patients and their doctors. Involving patients as partners in their health care can only be beneficial to the people, patients of this country.

REFERENCES

[1] The Patient's Charter and You DOH January 1995.
[2] Neuberger J. Availability of information in an open society. *In:* Marinker M. ed. Controversies in health care policies. *BMJ* 1994. 27–41.
[3] ABPI Compendium of Patient Information Leaflets 1995–6. Datapharm Publications Ltd 1995.
[4] Improving patient information and education on medicines. International Medical Benefit/Risk Foundation RAD-AR, *Lausanne*. October 1993.
[5] Proprietary Association of Great Britain. OTC Directory Treatment for common ailments. PAGB 1994.
[6] Critical Appraisal Skills Programme. Report to the King's Fund Development Centre. CASP November 1995.
[7] Baker R, Streatfield J. What types of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction. *Br J Gen Prac 1995;* **45:** 654–659.

Proc. R. Coll. Physicians Edinb. 1996; **26:** 581–593

QUALITY OF CARE IN THE CHANGING NHS*

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I am honoured to be here giving the 1996 Sir Stanley Davidson Lecture. He was a generous benefactor of the Edinburgh Royal College and a distinguished physician. I hope that his ghost will not be baffled or upset by the fact that I, who am not a physician, pontificate on this supremely important topic. I apologise that my own experience is based in England but my ancestry is Scottish and my national service was in a Scottish regiment. It is for you to judge whether anything that follows is relevant north of the border.

From the title assigned to me, I have assumed you would like me to talk about both quality and change, and the interrelationships between the two, in the context of the NHS. What I want to say falls into four parts, namely: concepts of quality; evaluation of Mrs Thatcher's 1991 changes in the NHS; three initiatives to improve quality; some thoughts about the future.

CONCEPTS OF QUALITY

Doctors are most likely to define quality of patient care primarily in technical terms. Was the diagnosis right? Was the care appropriate? Were the results acceptable? Without doubt these are important questions and perhaps *the* most fundamentally important, but they are not all-important. There are other questions that can properly be asked about the care setting, the manner in which people are treated and what precedes and follows this particular episode of care (Fig 1).

I have argued elsewhere that quality in our field is complex, elusive and multi-dimensional.[1,2] Besides the techical dimension already referred to, there are some five other dimensions (Table 1). It is not my contention that these are the only possible ones, but they seem to cover most of the ground, including the population aspects of health care (equity, relevance, public cost) as well as the individual.

Not surprisingly, these elements of quality sometimes pull in different direc-

TABLE 1

Questions that help to define and expand the quality label.

Effectiveness	Is the treatment given the best available in a technical sense?
Acceptability	How humanely and considerately is this treatment/service delivered?
Efficiency	Is the output maximised for a given input, or (conversely) is the input minimised for a given level of output?
Access	Can people get this treatment/service when they need it?
Equity	Is this patient or group of patients being fairly treated relative to others?
Relevance	Is the overall pattern and balance of services the best that could be achieved taking account of the needs and wants of the population as a whole?

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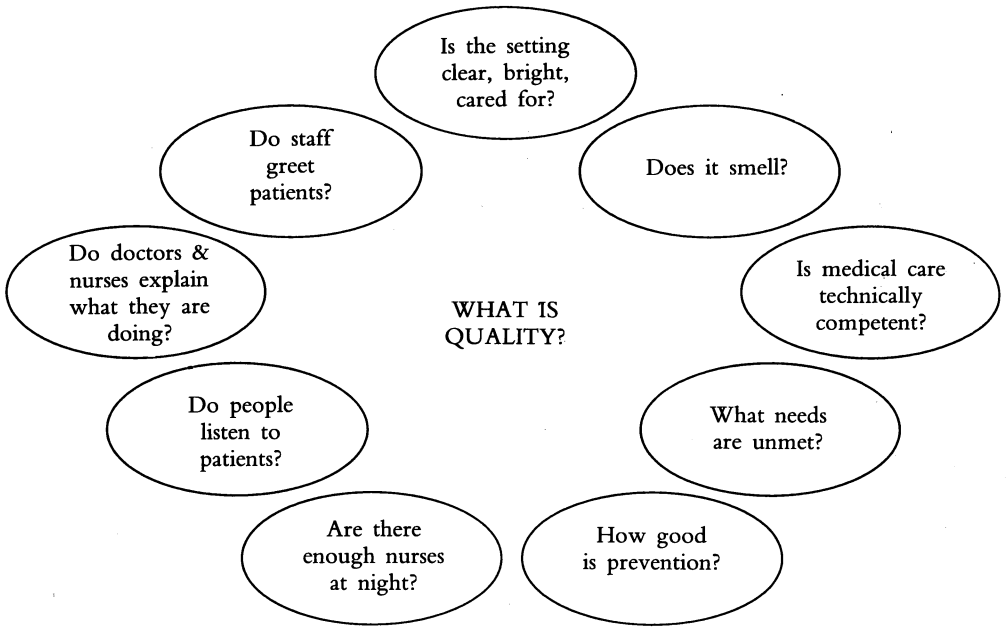

