Quality in healthcare – Part 1

How did it all start? – a historical perspective

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Sri Lanka Journal of Obstetrics and Gynaecology 2012; **34**: 27-28

Nowadays, the name of the game is **'quality'**; the terms 'best practice', 'evidence-based medicine', 'clinical and cost effectiveness', 'clinical governance' and 'clinical audit' are common currency. When we were training, these terms were unheard of. (The only 'audits' we knew of were the people from Head Office, who periodically appeared to check whether the pharmacists have been pilfering drugs and doctors have been breaking plates in their quarters!).

It would be educational, and hopefully interesting to examine 'how did it all start?'. This article will deal with this aspect, and subsequently we would examine each strand individually. It would be self-gratifying to think that we doctors stared the ball rolling on quality. Unfortunately, this is not so. It was essentially politically driven.

UK in the 1970s

The Labour Party was in power and unrestricted public spending was the name of the game. By the end of the decade, the inflation was out of control, interest rates sky high and the economy was in dire straits. Mrs. Margaret Thatcher was swept into power with the promise of 'putting the house in order'. First few years were spent on seeing off 'union power' and then privatising gas, coal, electricity, water, telecom and the BOAC which were all originally state owned and losing large amounts of money. Then she turned her attention to the NHS which was making a big dent in the public purse. She asked questions such as: 'Why does it cost ever increasing amounts? Who is accountable for the money spent?' Answer was 'Don't know'. She was minded to privatise the NHS too, but was advised that it would be 'political suicide'. So, instead she appointed a committee headed by a man called Roy Griffiths to investigate. He was the MD of the Sainsbury's supermarket and was asked to apply the tests and discipline of the market place to the NHS.

Griffiths

In 1983, he reported with wide ranging recommendations. Among these, were the following concepts:

a clear management structure

accountability

effectiveness

value for money

quality control.

At the time, he was roundly criticised by the medical fraternity as 'an outsider trying to interfere with something he does not understand', i.e. healthcare. However, subsequent events have justified his foresight (as we shall see).

Late 80s and 90s

In 1989, the government produced a White Paper called *Working for Patients*. This was the beginning of the 'internal market' and a central feature of it was quality. In a section called 'Physicians: audit thyself', the concept of auditing our practice was introduced and clinical audit was born.

So, the question was, 'Are we doing the right thing?'

'But, what is the right thing?'

Nobody knew, as everybody was doing 'their own thing'; i.e. there were no standards.

The Royal Colleges rallied round and appointed working parties to examine key elements of care. They scrolled through the evidence and came up with

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expert opinions and recommendations. Thus, the concepts of 'best practice', 'evidence based medicine' were born and these eventually led to 'guidelines'. In fact, our Royal College was a leader in this respect.

At first, there was considerable resistance amongst doctors for the imposition of diktat from above, as this was seen as interference in their clinical freedom. However, with passage of time, guidelines have become 'part of furniture'.

2000s and NICE

The Royal Colleges were coming out with recommendations about all sorts of 'best practice'. However, some of these were quite expensive, and would have cost a fortune if they were to be implemented throughout the country. The 'best practice guidelines' had given the doctors a licence to ask for more and more resources. So, the government faced a serious dilemma.

The solution was NICE. This was created in 1999, but came into real force in the 2000s. Its task was to consider various interventions, not just with effectiveness in mind but also their cost, in the context of 'limited resources'. Sceptics called this 'rationing'; government called it 'value for money' or 'cost-effectiveness'. So, although officially it stands for clinical excellence, in reality it is more for cost effectiveness.

Clinical governance

This concept was introduced in 1998 by the then Chief Medical Officer, Liam Donaldson. The idea was that the quality of healthcare would not improve unless people were made accountable. Hence the central plank of the concept was to make the CEO of the Trust personally responsible and accountable for the standards of the healthcare delivered by his organisation (of course in practice, this responsibility gets passed 'down the line'). Later, quite a few things got added to it, and now it is an over-arching umbrella incorporating a whole lot of concepts, around a central theme – 'quality'.

Risk management

'Safety' too became an important issue. As there couldn't be quality without safety, risk management is now considered an important part of clinical governance. However, risk management has its own, very important place in the healthcare delivery in the UK. This has come about, not so much because of managers' deep concern about patient-safety, but from the pressures of litigation.

The costs of settling the claims have become so high that an individual Trust is no longer able to foot the bill. Hence, they take out insurance (just like we do for our cars). These companies (Clinical Negligence Scheme for Trusts (CNST) in England and Welsh Risk Pool (WRP) in Wales) have become increasingly aware of best practice guidelines, audits, and above all, risk management strategies.

Every year, the hospitals are sent a long list of conditions to which they must sign up, if they were to be covered. These include above concepts and also issues of education, training and revalidation. Inspection teams arrive periodically to make sure the conditions are adhered to, and they are treated with utmost respect by the management! If the hospital is found wanting, the premium would go up.

In truth, CNST and WRP are the main drivers for improving quality of healthcare in a wide range, not just safety. It is rewarding to see that in SL, we are beginning to address these issues although no such stick is being branded. But who knows, it may only be a matter of time!

Conclusion – back to Griffiths

The 'drivers' for quality are a combination of political pressure; peer pressure (Royal Colleges) and fear of litigation.

With passage of time, it is now easy to appreciate the foresight of Griffiths. Almost every question he asked has resulted in the development of a major theme or concept:

Who is accountable? ⟶	Clinical governance
What works?	Clinical effectiveness
How do we know?	Evidence-based medicine Best practice guidelines
Value for money?	Cost effectiveness/ NICE
Quality control	Audit