Quality and professionalism in health care: a review of current initiatives in the NHS

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Since the start of the 1990s the NHS and the clinical professions have made significant investments in quality management in health care, and a plethora of initiatives has been aimed at service improvement. From a patient's perspective the extent to which these exercises have been cost effective is uncertain, although they have certainly involved great effort and enterprise on the part of many clinicians and managers. An important opportunity now exists to integrate this work into the mainstream of clinical and general service management. If clinicians can accept quality management concepts as central to their professional ethos and regulatory structures this could help them to maintain their professional authority and protect them and their patients from imposed decisions based on inadequate understanding of health care costs and benefits.

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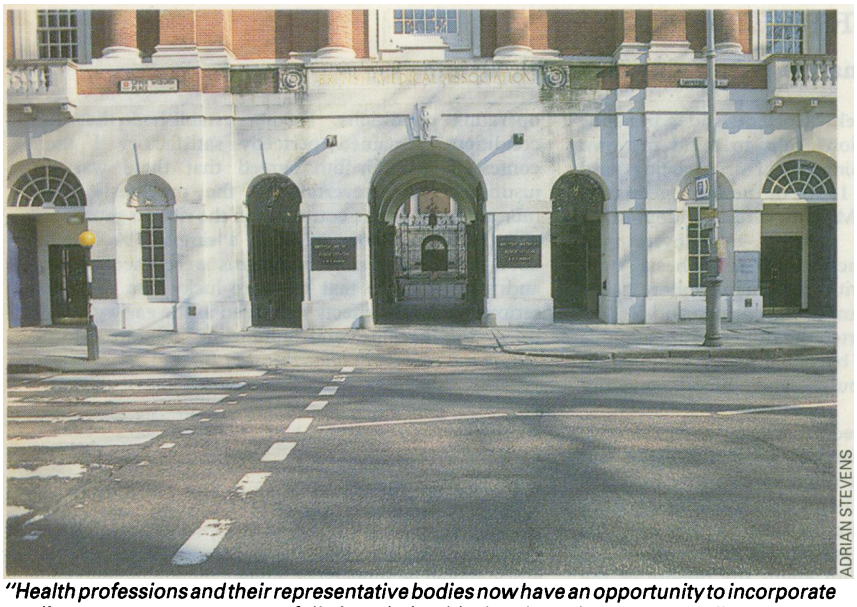
BMJ 1996;312:626-9

Maintaining and improving standards of service and care are central to professionalism in health care. The origins of the bodies that now represent and regulate medicine, nursing, pharmacy, and other professions in the health sector are closely related to the need to protect the public from "quackery" and the excesses of competition. This is appropriate in a service where users—patients—are often profoundly vulnerable.

Strong institutional structures underpin health care professionalism throughout the United Kingdom. Nevertheless, the creation of the NHS internal market has been accompanied by a plethora of initiatives and techniques aimed at improving quality. Many of these challenge traditional assumptions of professional authority. Despite the questionable public popularity of managers, the balance of power in the NHS and other European and North American health care systems seems progressively to be shifting away from clinicians towards health system managers.

This brief review outlines the factors driving such trends. It explores some of the tensions underlying the debates about health care quality issues such as clinical effectiveness and efficiency, clinical audit, institutional accreditation, and individual reaccreditation and examines the importance of quality management to the future development of the health care professions.



ADRIAN STEVENS

"Health professions and their representative bodies now have an opportunity to incorporate quality management concepts fully into their ethical and regulatory systems"

Forces driving change

Survival in good health is valued not only because people want to avoid pain and other forms of suffering, but because without it they cannot enjoy all the positive aspects of life. Arguably, the true wealth of a community is best measured by the health status of its population rather than by financial measures such as gross national product.[1]

In the 1950s and 1960s more spending on health care was often assumed to lead automatically to better health and so greater general well being. But more recently enhanced awareness of other determinants of health—such as housing, employment, and family and social (class) positioning—has promoted a more critical political approach to health service funding in all developed countries.

