Counterpoint

Random reflections on the Wimpole Street principles

There is perhaps a reason why many languages don't have a synonym for the English word 'policy'. The term has a strong link with words such as 'political' and 'policy' and therefore associates easily with complex decision-making and external control. Strangely enough the Americans and the British seem to be using the word 'policy' in a more neutral way, trying to rationalize the decision making processes around setting goals and defining ways to reach these goals. The Webster Dictionary defines 'policy' as a selected, planned line of conduct in the light of which individual decisions are made and co-ordination achieved. This nice neutral description is softening the power play and harsh realities that usually lie behind notions such as 'selection', 'planning', 'conduct', 'individual decisions' and 'co-ordination'. The question 'who wants to influence whom to achieve what' is essential in 'individual decisions' and 'co-ordination'.

The existence of functioning audit, CQI projects, practice guidelines, accreditation, certification, quality systems, clinical pathways, patient surveys and registries is one thing. Whether development, individual freedom and societal values with soothing language is more effective than calling things by their name.

These thoughts came to my mind when I was reading 'A framework for evaluating governmental quality initiatives: the Wimpole Street principles'. The authors present a thoughtful list of evaluation criteria for British government policies on quality of care in an attempt to create more coherence and continuity in the various approaches introduced since the mid-1980s. They state that with minor amendments of language the framework might also serve in other countries and systems. However, before implementing this framework in other countries the following should be considered:

1. The role of government differs from country to country. The English National Health Service experience is only partly representative of the way governments all over the world are involved in decision making in health care. Notably the financing and administrative role is lacking in many countries. Furthermore, there are large differences between government involvement in areas such as public health, acute care and social care. The roles of government assumed in the document may be played by other actors such as (social) insurance companies or be diluted in health care systems where the role of a ministry of health is marginal.

2. The problems of coherence and continuity in the policies in Britain and the shift in jargon are not only the reflection of changing ideas on quality of care but also the result of a political two-party system. Countries with a multiparty system are less inclined to create new rhetorics and shifts in civil servants after elections. The paper therefore seems to address a problem (lack of policy continuity) that is inherent in the type of political system but which does not necessarily exist in other countries. My own country, The Netherlands, reached agreement over quality terminology between 1985 and 1987 and there has been consistency in the quality policies of the government since then, irrespective of the political background of the cabinet.

3. The framework does not address the necessity to define goals for the health care system at the national level. The ultimate way to evaluate quality initiatives at the national level lies in the extent to which they contribute to the outcomes the health care system wants to produce. The existence of functioning audit, CQI projects, practice guidelines, accreditation, certification, quality systems, clinical pathways, patient surveys and registries is one thing. Whether they help us to achieve the health goals on the national level the community wants to achieve, is another. It is necessary not only to address different perceptions but also to obtain a clear perspective of government on the desirable balance between the effectiveness, efficiency and equity of the health care system as expressed in the health of the population (length of life, quality of life), costs of health care and access to health care. The more explicit the targets, the clearer the possibility of judging government policies on their results. Policies on quality initiatives should therefore not only be comprehensive and consistent but also clear on what they want to achieve.

4. The framework has four chapters: policy, organization, methods and resources. If one wishes to evaluate quality initiatives in the whole health care system it is a challenging idea to consider the health care system as one big organization and use for example the EFQM model to assess whether all nine dimensions of a quality system as conceptualized in this model are in place. Comparing the Wimpole Street principles framework with the EFQM model it seems that several dimensions are missing. Four have to do with the assessment of results (key performance results, satisfaction of clients, satisfaction of employers and satisfaction of society). This was already addressed in my previous point about the lack of goal orientation. However, in a framework for evaluating national quality initiatives one
could consider evaluating not only the impact in terms of effectiveness, efficiency and equity (key performance results of the health care system), but also the satisfaction of patients, health care professionals and citizens. Another dimension missing is the one on leadership. The Wimpole Street principles seem not to evaluate the leadership capacity of the government itself. Was this issue too sensitive? I challenge the Wimpole Street Group to assess the leadership of British governments under Thatcher and Blair against the relevant criteria of the EFQM model.

5. The chapter on methods contains important notions on the need for sufficient evidence on the (cost) effectiveness of standards and quality methods with respect to their effect on behavioural change. I fully agree with the authors that too many quality initiatives are more opinion-based than evidence-based. However, it would be a mistake to put all cards on the scientization of quality. If the systematic reviews of professional change in behaviour teach us anything it is that change is very context-dependent. It is an illusion and dangerous to assume that contexts of individual patients and professionals can be standardized in such a way that they can be regulated solely with guidelines and indicators. In this respect the tone of the present British debate on clinical governance and the National Institute for Clinical Excellence is perhaps a bit over-optimistic.

6. The Wimpole Street principles reflect the growing awareness that quality improvement is an integrated element of all management functions in the health care system, starting with management of the care processes through the interactions of professionals and patients/clients. The principles can help policy makers to reflect on the most effective way to influence these primary processes in the health care system. However, be aware that this drug is culture- and language-specific and should be administered in the appropriate dose and context by knowledgeable evaluators. The Wimpole Street Group demonstrates with this document that they are no wimps. On the contrary, the document reflects a sincere attempt to contribute to the consistency and effectiveness of government policies in the field of quality of care and those are values that seem to exist even in countries where the word ‘policy’ is not spoken.

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