individual practitioners' prescribing. These include formularies, prescribing groups, sharing prescribing data, and incentive schemes.[24] The box gives the main lessons that can be learnt from New Zealand by primary care groups and local health groups.

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