FIGURE 1

tions. For example, technical quality pulls in the direction of large specialist units, each handling a volume sufficient to develop and maintain relevant skills. On the other hand access and acceptability favour decentralisation, all other things being equal. Access to care falls with the distance of a patient's home from the specialist centre,[3] as most patients prefer not to travel far. Thus these three criteria, technical quality, access, acceptability, are in some circumstances incompatible and one is led ineluctably into the business of trade-offs. How much local access should we surrender in the interests of technical quality?

Obstetrics provides an interesting example, because in this speciality there is an inherent tension between 'normality' and safety. I can remember the time when England's Chief Medical Officer, Sir George Godber, believed that all births should be in hospital so that consultant care would be available in the event of abnormality. That would not be the view today, which shows that these balances and tradeoffs are not necessarily stable over time. Patients have become less biddable, and greater decentralisation may have become more possible technically, through improved skills and enhanced technology, for example, telemedicine.

Another basic conceptual point is Donabedian's differentiation between structure, process and outcome.[4] Table 2 illustrates these aspects in the context of assessing technical quality and patient acceptability in an intensive care unit. Structure represents the setting for care, including staffing, their qualifications and the equipment required. Process defines what is done and how it is done. Outcome, which is ultimately what matters, is the bottom line for the patient. Because of time lags and other influences on outcome, we often have to use structure and process indicators, as surrogates for it. That is fine, so long as we recognise what we are doing and accept the inescapable duty to test continually

TABLE 2

Assessing quality in an intensive care unit.

	Structure	Process	Outcome
Effectiveness	Staffing level and skills Equipment Access to theatres etc.	Workload (i.e. volume of cases treated) Compliance with protocols where relevant Data based peer review Infection and complications rates	Survival rates compared with similar units for matched cases
Acceptability	Is the setting frightening or reassuring? What provision is there for relatives (e.g. privacy for counselling, overnight accommodation?)	Is explanation to relatives required and recorded in notes?	Is there follow up of patients and of relatives to obtain their opinions and suggestions for improvement?)

the assumed link between structure and process on the one hand and outcome on the other. We must not fool ourselves. Staff professional qualifications, for example, are not of themselves a quality guarantee. The test is one of a proven link to outcome, including patients' views of the care that they are receiving (the acceptability criterion).

In the business world, which was my own initial background, there is often reference to the bottom line, meaning sustainable financial performance as measured by earnings per share. In principle, investors can compare the relative attractiveness of companies in widely different businesses by a single measure of this kind. Of course, the world of business is not that simple, witness the increasing concern about environmental damage, but there remains an important sense in which business performance is ultimately judged by a single set of financial measures, sustained over time. That is not at all the case in a service like the NHS, where finance is simply a constraint, within which performance has to be assessed by other, more complex criteria.

After the Griffiths Report of 1983,[5] which introduced general management into the NHS in place of the previous professional hierarchies operating by consensus, many health authorities in England established a senior post entitled 'Director of Quality', or something similar. These posts were often held by nurses who had been displaced by the elimination of senior management posts in nursing. All too often the holders were inadequately supported and their role was vague. Quality assurance passed within a few years from being flavour of the month to a danger of being discredited. Now, I am told, NHS Trusts favour approaches with a more commercial cutting edge like downsizing and business process re-engineering. While I have nothing against a hard-headed approach to reshaping organisations, I sincerely hope that the health care professions will stand firmly by a commitment to quality of care (defined broadly to include concerns of equity, relevance and cost) as the bottom-line result that matters most. From

its inception, the NHS was intended to ensure that 'every man and woman and child can rely on getting all the advice and treatment and care they need in matters of personal health', irrespective of their means or any other factor irrelevant to their real need.[6] That should remain our collective aim, against which we assess our performance.

EVALUATING MRS THATCHER'S NHS CHANGES

Mrs Thatcher's review of the NHS was precipitated by a perceived funding crisis in the autumn of 1987, when the Presidents of the London Royal Colleges of Physicians, Surgeons and Obstetricians/Gynaecologists made a public attack on the government for underfunding the health service.

