

# Quality Improvement in General Practice -

*the Australian & Scottish Perspective*

By Dr Stephen Tong, Editorial board member

Invited speakers at the FM Grand Round 18<sup>th</sup> Aug 04 were Dr Rodney Nan Tie, Senior Lecturer & Trainer, School of Medicine, James Cook University, Australia & Dr Douglas Murphy, Associate Advisor, Vocational Training for Family Practice, NHS Education for Scotland, UK. A/P Goh Lee Gan, chairing the session, noted that quality improvement is important in general practice. The Ministry of Health has also been keen to look at measuring quality of health care. However, in Singapore & current climate, even our managed care systems tend to be more concerned about cost control rather than quality control. This session also represented a second leg of a course that started in Glasgow in Mar' 04.

*Quality is important in today's practice settings and patients' care. What then is quality and how can it be evaluated?*

## THE AUSTRALIAN PERSPECTIVE

Dr Rodney Nan Tie discussed how factors like education, remuneration, lifestyle, infrastructure & individual factors like personality, motivation & culture have influences on quality. These influences would have bearing on the measuring of quality & ultimately quality improvement.



Dr Rodney Nan Tie

In Australia, in the 30 years prior to 1984, the main changes to the health care system affecting quality of GP care were in the areas of improvement to education. 1958 – Australian College of General Practice 1963 – Undergraduate GP teaching 1968 – First GP examination 1973 – Family Medicine Program 1984 – Medicare

Medicare in Australia, implemented in 1984 is a Government Health Insurance program has its pros & cons. While it resulted in the majority of the population having free GP consultations & improving public access to GP care, it also resulted in increasing government control, shorter consultations time (remunerations of doctors being dependant on number of patients seen) & a general loss of respect for GPs as their services are not valued because it is free.

On a positive note, Medicare allowed for further development of GP training & quality assurance programs, rewarding doctors with proper accreditation in GP training programs. From 1987 to 1989, the Royal Australian College of General Practitioners (RACGP) developed Quality Assurance with their Continuous Professional Development (CPD)

programs, & subsequently linked these to doctors' remuneration. In 1994, quota on GP training position was imposed and 2 years later, GPs access to Medicare was limited only to those with FRACGP.

In the late 1990s Practice Accreditation and Practice Incentives Programmes were developed & implemented to ensure clinics maintain standards & quality of care. In the year 2002, the government developed General Practice Education Training (GPET) program & took over the training for the RACGP.

## In Summary

These series of development resulted in increased government control over the practice of GPs, increased paperwork & costs, as well as a general decrease in income & morale to the GPs. However by using financial incentives, the government has increased ability to enforce compliance to QA & CPD programs as a result increasing standards of care & a gradual push towards recognising GP as a specialty.

## THE SCOTTISH PERSPECTIVE

Dr Douglas Murphy discussed importance of quality assurance & professional development in primary care in Scotland, and the system of appraisal & revalidation process that is implemented. *The GP appraisal system* in Scotland covers aspects like success & problems at work, learning & development needs, goal setting & reviews of previous goals, reviews of complains, & carrier ambitions. It is conducted by peers, time protected, & with resources for needs identified.



Dr Douglas Murphy

Purposes of appraisal are to help identify educational & development needs, support preparation for revalidation & to reassure the public. However, this appraisal is not an assessment of performance, is not a pass/fail process, nor is it used as mechanism to deal with under performing doctors.

By the end of 2004, the GMC will give all doctors(except those who opt out) a licence to practice. From 1 January 2005, any doctor who wants to practice must hold a licence to practice. In April 2005, the GMC will start to invite doctors to be revalidated, & it is expected that it will take 5 years for all doctors to be revalidated for the first time. The GMC will revalidate doctors every 5 years thereafter.

Under revalidation, doctors are required to show to the GMC that he has followed the principles of *Good Medical Practice* that are relevant to his practice. The Scottish GP appraisal scheme has been designed to support doctors do this by focusing on 1 of 5 core categories of evidence in their appraisal each year. This makes the production for evidence & the agenda for appraisal manageable, & gives the doctor choosing the appraisal route to revalidation an effective method of showing that all seven headings of *Good Medical Practice* are covered.

The GMC will not prescribe & has no legal power to say exactly what information a doctor should collect & retain. The information should just cover all 7 headings of *Good Medical Practice* : good clinical care; maintaining good medical practice; teaching & training; relationship with patients; relationship with colleagues; health and probity.

The doctor decides how to show the GMC that he has followed these principles through 2 main ways - appraisal route or independent route. It is anticipated that the majority of GPs in Scotland will choose the appraisal route, which is why the appraisal scheme has been designed to support revalidation in addition to other functions.