QUALITY IN HEALTH CARE

Editorial

Improving care at the primary-secondary care interface: a difficult but essential task

Improving the quality of care delivered at the interface between the primary and secondary sectors will be one of the challenges of the next decade for health professionals working in Europe. Healthcare purchasers attribute much of the explosion of costs in health care to the inappropriate use of care at that interface. In some countries there is a move towards shifting care from secondary to primary care. No one has a monopoly on care that is delivered at the interface and getting the balance of influence right is crucial.

In Germany, where there is a long tradition of specialist care in private practice, the balance between general practitioners and specialists tipped dramatically towards specialism when the government introduced a chip card held by the patient that allowed unlimited access to secondary care. This stimulated demand that led to a dramatic increase in expensive services—for example, the number of knee arthroscopies in some regions doubled every three months. This rise was only stopped when such procedures were made financially less attractive by the introduction of regulations and tough fees for the service. We need to understand how health care professionals from both sectors can work effectively together to provide good quality care. Initiatives that aim to improve the quality of care delivered at the primary-secondary care interface could be an important part of this process.

Much attention is given to referral rates—perhaps because not only can they be easily measured but they are seen as a way of controlling costs. A recent European study based in 15 countries showed large differences between countries in rates of referral from primary care to a specialist. In Norway 8.1% of all general practice consultations result in referral to a specialist but in Germany and in the United Kingdom only about 5% prompt a referral and in France 2.6%. The workload of the general practitioners seemed to be an important determinant of referral rate. One conclusion of this study was that doctors with low referral rates provide additional care themselves through extra consultations.¹ Better indicators of the quality of care than actual referral rates may be the process of referral or its appropriateness and outcome. But, however the quality of care is assessed, it is likely that variations in processes and practices will be found between countries, between regions, and between practitioners.

Audit of care within practices and in peer review groups is being developed throughout Europe,² but we have to

acknowledge that participating doctors may have differing views about the purpose of audit. We generally suppose that good audit has a scientific basis and that the audit cycle is followed in the way set out in texts. But this is often not the case.^{3,4} There is still much to understand about how to involve practitioners in audit and how audit can change practice. On the basis of my own experience in Germany of training more than 700 general practitioners and specialists to be moderators of peer review groups (quality circles)⁵ my view now is that practitioners participate primarily not to improve the healthcare system itself but rather to overcome feelings of insecurity and to improve performance; to get feedback from peers about decisions they have already made and to exchange ideas about problems of daily practice. These motives need to be recognised, understood, and valued if audit is to develop as a process that promotes change.

Processes within primary care account for only part of the jigsaw that is care at the interface between primary and secondary care. Assessing the quality of care in a genuinely reflective way that goes beyond referral rates and access to specialist procedures will require the cooperation of all relevant healthcare professionals from both sectors. It is often argued that primary and secondary care givers have little contact with each other and little knowledge of each others' concepts and experiences. Audit in small groups could help them to find common ground and a common language. In this issue of *Quality in Health Care* a national survey of audit activity across the primary-secondary care interface in England and Wales clearly shows a widespread feeling of successful groups working together as perceived by the doctors participating in interface audit—although many audits were categorised by the researchers as incomplete (Eccles *et al*).⁶ Perhaps we should be more optimistic about the benefit such group work offers to the participants and the scope it has to change some things for the better for the patient. Eccles *et al*⁶ report that in their survey about one third of all audits and a quarter of incomplete audits resulted in some change.

Setting up and developing interface audit that involves healthcare professionals from both sectors so that it works is a huge undertaking. And it seems to be one that is worth the effort. But in the process of working to include the views of the professionals from both primary and secondary care the views of patients must not be left out. For example, although healthcare professionals may take the view that they commu-

nicate and collaborate well through, say, shared care arrangements for people with diabetes, some patients might not be so keen about "being shared" and having to share their problem with two doctors. Understanding patients' values, their perceptions, and judgements about care⁷ and the cooperation between care givers will be an important part of the agenda for audit at the interface.

JOACHIM SZECSENYI

Managing Director AQUA,
Institute on Applied Quality Improvement
and Research in Health Care,
Hospitalstrasse 27,
D-37073 Gottingen,
Germany

- 1 The Royal College of General Practitioners. *The European study of referrals from primary and secondary care*. London: RCGP, 1992. (Occasional paper No 56.)
- 2 Grol R, Wensing M, Jacobs A, Baker R, eds. *Quality assurance in general practice. The state of the art in Europe*. Utrecht: Nederlandsen Huisartsen Genootschap, 1993.
- 3 Baker R, Robertson N, Faroogi A. Audit in general practice: factors influencing participation. *BMJ* 1995;**311**:31-4.
- 4 Grol R, Wensing M. Implementation of quality assurance and medical audit: general practitioner's perceived obstacles and requirements. *Br J Gen Pract* 1995;**45**:548-52.
- 5 Bahrs O, Gerlach FM, Szecsenyi J. *Aerztliche Qualitaetszirkol. Ein Leitfaden fuer den niedergelassenen Arzt*. Cologne: Dt Aertzteverlag, 1995.
- 6 Eccles MP, Deverill M, McColl E, Richardson H. A national survey of audit activity across the primary-secondary care interface. *Quality in Health Care* 1996;**5**:193-200.
- 7 Kelson M. User involvement in clinical audit: a review of developments and issues of good practice. *Journal of Evaluation in Clinical Practice* 1996;**2**: 97-109.