When the resulting government report *Working for Patients*[7] was published in January 1989, it said nothing about funding. Instead it contained an uneven and disparate assortment of seven measures, ranging from half an extra consultant post per NHS district (something that scarcely required a review) up to the introduction of trust status for hospitals, GP fundholding and, implicitly rather than explicity, the purchaser/provider split. Not all these measures came from the same ideological parentage. For example, the health authority as purchaser is a modification of the old style welfare state, collective action in a new guise, where an arm of central government decides what is good for us. GP fundholding is quite different; it assumes that the best proxy for us as consumers in the health care market place is our GP.

Opponents have at times alleged that the Thatcher changes were aimed at privatising the NHS. A few extremists in the right wing policy thinktanks may have wanted that, but I see no evidence to suggest it was the intention of the five politicians primarily involved. The Chancellor of the Exchequer today and formerly Minister of Health, Ken Clarke, for example, has never been one to hide his views. He was committed to the concept of an NHS and, so I suspect, has little quarrel with the principles underlying it. What collectively the five ministers who conducted the review seem to have wanted was a more efficient and more responsive NHS, which they believed to be achievable within the constraints of central government funding, provided that the NHS was freed up from a command-and-control structure and bureaucracy.

Some elements of what they prescribed were very radical, yet they would have no truck with pilot projects, designed they said to procrastinate, nor with research and evaluation, proposed by academics who tended in their view to have suspect left-wing leanings. All this was understandable, but silly. The truth is that no structural change and no management initiative in something as complex as the NHS produces precisely its intended effects—even if those effects are much more explicitly spelled out than they were in this instance, where one could be forgiven for wondering what problem this heterogeneous set of solutions was designed to solve. The law of unintended consequences brooks few exceptions in the world of management. Any initiative, however inspired, produces a new set of issues to be tackled.

Because Government would not at that stage agree to evaluate the changes enshrined in the NHS and Community Care Act 1990, we in the King's Fund decided to earmark £525,000 (a modest sum, but a substantial one for us) and called for research proposals in the summer of 1989. In the event 72 applications were received, of which 7 were selected, partly for their intrinsic strengths and

partly for their combined coverage of the issues (Table 3). One mistake we made was to insist on short-time scales. We wanted as much evidence as possible by the date of the next general election (in the event May 1992) so that, if there were to be a change of Government, it would not jettison the changes, without looking at the facts. Since in the event there was no change of Government, we need not have hurried and the evidence when it came would have been more complete.

As it was, however, the findings of this research programme, published in 1993 as *Evaluating the NHS Reforms*,[8] remains the best summary we yet have of how Mrs Thatcher's changes are affecting the NHS. Table 4 shows my own interpretation, based on this book, of the gains and losses for the NHS, as signalled at that very early stage.

TABLE 3

Evaluating the NHS reforms.

Researchers	Institution	Topic	Methodology
Jones, Lester, West	Cardiff	Services for elderly (hospital, primary and community health)	Interviews of 1,500 sample in 1990 and 1992
Bartlett, Le Grand	SAUS, Bristol	Hospital costs	Statistical comparison of Trusts and Non-Trusts
Appleby, Little, Ranade, Smith, Robinson	NAHAT *et al*	Extent of competition Attitudes of managers	Statistical estimates of the degree of competition. Interviews with managers
Glennerster, Owens, Matsaganis, Hancock	LSE	GP Fundholding	Interviews with 17 fund-holders
Mahon, Wilkin, Whitehouse	Manchester	GPs' and patients' views on choice of hospital	Postal questionnaires and interviews in 1991 and 1992
Kerrison, Packwood, Buxton	Brunel	Medical audit	Case study of 4 hospitals
Seccombe, Buchan	IMS, Sussex	NHS personnel function	Postal survey and case studies 1991

TABLE 4

How successful have the Thatcher NHS changes been?

Gains	Losses
↓ Longest waits	↓ Access to residential care
Some gains for patients of GP fundholders	Feared increase in differences/inequalities
↑ Local flexibility in personnel matters, e.g. skill mix	↑ Transaction & administrative costs
↑ Contestability of prices	↓ Ease of referral across administrative boundaries
↑ Emphasis on consumer responsiveness by providers	
↑ Leverage for purchasers & for all GPs	

THREE INITIATIVES TO IMPROVE QUALITY

Whether the NHS and Community Care Act 1990 has been good for the quality of health care is a hard question to answer for all sorts of reasons. The time scale is still too short. There are too many variables at work for cause and effect to be clear. There are bound to be tradeoffs of gains and losses, as more information accumulates about performance (a benefit) versus higher transaction costs (a disbenefit). Since this paper is concerned with the interrelationships between quality and change, it seems worth taking three examples of initiatives that were (or could be) more clearly focused on specific quality gains, and see what we can learn from them.

