Editorial

Competition and Quality: Friends or Foes?

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The extensive promotion and proliferation of articles and learned essays on Total Quality Management (TQM) have filled the pages of magazines, conference proceedings and academic journals such as this over the past few years. A limited number of commentators have stuck their necks out to question some of the supposed gains that such a managerial revolution can have in terms of the intended beneficiaries, be these health care organizations, professionals, or the much championed users of services—the patients themselves. That this debate takes place is a healthy sign that thinking people wish to innovate, to test theories and ultimately to learn more for the benefit of the public they both serve and of which they are a part.

One of the problems that becomes increasingly clear is that TQM itself does not have a single definition, nor is it universally understood. In this sense it is not unlike most other aspects of quality, in that the concepts, definitions and language of articulation are highly contested and depend in large part on the stakeholder group [1]. Without regurgitating the multiplicity of viewpoints here, it is worth noting that probably the most compelling reason for the introduction of TQM is that it is a learning model for organizational change. The health care environment (structure) provides the learning context for developing processes that lead to continuous quality improvement (CQI) for the organization and, ultimately, to health gain and improved quality of life for the general public it serves.

In a particularly enlightening review of the benefits of TQM in the industrial sector, Powell [2] discovers that the critical factors in the advantages of this approach over other forms of quality assurance—its competitive advantages—are senior management commitment, employee empowerment and a culture of openness. Other related components of TQM, such as benchmarking, measurement and training, are only of secondary importance when trying to change a culture in the direction of CQI. I suspect these findings will also have resonance in health services, despite the rather unique set of social relations found in health care organizations.

Against this backdrop we see an emerging focus of attention on the development of organizations that must compete to survive in a supposed health market. Different countries are at different stages in this process, but commonality is found in the increasingly tight fiscal environment that faces all health care systems. In the UK, as in many other countries in Europe and beyond, new structures have been imposed to imitate a market environment, such as the internal market and a culture of contracting for services between purchasers or commissioners and providers. Part of the intention is to enforce efficiency gains through competitive behaviour, albeit couched in terms of quality improvement.

At the recent European Healthcare Management Association conference in Lisbon, Portugal (June 1996), Wistow and Hardy [3] raised the dilemma of directives from Government to collaborate and then to compete, without consideration of the contradictory nature of such exhortations.

The different approaches to training taken by two neighbours in the European Union help to illustrate this dilemma for quality improvement. In France some 70% of hospitals spend their mandatory 1% of budget* on training by giving

* Recently an increase to 2.1% has been approved.
it to the Association Nationale de Formation Hospitaliers (ANFH). This independent but public organization offers each participating organization an opportunity to develop a training programme appropriate to its needs by sharing information across the health service, as well as by building up a library of good practices. In the United Kingdom, by contrast, since providers were formed into independent Trusts even though still within the National Health Service (NHS), their relations with the Institute of Health Care and Development (IHCD)—the nearest equivalent to the ANFH and until recently called the NHS Training Directorate—are strictly on a commercial basis. They buy whatever training packages the IHCD wishes to offer. The likely response to this situation is that Trusts will “go it alone,” with worrying consequences in many cases, since good practices will not find the same easy conduit as in France.

Another disturbing development, from a quality point of view, is the increasing tendency of health care organizations to insist on secrecy clauses and the shutting up of whistle-blowers—people who identify problems and articulate them so they can be resolved. Current political debate in the UK has centred around the need for legislation to protect such people from being dismissed for speaking out. Arguments in favour of secrecy have usually centred around notions of commercial sensitivity. Iezzoni [4] has identified the increasing trend to withhold information about the methods by which quality measurement tools have been developed, yet another example of this tendency. The issue for a public service centres around notions of democracy and accountability, which are themselves contingent upon empowerment through participation and openness, the components of successful TQM.

Donabedian, at the recent ISQua conference in Jerusalem, tackled the difficult subject of effectiveness of quality assurance [5]. He admonished us to beware the undesirable consequences of QA, which include “an ambience of fearfulness that leads to resistance, evasion, concealment and ultimate demoralization.” If TQM is to have any role to play in our health care organizations, it must welcome openness and be prepared to accept and even encourage critical comments from within as well as from outside, as this will represent an empowering of employees and patients alike. Only in this collaborative way can we all learn together and create the opportunity for a meaningful, rather than vacuous, culture change towards continuous quality improvement. I hope that the editorial decision to incorporate a new section in this journal, entitled “Every Defect is a Treasure,” will provide an opportunity for colleagues to share their organization’s mistakes or unwitting actions which led to adverse outcomes, unintentional though they undoubtedly were, in a climate of learning rather than with fear of penalty.

REFERENCES