Other factors have also led politicians to question the principles underlying the welfare state and added to pressures to contain health and social service costs. They include the oil crisis of the 1970s, the emergence of far eastern and other previously non-industrialised countries as economic competitors, and the increasing cost of health care technologies available for treating the diseases prevalent in aging populations. The globalisation of economic activity and changes in political ideology have profoundly changed the social climate in which agencies such as the NHS exist, giving credence to beliefs that the funding, organisation, and delivery of health services must radically change.

Quality management

Against this background the reforms of *Working for Patients* (a white paper title which in itself embodied an implicit challenge to the health care professions) were introduced in the NHS at the start of the 1990s. The emerging NHS internal market has seen much effort put into many types of quality management initiative (see box).[2] Given such an apparently disparate range of activities, together with the competing claims of health professionals, managers in NHS trusts, and managers in health authorities all to be the true guardians of health care quality, it is not surprising that a degree of confusion and cynicism has resulted.

There have also been many attempts by academics to model and define health care quality. In the United Kingdom the best known of these include Donabedian's distinctions between quality related to structure, process, and outcome and Maxwell's six dimensions—effectiveness, acceptability, efficiency, access, equity, and relevance.[3] The use of such approaches can help promote valuable insights into the strengths and weaknesses of services. But complex intellectual analyses of "quality" risk leaving many health care workers uncertain and worried that their working lives are being diverted towards the pursuit of a chimera called quality that has little to do with patients' real needs.

Quality (management) initiatives in the NHS

Initiative/technique	Description
Accreditation systems	Techniques for assessing institutional fitness to practise
Anticipated recovery pathways	Multidisciplinary methods for planning and monitoring treatments
Audit	Process for the systematic, cyclical review of the objectives and standards of practice
Benchmarking/benchmarking clubs	Set of techniques for comparing processes between competitor organisations
Business process re-engineering	Radical review of organisational activities, implemented using the methods of total quality management (TQM, see below)
BS 5750/ISO 9000	A form of accreditation based on review of documentation of standard operating processes
Clinical audit	Multidisciplinary, professionally led systematic review of patient care
Cochrane Centre	Part of the NHS research and development programme; it organises systematic reviews of randomised controlled trials and other evidence of the effectiveness of clinical care
Communications programmes	Good communications between providers of services and all their internal (same organisation) and external customers are an integral part of quality management
Complaints systems	The facilitation and analysis of customer complaints is also important in total quality management (see below)
Consumer surveys	Large numbers of surveys and monitoring exercises, of varying quality, have been conducted by NHS agencies since 1990
Disease management	Term commonly applied to health care quality management initiatives funded or run by the pharmaceutical industry. Also linked to the US term "managed care"
Effectiveness Bulletins	Produced by academic teams in York and Leeds as a part of the research and development programme's push towards evidence based care
External probity and VFM (value for money) audit	Includes NHS studies such as those commissioned by the Audit Commission. External audits may have either or both policing and developmental functions
Inspectorates	Public service health and welfare inspectorates include the Health Advisory Service and the Mental Health Commission
King's Fund organisational audit	A form of accreditation and linked developmental support run by the King's Fund, an independent policy and educational institution
Medical/professional audit	Unidisciplinary audit
Patient's Charter	A set of monitored patient rights and standards first established in 1992 as part of central government's Citizen's Charter initiative
Patient focus	An approach originally developed by US management consultants, designed to ensure that patients' "journeys" through care processes are timely and convenient
Performance indicators and targets	As contained, for example, in the Health of the Nation programme
Protocols/guidelines	Sets of treatment options and agreed decision making criteria, which may serve as a basis for systematic evaluation of clinical and allied care standards
Quality of life measurement	There are now over 400 English language instruments available for assessing quality of life, either in relation to specific conditions or overall wellbeing
Quality management assessment systems	A form of organisational audit. Examples include the Malcolm Baldrige award in the US and the European Quality Award
Risk (and claims) management systems	An approach to quality improvement based on techniques designed to minimise the risk of unwanted events for which the organisation might be liable or otherwise incur costs
Total quality management	See text: TQM techniques seek to enhance organisational sensitivity to customer requirements and optimally involve everyone in an organisation in meeting them

In fact, quality definition and quality management involve two conceptually simple tasks:

- agreeing the desired attributes of any given type of good or service; and
- establishing ways of working to produce goods and services with such attributes as efficiently as possible.