Waiting lists initiatives

In recent years Government policy, charter standards and management appraisal have concentrated on reducing long waits and quite rightly. Long waits, often by elderly people for relatively straightforward operations like cataract removal, hernia repair and hip replacement, are a major source of misery and a quality failure of the NHS. They can be tackled by intelligent action[9] though they appear to be endemic in large public hospital systems. Nevertheless real progress has recently been made in tackling the longest waits (Figs 2, 3 and 4).

However, gains in quality are seldom cost-free. The NHS is sufficiently hard-pressed that if the Government extracts, as it has, a gain of this magnitude in access for those waiting longest, one can be fairly sure that something else has suffered. What that is can be hard to pin down, partly because the Government has chosen to ignore it. The instruction was to eliminate long waits. General managers were left in no doubt this was what they were expected to deliver and they acted accordingly, transmitting that message to everyone else, including the

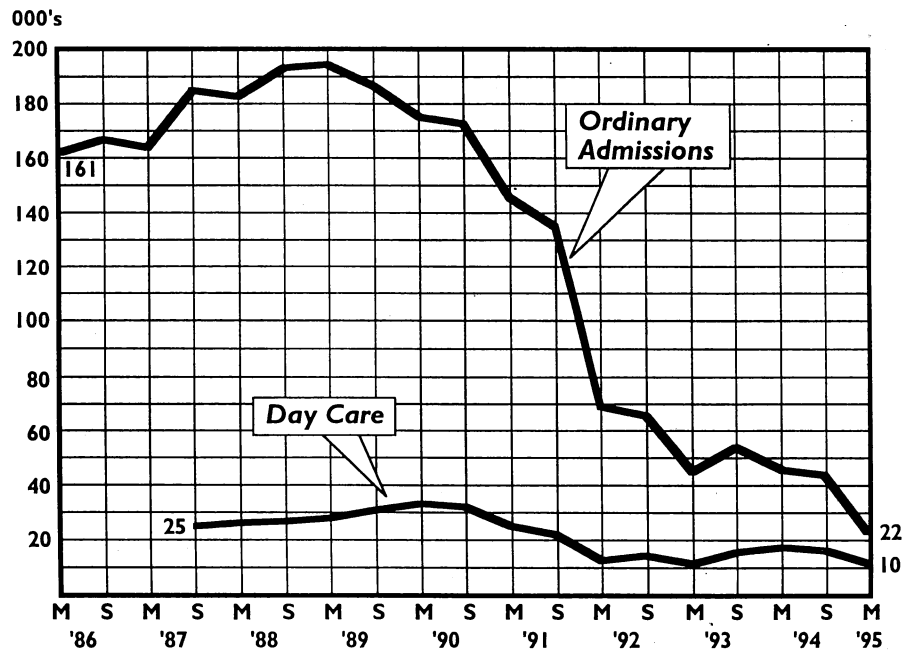

FIGURE 2

Those waiting over 12 months (England)

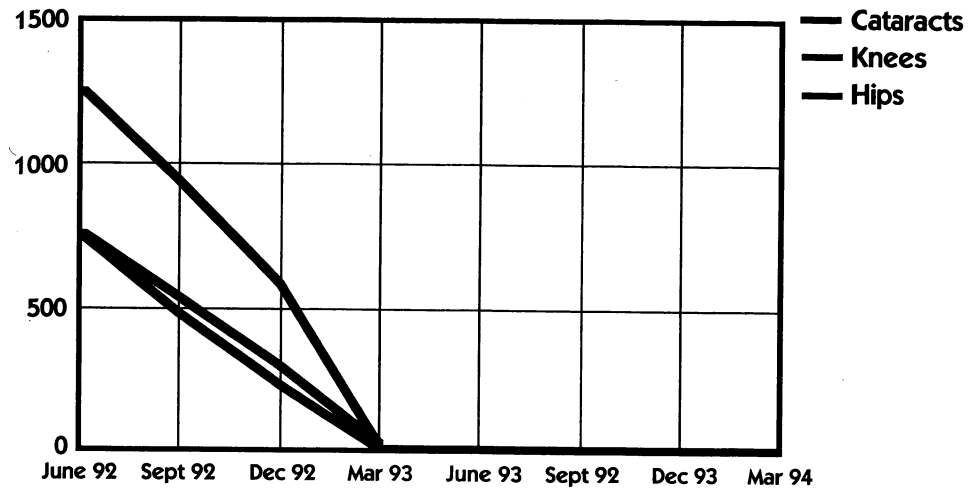

FIGURE 3

Number waiting over 18 months for hip, knee and cataract operations. Ordinary admissions and day cases combined.

