

# Quality of care in general practice: into the next century

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**Abstract** Although many interesting developments can be seen as far as quality assurance in general practice is concerned, results from studies in Europe reveal that further actions are required to make quality assurance a normal part of general practice care. Some of the important new steps for the next decade are: integrating existing quality assurance methods in an overall 'system' for managing, assuring and improving patient care, development of new, practical methods for quality assurance at a local and practice level, development of a methodology for evaluation and research in the field of quality assurance, development of programmes for educating doctors and practices on quality assurance methods and international collaboration in this field.

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## Introduction

*'I believe that it will be quality methods and philosophies adapted to the special circumstances of health services that will emerge as the most important response to problems of health provision in the 1990s'.<sup>1</sup>*

Quality assurance is a new and challenging issue in family medicine today. Many interesting developments and projects can be seen in various European countries, particularly in the UK, the Netherlands and the Scandinavian countries. They provide some understanding of the way quality assurance in family medicine can be performed and implemented effectively. However, this is a slow process which occasionally encounters serious barriers. The quality assurance activities, currently performed, are mostly ad hoc actions or projects by interested institutes or groups of people. They are usually not integrated on a broad scale in normal family practice care. Also, it is still unclear which methods, strategies and tools are really effective, feasible and acceptable for general practitioners. In most European countries GPs are hesitant towards or even feel threatened by this new quality movement. The question is: which developments are important or required in order to successfully implement a systematic quality assurance in family practice in the years to come? How to enter the next century?

This paper discusses the importance of setting up an overall system for performing and managing quality assurance, the necessity of developing education and research on quality assurance methods and the importance of European collaboration in order to implement quality assurance on a broad scale in general practice. It will start, however, with a brief overview of the state of the art in quality assurance in general practice.

## The state of the art

Many authors expect a deepening crisis in health care in the next decade: more competition between care providers and in-

creased pressure on GPs, both from the patients and the insurers/managers in health care. Developing systems for quality assurance is considered one of the main answers to these problems. The concern with quality is certainly not new. Doctors have always attempted to provide good quality care for their patients and to improve their knowledge and skills, when necessary. The range of thought about assuring and improving quality in health care, however, is gradually changing; quality assurance is developing a new face, incorporating the following ideas:<sup>2-6</sup>

- assessing and improving the quality of care as a normal part of the daily work and the practice management;
- practice performance becomes more visible to others; practice goals and criteria are made explicit and information on actual performance is collected regularly;
- improving care does not only mean education for the GP, but also activities for the whole practice team, with everyone involved and committed;
- focus is not only on the competence and performance of the care providers, but also on the achievement of good patient outcomes, the efficiency in the practice and the collaboration with others;
- these activities should be managed well; well-tested and effective methods are applied.

So, ideally, quality assurance means continuous and systematic activities integrated in normal practice care, visible for all other parties in health care as a firm demonstration that general practice is taking quality seriously.

The question is: what has been achieved of this ideal so far? The WONCA-SIMG conference has shown many important achievements in this new field. Numerous well-designed studies and projects have been presented. New exciting methods and programmes have been introduced, such as national standard setting (Dutch College), practice activity analysis (APO-system, Denmark), practice visits (U.K., the Netherlands, Canada, New Zealand), peer review groups and quality circles

(Germany, Belgium, the Netherlands, Ireland), quality tools (Sweden) or the use of trained 'facilitators' (U.K. and the Netherlands). Most of these activities are, however, relatively isolated and hardly integrated in normal general practice care. The challenge is to implement systematic quality assurance widely among GPs and practices. In order to achieve this goal we need to know the current state of the art and the problems related to such an implementation.

The WONCA European Working Party on Quality in Family Practice (EQUIP) has performed an inventory of quality activities in general practice in 17 European countries (survey among about 100 key-persons). The results show that while most countries are at the very start of implementing quality assurance systems, others are in the midst of it.<sup>5</sup> There are, however, many promising projects and efforts, which may help countries and organizations to learn from each other and speed up the developments.

