VIEWPOINT

Millenium 2000: Is quality care a realistic target?

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Abstract: This is a revised version of a keynote address given by Professor John Howie at the Wonca regional conference in Christchurch, New Zealand which was held during June 2000. The main theme of this address revolved around how we define and measure quality in general practice, with a secondary plot of how universities, colleges, medical associations and governments can, or could, work together to implement this. The full address was published in the *New Zealand Family Physician* in 2001; 28: 233–37.

Key words: Consultation Quality Index, core values, good practice, interpersonal care, quality care.

Introduction

The uniting issues are the importance of a vision of quality, based on the 'core values' of general practice, and the need to develop a theory which encompasses them.

Can quality be defined?

Quality has been defined as having two components:

- the opportunity to access care
- the nature of care once the patient reaches it.

The second element can be further divided into two: the biomedical and the interpersonal components. This discussion centers on the second, arguably the more important, and certainly the more difficult to research and teach. Any working definition needs to reflect the core values of the discipline, which include holism and patient-centerdness.

Can quality be measured?

In the UK setting, consultations tend to be more holistic. Patients are more 'enabled' by them when the consultation is longer (our mean is around 8 min per consultation) and when patients know the doctor they are seeing.[1] We have created a Consultation Quality Index (CQI) for doctors based on:

- the mean consultation length
- the continuity they provide
- and the enablement achieved.[2]

We have proposed that it could be used as a proxy for patient-centerdness in further research and teaching on the interpersonal aspects of quality of care.

What are the determinants of quality?

In the UK setting, higher CQI scores are found in smaller, rather than very large, practices (15 000 patients). Doctors in training score better than do young principals – probably because they can take time to see patients they do not know well. Casemix does not appear to influence the score, and nor does working in a deprived setting.

Particularly interesting is that patients who speak languages other than English at home give higher enablement scores, and that these are higher (and consultation lengths shorter) when they consult in their own language.

Finding a theory of practice

I have provided a theory of good consulting practice elsewhere.[3] In brief, if 'needs' are put on the left side of an equation, and 'outcomes' on the right, 'values' become an intervening variable (patient-centerdness and holism), as does the 'context' of the consultation (for example, workload and/or incentives).

My theory argues that the interaction of the values of doctors and patients determines which needs are

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met, and that context determines the extent to which there is opportunity to express these values.

Which ever country we look at, the questions seem the same:

- What is the trade-off between 'access' to care and the 'quality' delivered?
- Do most people actually have a choice about whether they receive better 'biomedical' and better 'interpersonal' care
- How do we identify and prioritize patient's concerns?
- How do we achieve accountability without defensive practice?
- How can governments create the contractual environment in which efficiency is not the enemy of effectiveness?

These issues can be highlighted by looking at three separate countries. In the UK, eight medical students graduate each year per 100 000 population; there is one general practitioner for every 1800 patients. Patients register with a general practitioner and care is free at the point of access. Incentives promote holism to a limited degree. A doctor sees around 30 patients a day. Training is mandatory, and the academic standing of the discipline is high.

Australia produces 6.4 graduates per year, per 100 000 population and has one general practitioner for 1000 patients, but the distribution heavily favors cities at the expense of rural areas. Training is again mandatory, but patients are free to move between doctors and incentives are variable, as is the academic standing of the discipline.

In Thailand, there are only 2.1 graduates, per year, per 100 000 population and an average of one generalist to 10 000 patients. The market economy dominates and many seek private primary care. Training is in its infancy and the academic standing of the discipline is low. Doctors in the state sector see over 100 patients a day.

Can there be one universal indicator of good practice?

It is unrealistic to discuss a single vision of 'quality' when some doctors have to see 120 patients in a day, whereas others see only 30. Similarly there are significant cultural differences across countries in terms of how patients conceptualize their needs and wishes, and although the theory of 'good consulting' is probably international, the benchmarking of its measurement may need to be re-worked country by country.

Also on an individual level different patients within a group (or the same patient at different times) may attach different values to the importance of good biomedical and good interpersonal care. Doctors continue to resist accountability, partly out of fear that it will be measured insensitively. Governments persist in alienating professionals with their crude use of incentives to increase efficiency at the expense of effectiveness.

What of the future?

In Christchurch, I argued that for good interpersonal care to flourish, researchers, educators, medical politicians and governments had to work together to achieve strategies to promote better interpersonal care. Moira Stewart has proposed an international definition of patient-centerdness which incorporates holism and the different preferences that patients have about they way they receive care.[4] It is a difficult definition to use in either academic or clinical terms. Most attempts to analyze it have relied on the use of video-tape consultations, looking for the doctor's 'patient-centred behaviors'. These, however, are difficult to reliably quantify, and even when present the association with evidence of clinical benefit is disappointing. There is an arguable case for switching academic focus from measuring consultation 'behaviors' to measuring 'outcomes' and associated 'processes'. The CQI described earlier in this paper could indeed be a useable proxy for patient-centerdness as we work to explore more fully the determinants and distribution of quality of care worldwide.

References

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