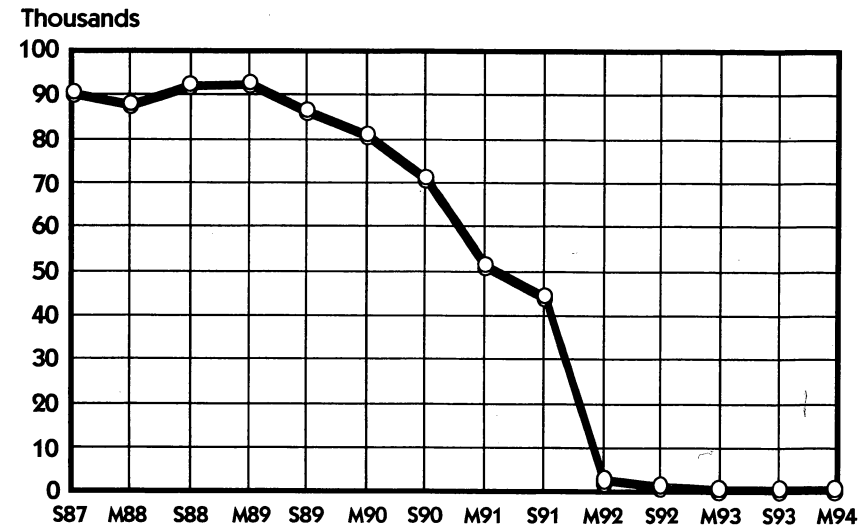

FIGURE 4

Number waiting over two years for treatment. Ordinary admissions and day cases combined.

consultant surgeons. Those at the top of the NHS did not appear to be interested in knowing the obstacles, the trade-offs made or the opportunity costs. Some of these we can guess at:

> Overall waiting-lists (including those for day cases) have grown, so part of the explanation lies in trade-offs between gains for those classed as non-urgent versus slightly longer waits for some of these classed as urgent. This may be an appropriate trade-off, but not necessarily one best made by Central Government fiat.

> With severe pressures on beds, there have at times been major problems in accommodating emergency admissions, leading to an increased use in London of the Emergency Bed Service refereeing system, and instances all over the country of long waits on trolleys, and occasional tragic failures to admit. Dr Sandy Macara, President of the BMA, has gone on record attacking the waiting list initiative,[10] on the grounds that concentrating resources on non-urgent cases has distorted clinical priorities: he called for more resources to reopen beds and suggested that in the short term the waiting lists for elective treatments could be allowed to grow.

Ironically the Government appears to have taken note of what Dr Macara said, if not quite in the way he intended. With money being very tight in the current financial year, the message seems to be going out to the providers from the Centre via the commissioning authorities that the target of nine months for elective cases can rise, in order to avoid crises in emergency admissions.

This example illustrates two important points. First the quality framework of Table 1 can be used not only to identify where one wants to make a major gain (in this case in terms of access), but also to monitor whether the gain is made at the cost of a quality loss in some other dimension, and whether that loss is acceptable. Second, Central Government should rarely mandate a single priority without seeking to estimate the consequences, and it should never do so without assessing what actually happens.

GP fundholding

The changes to the NHS foreshadowed in *Working for Patients* do not form a single, coherent whole. Nor is their objective spelled out, except in the most general terms. 'We believe that a National Health Service that is run better, will be a National Health Service that can care better' says Mrs Thatcher in her foreword. 'We aim to extend patient choice, to delegate responsibility to where the services are provided and to secure the best value for money.'[7]

GP fundholding has sometimes been called the 'wild card' of the reforms. The fundamental basis for it is to use the GP as an agent for each of us in the health care market place, on the grounds that we cannot make fully informed choices for ourselves, and decisions have to be made within financial constraints about whom to treat, at what cost. *Working for Patients* suggests[11] that the GP fundholding scheme was intended to strengthen GPs' influence on hospitals and their consultant medical staff, to enable GPs to refer across District boundaries to a hospital selected by them, and to give GPs an incentive to offer their patients a choice of hospital.