In essence all the various systems available to help improve health care quality, from professional audit and quality assurance programmes to commercially marketed disease management and "total quality management" tools, include only three key elements:

- techniques for understanding the requirements and expectations of service customers/users/patients—in the customers' order of importance;
- techniques for overcoming barriers to cooperation between groups within organisations, for sharing information and skills, for facilitating individual and organisational learning, and for releasing individual energy and enthusiasm into efforts aimed at meeting or exceeding customers' expectations; and
- empirical techniques for measuring performance and attaining agreed standards and for analysing and improving the processes of producing and delivering goods and services.

Value for money?

In ideal settings, where people needing goods and services have a good understanding of the attributes of these goods and services and can pay for them directly, approaches of the type indicated above represent a potent protocol for commercial success. Furthermore, the pursuit of sectional profit will be consistent with overall public interests. The only losers will be those producers or service suppliers who fail to invest in quality. Quality is also free to those that achieve it in the sense that it is often cheaper to do something once well than to have to repeat poorly done work, although in areas such as health the costs of good care normally exceed those of neglect.

But ideal worlds are hard to find. The health care market is by no means perfect. Critics of health care

quality management have questioned the evidence of the effectiveness of the techniques used. They have questioned the extent to which patients have benefited from the up to £1 billion spent in the NHS on various forms of audit, service standard setting, data monitoring, and other types of quality initiative since the start of the 1990s.

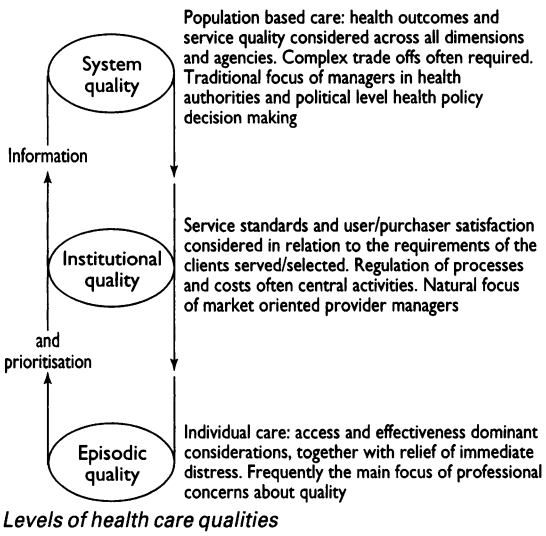
It has been suggested, for example, that in complex areas such as the care of seriously ill patients the simplistic application of market based concepts of consumer sovereignty may undermine professional-patient relationships. And if misapplied the use of easily measurable indicators to assess performance in the health sector could draw attention away from aspects of care which, although difficult to measure, are more important to the wellbeing of both individuals and populations. At worst, critics claim, the aggressive managerial pursuit of better quality can merely serve as a smoke screen to conceal reductions in staffing, and ultimately in the provision of care itself.

Balance and integration

Such concerns have some substance. But they should not be permitted to detract from the fundamental point that—despite the conflicts over control and funding within the NHS—professionals, politicians, and managers share important common interests in trying to ensure that health care processes are genuinely effective and efficient in meeting patients' requirements. Conducted with integrity quality management programmes address precisely this issue. And there is currently little reason for complacency about issues such as, say, standards of communication with patients within the NHS.