Courses for continuing medical education (CME) and small group educational meetings are widely used in most countries (table 1). New methods that have proved their value in specific projects, such as peer review or quality circles, chart audit, practice visits, use of facilitators or patient reports on the practice performance, are not yet common. Each of the 17 countries was asked to name the most important requirements for the implementation of quality assurance. In rank order these are: providing resources for quality assurance (staff, reimbursement, extra time); educating GPs and practice teams about the concepts and methods of quality assurance; development of policy statements, structures and leadership by the professional organizations; and the development of feasible and effective quality assurance methods and guidelines.

A specific picture of the problems and requirements for implementation of systematic quality assurance was acquired by depth-interviews with a representative, stratified sample of 120 GPs from the Netherlands (response 75 per cent), car-

ried out by experienced, trained colleagues.<sup>7</sup> The answers provide a good view of existing problems. The first problem is located in the knowledge GPs have of this field. Most GPs associate quality assurance with CME and educational activities in small groups (>80 per cent). Less than 25 per cent think of guidelines, audit in the practice or practice quality meetings. However, more than 50 per cent of the doctors claimed to have frequent experience with the use of the Dutch national standards in their practice.

GPs see an increase of the existing workload and the extra time and money involved as the major problem in the im-

plementation of systematic quality assurance in their work setting (table 2). Lack of understanding and skills, lack of practice policies and lack of contact with colleagues are also experienced as barriers. The most important requirements to achieve the implementation goals, as viewed by the GPs, are: obtaining information and education about quality assurance, regular quality meetings with colleagues, support in collecting practice data and support in setting up peer review or audit in local groups of GPs. Financial support and time for taking part in quality assurance activities are also considered highly relevant by the majority of the respondents (table 3).

**Table 1** Method for quality assurance: frequency of use in 17 European countries

	Widely	Occasionally	Never
Courses, CME meetings	16	1	–
Small group education	10	7	–
Audit with data from funders/registration systems/hospitals	6	7	4
Individual instruction of GPs/practices	5	7	5
Peer review, quality circle	3	9	4
Chart audit	3	11	3
Patient surveys	2	12	3
Incentives, sanctions	2	5	9
Practice visits	1	9	7
Audio-videotaped contacts	1	11	5

Source: Grol et al.<sup>5</sup>

**Table 2** Problems in implementing systematic quality assurance, as seen by GPs. Percentages (n=120)

This is a problem:	Very much so	More or less	No problem at all
Increase of existing workload	47	42	11
No systematic quality policies in my practice	33	43	24
Insufficient contact with colleagues	29	38	33
Don't know how to manage QA	25	46	29
Costs too much extra time/money	27	53	20
Insufficient staff in the practice	16	22	62
No quality policies in the district	8	22	70
Not convinced of importance of QA	5	12	83
Colleagues/staff negative about QA	4	24	72

Source: Wensing et al.<sup>7</sup>

The data from the European survey as well as from the interviews with family doctors in the Netherlands reveal that further actions are required to make quality assurance a normal part of general practice care. Some of these activities will be discussed here in some more detail:

- development of a comprehensive system for 'quality management';
- research on QA methodology;
- education in QA concepts and methods;
- European collaboration.

### The quality management approach

One of the challenges for the next decades is to integrate the feasible and effective quality assurance methods in 'an overall system for managing, assuring and improving performance'.<sup>4</sup> Development of guidelines, performing 'audits' and quality improvement programmes will only influence the quality of patient care when they are not isolated cases and are 'managed' well on various levels:

- at a *central level* professional organizations should adopt the 'leadership' in the quality assurance activities, develop methods and tools as well as policy statements for it, stimulate the teaching of quality assurance methodology and arrange the provision of resources for doctors and practices to take part in such activities;
- at a *local level* structures for collaboration, guideline setting, review and education between GPs, other care providers and hospitals should be set up;
- at *practice level* we need quality systems integrated in normal practice work, including quality circles, continuous data collection and feedback, quality projects and reports on these activities;
- at an *individual level* each care provider in general practice should make a personal plan for audit, study and training and regularly evaluate the progress.