Seen within the framework of Table 1, it seems that GP fundholding was intended primarily to increase choice (within the dimension of acceptable quality) and value for money (within the efficiency dimension). The empirical question is whether it is doing so, and whether there are trade-offs in terms of losses of quality in any of the other dimensions of Table 1.

GP fundholding was one of the aspects of the NHS changes included in the King's Fund research programme, in a study led by Professor Howard Glennerster of the London School of Economics. His team's early findings were published in 1992[12] and included in the 1995 King's Fund report, *Evaluating the NHS Reforms*.[8] Professor Glennerster started as a sceptic, but in time became an advocate: 'fundholding is probably one of the few parts of the reforms that is leading to the competitive efficiency in the hospital system that the reformers hoped for.'[13] While recognising that 'early joiners' to the scheme may have been

tempted by Government approval and by intrastructure support (including computers), and acknowledging that transaction costs have increased. they concluded that at the micro-level GPs were better contractors than districts; GPs had better information and stronger motivation to respond to patients' dissatisfaction and could squeeze marginal improvements out of hospitals without the massive public confrontation that districts faced if they changed provider.[14] Professor Glennerster's latest review with Jennifer Dixon on fundholding in the BMJ[15] concludes:

> 'Fundholding has curbed prescribing costs and given general practitioners greater power to lever improvements in hospital services—for example, reducing waiting times for hospital treatment—but fundholding practices may have received more money than non fundholding practices. The impact of funding on transaction costs, equity and quality of care (particularly for patients of non-fundholding general practitioners) is unknown. Research into costly reforms such as fundholding needs to be co-ordinated.

In terms of the feared loss of quality, the main dangers were expected, by opponents, to be loss of equity (for example patients of fundholders gaining at the expense of non-fundholders) and what is offensively called cream-skimming (discrimination against potentially high cost patients to keep them off fundholders' lists). As yet, there is no evidence of the second of these occurring, which is a tribute, at least in the short term, to the triumph of GPs' commitment to the principles of the NHS over their self-interest. It is a continuing danger to which to be alert. The first—some inequity between fundholders' patients and the rest—has occurred, but could be counteracted by an effective district health authority determined to extract from providers any benefit obtained by GP fundholders for their patients. GP fundholders, like small boats, can manoeuvre faster than the ocean liners of the health authorities, but the latter actually have the greater buying power, and should use it.

The Government's objective is that half the population should be covered by fundholding this year. Meanwhile the Opposition is committed to abolishing fundholding, should it win the next election.[16] Either way, it will be important to see whether some of the advantages of fundholding can be obtained by other means, if only because a large number of GPs do not want to go down that route. There do seem to have been some real gains in quality for the patients of GP fundholders. It is not so clear whether that has been at the cost of loss of quality for others. That is where the (inevitable from researchers) call for more research is valid. With any major move of this kind, it is crucial to establish whether the gains outweigh the losses. That question is just as crucial for advocates as for opponents since one virtual certainty is that, at some point, the political wheel will turn and then the only defence of the changes will be objective evidence.

Tackling health inequalities

My third example of a quality initiative is one that has not recently been undertaken in the UK, but ought to be. A sharp social class gradient has long been documented in health.[17] The gradient has persisted despite the NHS. Indeed since 1980 it has almost certainly increased, because income inequality has grown rapidly in this period.[18]

For virtually all diseases, morbidity and mortality are substantially lower than average for social classes 1 and 2 and are higher than average for class 5, with

step by step increases in between. The differences occur in all age groups, including children, for whom mortality rates are more than twice as high in social class 5 as in class 1, and differences in childhood accident rates are of the order of five times or more.

Why, if we have an NHS dedicated among other things to objectives of equity, should these differences persist, and even increase? What can we do about it?

Four points stand out. First, it is most unlikely that problems of this kind will solve themselves. Second, effective action to counter inequalities has to be cross-sectoral including, for example, housing, poverty, smoking and diet, and extend more widely than the National Health Service. Third, it will have to be selective. While Patrick Jenkin, as Secretary of State for Social Services in August 1980, may have rejected the recommendations of the Black Report on political grounds, the report was unrealistic in making a vast number of recommendations at an estimated cost of £2 billion a year.[19] A realistic programme will have to start with fewer objectives and should be learning from the other two initiatives that I have described monitor and learn from what happens. Finally, an initiative to tackle health inequalities should involve trade-offs with other aspects of quality. If one takes a strictly utilitarian view, to maximise total health gain (measured for example by quality adjusted life years (QUALYs)), regardless of the distribution of the gains, then there will be cheaper and easier methods than tackling health inequalities. Improving immunisation rates in the poorest neighbourhoods, or reducing smoking among the poorest teenagers, or equipping them better to earn a living, are none of them easy things to do. But they are not impossible, given the will and the imagination, and we need to do them.

