Improving primary health care delivery: still waiting for the magic bullet

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See related research article by Szecsenyi and colleagues at www.cmaj.ca/lookup/doi/10.1503/cmaj.110412

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It is my experience that few people are short of answers about how to improve health care delivery. The opinions flow even more freely when it comes to suggesting ways to improve primary care.

A recent study by Szecsenyi and colleagues adds to the number of options.[1] The authors show that the use of a European-wide accreditation system of primary care practices in Germany led to a significant improvement in practice management across a range of domains between the first assessment and the second assessment three years later.[1] Their study should help to convince policy-makers and professional bodies not already doing so to consider accreditation as a means of improving quality. Indeed, many medical colleges have highly developed accreditation systems.

Before we get too excited that the magic bullet — whose existence was questioned in *CMAJ* 16 years ago[2] — has been found, it is worth considering the context in which the study by Szecsenyi and colleagues was conducted. First, primary care practices in Germany were directed by the government to participate in some form of quality-improvement program, so why not the one the authors evaluated? This means that, although ostensibly voluntary, this accreditation process was beginning to look like its tougher cousin, regulation. Second, general practice in Germany exists within the context of patient choice, so having a seal of approval in terms of practice quality might well be seen as a competitive advantage.

One needs also to consider the limitations of accreditation programs, or any system that uses standards as a means of improving quality. Standards tend to look at structural and process-related aspects of health care delivery. The standards themselves, depending on the means adopted, have to be precise. In the program evaluated by Szecsenyi and colleagues, a checklist was used. However, this can cause problems in assessment if a health care provider has found an innovative way of getting the same or better outcomes by using a seemingly noncompliant process. Also, definitions of quality change. For example, the standard used for hemoglobin A_{1C} (HbA_{1C}) in the National Health Service's general practitioner contract in the United Kingdom has likely been too low, causing more harm than good. General practitioners pursuing higher HbA_{1C} levels in patients with type 2 diabetes may miss the standard but provide better care.[3]

The greatest risk with standards, whether they are part of an accreditation system, a means of payment within contracts, a part of a regulatory process or a part of another system, is that they could completely miss the point. This is especially true of standards within primary care. What is desired of a good general practice varies by country, chiefly driven by whether there is an obligatory gate-keeping function and a registered patient list or not. The relation between excellent general practice and the efficiency of a health care system is well established.[4] However, those who set standards do not always have a clear view of why it is that strong primary care supports such efficiencies. There are useful pointers in the literature.[5]

In the accreditation program evaluated by Szecsenyi and colleagues, the visit was by an assessor who used a checklist. Other accreditation processes use a team of senior peers to make the assessment. This approach has three advantages. First, the visiting team is able to assess whether a noncompliant, but effective, process, such as the one described earlier, constitutes a "pass" — a so-called intelligent assessment (albeit with greater

Key points

- Accreditation systems offer one option for improving health care delivery.
- Such systems, however, may use standards that focus too heavily on structural or process-related aspects of health care delivery and risk stifling innovation.
- The benefits of accreditation can be maximized, for example by having senior peers make the assessment and ensuring that the standards are regularly updated and focus sufficiently on outcomes.
- Accreditation is a valuable tool and should be seen in the context of a range of efforts by policy-makers and professionals to improve quality.

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interobserver variability). Second, having senior peers visit raises the social aspects of change; it is one thing to get a cross marked on a checklist, another entirely to have an icy glare over silver-rimmed spectacles. Third, the opportunity for spread is enormous; in my personal experience, accreditation visits of these kind lead to rapid exchange of emails to share ideas and solutions.

The use of senior peers in accreditation programs matches what we know about successful models for change. The world is not short of models for change, but one of the more useful ones that I keep returning to is that by Gustafson and colleagues.[6] They emphasize five factors likely to affect change: desire to change; social context; viable alternatives; ability to change; and feedback. In the study by Szecsenyi and colleagues, there were at least two factors increasing the desire to change: the need to participate in a quality-improvement program and a competitive environment. The social context was weaker, although it was aided by the use of a European-wide professionally led program. It could have been strengthened by the addition of senior peers and greater sharing between practices. Viable alternatives came in the form of the clear standards; however, it was not clear whether practices actually had the ability to change. Finally, although the second assessment three years after the first visit provided useful feedback, one might speculate that a third visit would reinforce improvements even further.

Successful quality-improvement programs have generally focused on all five factors in the model described by Gustafson and colleagues to affect change.[7] In contrast, policy-makers often focus on one factor, especially if it relates to building tension for change. Efforts to build tension for change often overemphasize the power of financial incentives. Such incentives are important but crude. In a recent study of the effect of pay for performance on the management and outcomes of hypertension in the United Kingdom, generous financial incentives were not as helpful as previously thought.[8]

Should an accreditation system like the one described by Szecsenyi and colleagues be used in a quality-improvement program? Yes, but the benefits from such a system could be maximized by including assessments by senior peers, increasing feedback, sharing ideas and solutions, and helping those being accredited to improve. Also, a close eye should be kept on the standards being used, to ensure that they are up to date, are driving improvements where desired and are benefiting outcomes that matter to patients.

References

1. Szecsenyi J, Campbell S, Broge B, et al. Effectiveness of a quality-improvement program in improving management of primary care practices. *CMAJ* 2011;183:2104.
2. Oxman AD, Thomson MA, Davis DA, et al. No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. *CMAJ* 1995;153:1423-31.
3. Lehman R, Krumholz HM. Tight control of blood glucose in long standing type 2 diabetes. *BMJ* 2009;338:b800.
4. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005;83:457-502.
5. Wilson T, Roland M, Ham C. The contribution of general practice and the general practitioner to NHS patients. *J R Soc Med* 2006;99:24-8.
6. Gustafson D, Alemi F, Cats-Baril WL. *Systems to support health policy analysis: theory models and uses*. Chicago (IL): Health Administration Press; 1992.
7. Wilson T, Berwick DM, Cleary PD. What do collaborative improvement projects do? Experience from seven countries. *Jt Comm J Qual Saf* 2003;29:85-93.
8. Serumaga B, Ross-Degnan D, Avery AJ, et al. Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom: interrupted time series study. *BMJ* 2011;342:d108.

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