Activities on these four levels should be closely linked.

The ideas for such quality systems come from industry, where 'total quality management' and 'continuous quality improvement' are the terms.<sup>1-4</sup> There is an increasing awareness in industry that quality assurance is profitable and that substantial investments in quality have to be made (5-10 per cent of the companies budget). The International Organization for Standardization has developed guidelines for setting up quality assurance systems, the so-called ISO-9004 standards. These are concerned with the structures, procedures, resources, responsibilities, training and education for a systematic quality improvement in an organization. Such guidelines may not be directly applicable to the average primary care practice setting. However, some of the basic principles of the industrial approach are also attractive for family practice, such as:

- a quality improvement 'culture' has to be created in the work setting (practice, group of doctors, et cetera) and clear 'leadership' in this development has to be taken;

**Table 3** Requirements for implementing QA: opinions of GPs. Percentages (n=120)

	(Very) much needed
Regular meetings with colleagues on QA	80
Information on the aim, background and plans on QA	76
Data about practice performance compared with other practices	69
Support in implementing data collection and evaluation of care in the practice	68
Support in implementing peer audit/review	67
Better financial reimbursement for quality activities	60
Support in automation of the practice	59
Education/training on concepts/methods of QA	57
Obligations/rules on QA from the professional organizations	47
Contracts with insurers with arrangements on QA	43
Feasible laws on QA	43
Arrangements with patient organizations on QA	15

Source: Wensing et al.<sup>7</sup>

**Table 4** Quality assurance and quality management

Quality assurance	Quality management
Ad hoc, incidental actions	Continuous actions
Emphasis on structure and process aspects	Emphasis also on practice management, patient outcomes and satisfaction and efficiency
Emphasis on control, retrospective assessment	Continuous improvement and prevention of quality problems
Restricted role in daily work	Central role in, normal part of day-to-day work
Mainly focused on GP's performance	Focused on (complex) care processes, management of care and collaboration with other care providers
Performed by GPs	All practice staff active, committed and responsible, use of additional staff

- all practice team members participate in and are responsible for the quality improvement process, so they should be informed about quality assurance concepts and methodology;
- quality improvement is continuous and focus is on the most important quality problems; specific projects are set up to work on these problems;
- taking the consumers of the practice seriously is crucial; these include not only the patients, but also the funders, the hospitals, and the other care providers;
- finally, a structure in the practice and in the local care provision setting for managing (coordinating, organizing and stimulating) quality assurance has to be set up.

Some differences between the classical quality assurance approach and the quality management approach are outlined in *table 4*.

### Example

A new methodology has to be developed for a quality management approach that will fit into normal general practice. We may speculate a little about such a methodology. For example, doctors and assisting personnel or family doctors from various collaborating practices meet once a month in a 'quality circle'. Sometimes other care providers or patients are invited or consulted in another way (through interviews, surveys or focus-groups). Once a year a 'quality plan' is made based on an analysis of existing quality problems (identified through brainstorming, surveys of samples of patients in the practice, a patient complaint system, critical incident analysis or analysis of available data on practice activities). Priorities are set; the most relevant problems are selected and addressed in structured 'quality improvement projects'. Such a project includes setting criteria or targets (for example, for the monitoring of hypertensive patients or the maximum waiting time for patients), data collection and analysis, identification of gaps in performance and the development of strategies for introducing changes.

In other words, the team follows a cyclic process until the criteria are met. Arrangements are made to complete these projects successfully, tasks are divided and one of the team members acts as the 'quality coordinator'. Some time is reserved for these activities and practical tools (e.g. software programmes) are available; extra staff for data collection and analysis may be hired. Specific training is provided by the professional organization to become skilled in these activities. Trained 'facilitators' give regular support to practices and groups in order to perform the activities well.

The results of the activities are presented to a broader audience in an annual 'quality report', which will be discussed with colleagues, and maybe with other care providers, hospitals, funders, and patient representatives.