THOUGHTS ABOUT THE FUTURE

Will the current NHS organisation survive?

Looking ahead, to the next general election and beyond, I believe that we face a paradox. The NHS will be hard to sustain, yet even more necessary in the future than in the past. It will be hard to sustain, because medicine will continue to develop new therapies that offer benefit to some, usually at additional cost, and will do so at a faster rate than the growth in our collective willingness to pay. It will also be hard to sustain because we are in an era when the post-war consensus that created and sustained the Welfare State has broken down. Yet, paradoxically, the NHS (or a set of arrangements based on similar principles) will be even more necessary, because few of us can face the costs of medical care with equanimity on an insurance basis. particularly as we grow older. If health care is something that we hold to be so precious, not only for ourselves but for others, that we wish to guarantee it collectively, then we have to make work a set of collective arrangements. If we did not have the NHS, we would have to create something like it, as in one way or another virtually every prosperous country has done, except the United States.

If like a character in a fairy story, I could be granted one wish, it is that Government would restrain itself from further NHS reorganisation as a way to fix problems that have little to do with structure. We have had four major reorganisations since 1974, an average of one every five years. Sadly, I suspect it is not mere accident that this more or less coincides with the electoral cycle. A case could be made for each of these reorganisations, and each has achieved

something, albeit also leaving some unintended consequences. But, taken together, the energy consumed, the cost, the disruption and the distraction are simply not worth it.

If the Labour Party is elected at the next general election, they will be tempted to reorganise, while denying that they are doing so in any major way. They have said that they will end GP fundholding and the separate legal identity of Trusts. The latter will come back under the health authorities, while retaining some management autonomy.

These two changes are likely to be more than semantic and, even if the honest intent is to minimise organisational disruption, the chances are that the disruption will actually be considerable. I can only plead that Viscount Falkland's wise maxim be borne in mind: 'When it is not necessary to change, it is necessary not to change'.[20]

Something that a Government of the Left will have to do—if not immediately then in its second term—is to make the NHS more locally accountable than it has recently become. This needs doing, partly as a counterweight to the very strong centralising tendency that has always been apparent in the NHS, and partly because democratic accountability through Parliament is simply not enough to make services responsive locally nor to give those who make tough local decisions on priorities and the future of cherished institutions the legitimacy to do so.

I suspect that the purchaser/provider split will stay in some form. In some ways this is ironic, since the development of purchasing has to date not been one of the great successes of the reforms. The skills called for were in shorter supply than those required by NHS Trusts, and there was no tradition (except perhaps in public health) of management in the commissioning mode. So the purchasing authorities were slow to get going. More recently, they have been affected by the growth of GP fundholding, and it has not been entirely clear whether, or how, these alternative forms of purchasing can coexist in the long term. What the purchaser/provider split offers potentially, however, is a freeing up of NHS purchasing from domination by loyalty to particular institutions or interests, with the possibility of using a wide variety of types of provider, including the NHS, the private sector and voluntary agencies. This is one aspect of the reforms that arouses strong international interest because fundamentally what countries want to achieve is the health and health care of all their citizens. This may or may not require central Government itself to be the dominant health service provider. The purchaser/provider split acknowledges a real tension between the duty to put the needs of the population first, continually questioning the quality, and the value for money of current services, and the responsibility to maintain, develop and lead institutions. Both tasks have to be done, but not necessarily by the same people.

Whatever the structure may be, what are the key challenges ahead?

Under Government of any party, funding will be a perennial issue for the NHS. Other than for brief periods, there will never be enough money. Changing needs, possibilities and priorities will require high degrees of flexibility in moving resources, which has never been a characteristic of large organisations, particularly those run by Government. Among the essentials are the following.

Concentration on knowing what therapies are effective and under what circumstances, and acting accordingly. One can question Kerr White's famous 1976 hypothesis that 'only about 10 to 20 per cent of all procedures currently used in medical practice have been shown to be efficacious by controlled trial'.[21] But with NHS resources always under pressure, it will be a continuing challenge not to waste them on therapies that offer little proven benefit. Among other things, this means making available to doctors much larger data-bases than you can carry in your heads. Advances in information technology make this more and more feasible.

