European family practice and public accountability

Martin N Marshall and Joze Braspenning


When readers of *Family Practice* become ill, they are unlikely to see a ‘bad’ family doctor. Health professionals use informal networks to choose a doctor to suit their needs. After they have seen the doctor, they will have the medical knowledge to be able to make a judgement about the quality of the care that has been provided. When friends or colleagues ask us to recommend a GP “who knows a lot about diabetes” or “someone who is easy to talk to”, we are usually able to help out.

The public is not so lucky. If a patient who has diabetes moves into a new town and has a choice of two or three local physicians or practices with which to register, they may not be able to find objective information to allow them to compare the quality of the care provided. More worryingly, they probably will not know that the quality of the care might vary dramatically between providers, nor that if they stay with their chosen physician for a long period of time that this variation could have a significant impact on their health.

In many ways, it is remarkable that patients do not make more demands for comparative data about health care. We live in an age when most people have free and easy access to information about many aspects of modern life. ‘Consumers’ are used to either making choices between, or expressing judgements about, a wide variety of products or services. Health care has not been immune from this trend. In the Netherlands, for example, hospital mortality rates are published in the form of ‘league tables’ in one of the weekly newspapers, enabling the public to identify the ‘best’ and the ‘worst’ institutions. GPs would be naive if they thought that they could ignore or reverse this information revolution.

The public is developing a taste for information and politicians will ensure that they do not go hungry.

The willingness and ability of European countries to progress towards greater release of comparative information about quality will be determined by several inter-related factors. The most important of these are the perceived purpose of public disclosure, the structure of the health system within the country, the expectations and demands of patients for information and the political imperatives. Examining the impact of these factors on the different countries provides a useful insight into the process of implementing a radical new health policy initiative in Europe.

Commentators cite a variety of reasons for placing more comparative information in the public domain. In the USA, where the dissemination of comparative information about quality has been a prominent feature since 1987, the original rationale centred around the exercise of choice by informed consumers. In countries such as Belgium and France, patients often shop around between doctors. Comparative performance data might contribute to their ability to choose the doctor who is most likely to satisfy their requirements. However, this would be an inappropriate reason for releasing data to the public in countries such as Norway or Denmark, where patients are registered with a named family doctor and have much less opportunity to exercise choice. Such countries are likely to be motivated by other factors when encouraging greater public release of comparative information.

In some countries, political demands for greater accountability are likely to dictate the pace of implementation. The National Health Service in the UK has seen a series of high profile medical disasters in recent years, leading to demands for greater transparency and more rigorous monitoring of performance. This has led to the UK government seizing control of the accountability agenda and to a series of top-down performance management initiatives, including the introduction of a framework for reporting comparative performance. This framework is at an early stage of development and currently reports primarily on public health and hospital-based criteria, but there is a clear intention to ensure that criteria more relevant to general practice will be published in the near future.

The British approach contrasts markedly with that seen in The Netherlands where quality of care is still seen very much as a professional responsibility and there is little or no political pressure to introduce the kind of controversial policies that are being seen elsewhere.

Received 11 April 2001; Accepted 4 May 2001.

National Primary Care Research and Development Centre, Williamson Building, University of Manchester, Oxford Road, Manchester M13 9PL, UK and Centre for Quality of Care Research, University of Nijmegen, PO Box 9101, 6500 HB Nijmegen, The Netherlands.
why might countries such as The Netherlands, where there is little ability to exercise choice and no public demands for accountability, be interested in the issue of public disclosure? The reason lies in the potential of public release to stimulate quality improvement more effectively than using the same information for internal professional purposes alone. There is increasing evidence that popular quality improvement initiatives such as the use of guidelines in The Netherlands, clinical audit in the UK and quality circles in Germany result in small, inconsistent and poorly sustained improvements in quality. Such approaches tend to keep performance data within the professional domain and so it is easy to ignore, discount or hide variations in quality. The public release of such data forces professionals to respond and increases their sensitivity to their relative performance. This risks leading to dysfunctional or unintended consequences, such as manipulation of the data or focusing inappropriately on what is being measured, but there is also some evidence that it can lead to significant improvements in quality. Some European countries recognize this potential and are using public disclosure as a tool to stimulate improvement. In France, for example, prescribing data are being made public in an attempt to improve practice and drive down costs, and in the UK comparative performance data are being linked to an incentive scheme which will reward those organizations who are demonstrated to be performing well.

The desire of the public to be informed about and involved in health decisions, the political demands for accountability and the imperative to improve quality will all contribute to greater disclosure of comparative information in general practice and primary care. Public disclosure provides an exciting opportunity for European health professionals, managers, policy makers and researchers to work together and learn from each other’s experience.

References