Is this fantasy or future reality? We may state that in most countries the sun set on such a systematic quality assurance only a few minutes ago. However, the outlined model is already applied in some practices in the UK and the Netherlands and may certainly be the face of quality assurance in general practice for the next century.

### Evaluation and research on quality assurance

Quality assurance is a new area for development and research in (family) medicine, which is, as far as its theoretical foundations and methods are concerned, located on the border of different fields, such as medicine, social sciences, management theory, educational theory, innovation theory. Methods developed for quality assur-

**Table 5** *Opinions of GPs on the use of national guidelines. Percentage (very useful)*

(Very) useful for:	1.5 years after start n=339	3 years after start n=1007
Peer group review/audit	84	90
Arrangements with colleagues	81	90
Continuing education	84	89
Self-audit	73	85
Recertification/licensing	39	36
Contracting/budgeting	25	13

**Table 6** *Diagnostic procedures in case of (imminent) miscarriage. Percentages (survey 313 GPs)*

Performed actions	First contacts	Follow-up contacts
Percussion/palpation	42*	42
Speculum	73*	70*
Vaginal toucher	59*	60*
Inspection of blood clots	23	17
Pregnancy test	30	36
Doptone	19	17
Ultrasonography (lab. facility)	17	15
Ultrasonography (by obstetrician/ radiologist)	39	37

Source: Fleuren, et al.<sup>8</sup>

\* Recommended in national guidelines

ance in hospital care are not easily applicable in general practice settings. Specific feasible and effective models and methods for systematic quality assurance in general practice have to be developed and evaluated, using scientific evaluation methodology. Such a methodology is currently being developed in many different projects, while scientific reports can be found in new quality assurance journals (Quality Review Bulletin, Quality in Health Care and Quality Assurance in Health Care). The importance of such evaluation activities can be best explained by an example: the evaluation of one of the central quality assurance activities in the Netherlands, the development and implementation of national standards and guidelines.<sup>5</sup> These are being developed by a rigorous procedure in which attention is paid to the scientific basis as well as to the feasibility in daily practice. More than 30

standards have been set since 1989. These are disseminated through the scientific journal for GPs and through the national structure for CME with local coordinators acting as intermediaries in their diffusion. The evaluation of quality assurance programme is focused on various questions:

- are the guidelines effectively disseminated; are they broadly accepted by GPs?
- are the guidelines being followed in daily care; what are the problems in adhering to them?
- have the desired outcomes been achieved, such as improvement of health, prevention of complications or cost reduction?

In order to study the diffusion and acceptance of the national guidelines regular surveys among random samples of 8-10 per cent of the Dutch GPs are performed. Four of these surveys have been completed so

far, the last one 3 years after the first guidelines were published. The results show for instance that the guidelines have met with a very positive response by GPs. They are increasingly regarded as very useful for educational activities and not for purposes of recertification, contracting or budgeting (table 5). Problems in following the guidelines are detected by surveys among GPs as well as by collecting information on actual performance. For example, *Fleuren* performed a survey among 313 GPs on following the national guidelines for the management of imminent miscarriage (table 6).<sup>8</sup> Although this is not recommended, about half of the GPs habitually refer patients with this problem for ultrasonography at first encounter. The most important problems in implementing these guidelines, according to GPs, were: the fact that the guidelines do not include the emotional side of the patient's condition, the patient's wish for ultrasonography and the need of patients to have more frequent contact with the doctor during this period of uncertainty.