Actually realising opportunities for improving health care often demands greater mutual respect and cooperation than currently exists between clinicians, trust managers, and health authority staff. Members of these groups often unnecessarily mistrust each other's underlying motivations. One key to achieving better mutual understanding lies in realising that each group is typically concerned with different—but equally valid—levels of quality (fig 1).[4]

The experience of many organisations in many parts of the world confirms that scientifically based approaches to analysing and changing ways of working can bring significant benefits, not least in terms of promoting greater internal consensus. Many clinicians and service managers firmly believe that quality management techniques have similar benefits to offer in health care and that participation in quality improvement exercises such as the Sigma projects in Trent and the West Midlands can add significantly to staff motivation and willingness to innovate.[4]



Levels of health care qualities

Hence, although it can be convincingly argued that there is no longer room for esoteric cults of quality, Japanese or otherwise, practised in isolated specialist departments, this does not mean that the investments in quality management made in the past few years should be abandoned. Rather, there is a good case for arguing that they should be built on as constructively and economically as possible. This will demand demystification of what such techniques involve and their integration into the mainstreams of clinical and other forms of health care—including purchasing—management.[5,6]

Clear policies and professional values

Both nationally and at district level the achievement of this goal of integration is likely to require clear decision making on issues such as organisational and associated clinical audit and the use of systems of accreditation and reaccreditation to confirm the fitness of institutions—from district hospitals to nursing homes and specialist centres to primary care practices—to provide services. Many people working in and using the NHS are currently looking for firmer guidance on what standards of care provision are acceptable. This is understandable in a time of rapid technical and social change and downward pressure on both central and local government service costs.

Similarly, there is a need for clear thinking both nationally and locally about public health and purchasing issues like needs assessments and the level of provision of specialist services. A National Health Service—even a primary care led one—has a responsibility for establishing credible systems for ensuring that sufficient volumes of the right things are being done in each locality, as well as that they are being "done right." (Secretary of State for health, Stephen Dorrell, in address to Manchester Business School, January 1996.) Improving clinical services also demands better use of health economics alongside better (quality) management, to enable more sensitive prioritisation of competing quality improvement goals and deeper understanding of the circumstances in which treatments are appropriate—that is, effective and efficient in meeting the needs of particular individuals.

Critically for the future of health service development, the health professions and their representative bodies now also have an opportunity to incorporate quality management concepts fully into their ethical and regulatory systems. The participation, for instance, of the British Medical Association[7] and the *BMJ* (joint organiser with the Institute for Health Care Information of the first European forum on quality in health care held this week in London) in initiatives designed to disseminate awareness of health care quality management techniques is of value not simply because of its immediate practical potential for promoting better care. It is important also in relation to the resolution of long term problems relating to the control of health care resources and the legitimacy of managerial interventions which influence clinical decision making.

Out of the health care crisis

Since the 1970s the power of health service managers has tended to increase, challenging if not superseding professional authority in many health care systems.[8] Patients and the public are uncertain about such developments, fearing on the one hand that decisions about their care may no longer be taken by individuals they trust but aware also that traditional professional

approaches—based mainly on fostering individual technical expertise—have not always guaranteed good quality care. In this sense there can be said to be a health care crisis, even at a time when people are living longer than ever before.

The integration of quality management concepts into the core activities of the clinical professions would enable their members to participate more fully in economic and financially based management decisions about health service development. Contrary to the fears of some of those concerned to eliminate neglect and inadequate care, this would not mean that clinicians would have to accept suboptimal standards of individual patient care as desirable on overall "quality" grounds. Rather, it should equip members of the clinical professions to work more effectively with each other and their non-clinical colleagues in the interests of their patients, and as members of their organisations. This in turn would help professionals to recover some key aspects of their eroded authority, and to ensure publicly acceptable balance in the processes of institutional and system wide health care decision making.