In another project almost 70 GPs recorded their performance for specific conditions on structured checklists.<sup>9</sup> These checklists have proved very reliable. The results show whether or not the GP followed the national guidelines and what the most important problems in adhering to them are. For example, the guidelines for the management of acute otitis media recommend a watchful/surveillance approach for children under 2 years of age and a conservative approach for children over 2 years of age. Antibiotics are seldom considered necessary for the older group. Data on performance in 360 first contacts of 67 GPs disclose that in the majority of the cases (54 per cent) simple analgesics were recommended as treatment.<sup>9</sup> In 20 per cent of the cases an antibiotic was prescribed, while in 12 per cent this was not in accordance with the guidelines. However, in 10 per cent it was recommended, but not performed. The guidelines suggest a follow-up appointment within 24 hours for children under 2 years of age. In most of the contacts with patients of this age group

**Table 7** Outcomes of blood-glucose tests in diabetes check-ups (N=449)

	Fasting (n=250)		Not-fasting (n=191)	
Good	<6.7 mmol/l	22%	<9 mmol/l	43%
Acceptable	6.7-8 mmol/l	24%	9-10 mmol/l	14%
Poor	≥8 mmol/l	54%	>10 mmol/l	43%

Source: Unpublished report by A. Zwaard & J. Dalhuysen.

**Table 8** Opinions of adult asthma and COPD patients on the provision of care (63 GPs from 34 practices)

Performance of GP	N	Poor	Fair	Good	Excellent
Examination of the cause of my complaints	610	9	38	30	23
Medication are effective	558	6	34	36	24
Accessibility of GP when my complaints get worse	596	3	32	41	24
Information given on the causes of my complaints	609	15	39	30	16
Information given how to use the medication	558	3	32	37	28
Information on side-effects of my medication	558	26	33	30	11
Information on what to do when complaints get worse	596	14	37	35	14

Source: Unpublished report by I. Smeele.

such an appointment was not made. This may particularly be a point of attention for education.

The group of GPs also collected data on specific outcomes of care, for example on the values of blood glucose tests in diabetes mellitus type II patients. Data from 449 check-ups showed that, according to the national guidelines, almost half of the patients had a poor health status (*table 7*). These data confirm the outcomes of other studies and stimulate further study of methods for improving the health status in diabetic patients.

A last example of the evaluation of the national guidelines of the Dutch College concerns reports of patients with asthma or COPD on the care provided by GPs. As preliminary data, some 600 patients from 34 practices gave their opinion in a written questionnaire. *Table 8* shows that there was room for improvement, particularly with regard to the information given to patients with these conditions.<sup>10</sup>

Various methods were used to evaluate the national guidelines (GP questionnaire, self-recording sheets, patient surveys, et cetera). The results show the positive as well as the problematic sides of guideline development and implementation, and make improvements and focused strategies possible.

### Education on quality assurance

Most GPs in Europe are hardly aware of these new developments and, even when they are, they are hesitant to embrace them. One of the most important requirements for implementation of systematic quality assurance is education on quality assurance concepts and methods.<sup>11-13</sup> These include:

- development of a positive attitude towards such a quality assurance,
- an attitude to reflect critically on their own performance and practice care,

- insight into and skills in methods of quality assurance.

For most GPs quality assurance consists of delivering good care and of a regular involvement in continuing education. The new approach of quality management demands specific training in methods and tools for the integration of quality assurance into the normal day to day care and into the practice and local work setting. It includes improving team work, quality circle methods, consensus development, systematic data collection, automation programmes, collaboration with other care providers, becoming a leader of quality assurance activities, making reports, et cetera. Courses on this methodology are being developed by many countries and will be stimulated by the WONCA Working Parties on Quality Assurance.

### International collaboration

A last challenge to be mentioned here is European and international collaboration. It is crucial to collaborate and to create a European family medicine. This should be done in the following areas:

- collaboration in clinical research and technology assessment to find evidence for good performance in general practice care and to underline specific guidelines and standards;
- collaboration in education to guarantee competence in practice;
- collaboration in setting up and implementing systematic quality assurance.

An action plan for quality assurance for the next decade may be formulated, including a European policy that can be discussed and negotiated with the various governments, setting up structures and networks for quality assurance in each country by the professional organizations and, maybe, a 'European Centre for Training, Development and Research on Quality in General Practice'.

Recently a professor of politics asserted, 'We have the choice between Eu-

ropeanism and Barbarism'. We may translate this into the choice between international collaboration and stagnation.

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