1 Sen A. The economics of life and death. *Scientific American* 1993;**268**(5):18-25.
2 NHS Management Executive. *The A-Z of quality.* Leeds: NHS Management Executive, 1993.
3 Maxwell R. Quality assessment in health. *BMJ* 1984;**288**:1470-2.
4 Foster A, Ratchford D, Taylor D. Auditing for patients. *Quality in Health Care* 1994:3(suppl):16-9.
5 Ribgy B. A role fit for purpose? *Journal of the Association for Quality in Healthcare* 1995:3:3-15.
6 Binney G. *Making quality work.* London: The Economist Intelligence Unit, 1992.
7 British Medical Association, Association of Quality in Health, National Association of Health Authorities and Trusts. *Partnership agenda: managing quality in health care.* London: BMA/AQH/NAHAT, 1995 (draft report of consensus meeting September 1995).
8 Freidson E. *The profession of medicine.* London: University of London Press, 1988.

(Accepted 13 February 1996)

Over the Counter Drugs

Patients, society, and the increase in self medication

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OTC

This is the first of four articles examining the implications of the availability and use of non-prescription medicines for health services in Britain and elsewhere

Self medication with over the counter medicines has long been a feature of the lay health system. With the reclassification of certain drugs, the public can buy preparations that were previously available only on prescription. Sales of over the counter medicines are now equivalent to a third of the NHS drugs bill; governments throughout the world see self medication as a way of shifting some of the cost of health care onto consumers. The trend towards increased self care and with it the increasing empowerment of patients has many potential benefits; collaboration between doctors and pharmacists will be critical.

Over any two week period, nine out of 10 adults will report having experienced at least one ailment.[1,2] Non-prescription medicines, commonly known as over the counter or OTC medicines, are used to treat one in four of these episodes.[2] Sales of over the counter medicines in pharmacy and grocery outlets reached £1268·5 million in 1994 (box 1)—about a third of the NHS drugs bill of £3·6 billion.

Box 1—Market breakdown for major categories of non-prescription medicines[3]

Pain	£196·4m (16·7%)
Skin	£143·5m (11·3%)
Cold	£93·9m (7·4%)
Cough	£68·1m (5·4%)
Sore throat	£72·7m (5·7%)
Indigestion	£73·9m (5·8%)
Total market (1994)	£1268·5m

In the late 1980s the government fuelled the over the counter market by making it easier to reclassify certain medicines from prescription only status to allow over the counter sale in pharmacies. Progress was slow at first, with 11 medicines being reclassified between 1983 and 1992 (table 1), but since 1992 a further 40 medicines have been reclassified. This widened range of non-prescription medicines has highlighted the role of pharmacists, to whom the public is increasingly looking for advice.

Box 2—Factors promoting and inhibiting the reclassification of drugs to pharmacy status

Promoters:
- Patient empowerment (increase in the autonomy ethic)
- Rise of consumerism
- Decreasing power of the professions
- Changing balance of power within the professions
- Pharmacists' drive to extend their role
- Government policy to contain the NHS drugs bill
- Possible influence of health care systems outside Britain
- Pharmaceutical companies' wish to protect profits

Inhibitors:
- Professionals' protection of their domain
- Doubts about patients' competence in self care
- Pharmacists' anxieties about increased responsibility

What is driving the POM to P changes?

Factors promoting and inhibiting the reclassification of drugs are shown in box 2. The deregulation is occurring against a background of pressure on the primary care drugs bill. Self care and self medication with non-prescription medicines are seen by governments throughout the world as a means of shifting some of the responsibility and cost of health care from government and third party payers onto consumers. Increasing scrutiny of NHS prescribing costs has pressured pharmaceutical companies to protect their markets. Reclassification of a drug not only creates potential new business in the non-prescription marketplace but can also promote an existing branded medicine that is also available on prescription. The pharmaceutical industry has therefore—unsurprisingly—embraced the opportunities offered by self medication. So too has the Royal Pharmaceutical Society, which has actively and consistently lobbied for moves from prescription only medicine to pharmacy status.

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BMJ 1996;312:629-32