Persistent, systematic pursuit of efficiency. I have no sympathy with mandated efficiency savings imposed by central Government on the NHS year by year. This is primarily a financial sleight of hand, by which real growth is said to be funded at a substantially higher rate than any increase in the overall NHS allocation. It is dishonest because there is no sound evidence for it, nor audit of it. But, as the Japanese have constantly shown in manufacturing, productivity can almost always be improved by the relentless, bottom-up, search for better ways to carry out any process.

An acknowledgement that rationing takes place in the NHS, that it is inevitable and that we must learn to do it in ways that are as fair as possible. Rationing has always taken place in the NHS by central Government imposing overall financial limits. These are translated into budgets down through the system and ultimately shape the decisions made by doctors, on whom to treat and by what methods. Our rationing is implicit and it is often not fair, because geography, education, persistence and luck, all play their part. It is depressing that politicians generally deny the need for rationing and, when it becomes obvious, blame each other. Something we need to do better in the future is to be open about the existence and inevitability of rationing in the NHS and decide the principles on which it should be based and the processes that we can collectively accept.

A shaping of demand, as well as a shaping of supply, and taking a cross—sectoral approach to health. Running the NHS well will be necessary, but not sufficient. As emphasised above in the discussion of tackling health inequalities, many actions besides treatment have a profound influence on health. We need not only to recognise this truism, but to act on it.

Maintaining morale in the NHS has never been easy and it will not be easier in the future. All the evidence suggests that morale is the single most important determination of performance in service organisations, such as the NHS.

What part does the pursuit of quality have in all this and how can it be pursued? Answering this question fully would require another lecture, or giving this one again in a different way. But it is no accident that several of the items in the list of key challenges, the pursuit of effectiveness and efficiency for example, correspond to the dimensions of quality in Table 1. That can and does provide a framework for assessing how well we are doing within the NHS, and for seeking to do even better. Table 5 suggests an action list for putting the framework to use.

What I have sought to do in this Stanley Davidson Lecture is to ask you, the experts, to look at quality of care in the NHS in rather a different way than you normally do in your clinical work. Often the macro issues of management and politics must seem irrelevant or a downright nuisance; nevertheless, there are issues that can only be seen by thinking about the NHS as a whole. Each of us can have some influence, even as individuals, and certainly as a medical Royal College. In the end we and our children will get the NHS that we deserve.

TABLE 5

Actions required.

Diagnostic use of quality concepts
Implementation of good ideas, usually by small incremental steps
Systematic elimination of waste and barriers to good performance
Commitment to quality for those served
Ongoing measurement of progress to support improvement
Viewing particular quality initiatives within the broader context of quality in a whole system
Emphasis on team performance
Recognition that every team member has a dual responsibility—to do the job well and to find ways to do it better

REFERENCES

[1] Maxwell R. Quality assessment in health. *Br Med J* 1984; **288:** 1470–2.
[2] Maxwell R. Dimensions of quality revisited: from thought to action. *Quality in Health Care* 1992; **1:** 171–7.
[3] Mayhew L. Urban hospital location. London: Allen & Unwin, 1986.
[4] Donabedian A. The definition of quality and approaches to its assessment. Explorations in quality assessment and monitoring, Ann Arbor, Michigan: Health Administration Press, Vol. 1, 1980.
[5] Griffiths R. NHS Management enquiry report (the Griffiths Report) London: DHSS, 1993.
[6] Ministry of Health, Department of Health for Scotland (1994) 'A national health service' Command 6502, London: HMSO.
[7] Secretary of State for Health and others, Working for patients CM555, London: 1989 HMSO.
[8] Robinson R. and Le Grand J. Evaluating the NHS reforms London: 1994 King's Fund Institute.
[9] Yates J. Why are we waiting? An analysis of hospital waiting-lists. Oxford University Press 1987.
[10] Macara A. *Br Med J*, 1996; **312:** 139.
[11] Op. cit. 7, 48.
[12] Glennerster H, Matsaganis M, Owens P. A foothold for fundholding. London: King's Fund Institute.
[13] Op. cit. 8, 105.
[14] Op. cit. 8, 100.
[15] Dixon J, Glennerster H. What do we know about fundholding in general practice?. *Br Med J* 1995; **311:** 727–30.
[16] Labour Party. New Labour: New life for Britain. London 1996.
[17] Townsend P, Davidson N, Whitehead M. Inequalities in health. London: Penguin Books 1992.
[18] Joseph Rowntree Foundation. Income and wealth. Vol 1, Inquiry Report, Vol 2, Hill J. A summary of the evidence. York: JRF 1995.
[19] DHSS. Inequalities in health. Report of a research working group chaired by Sir Douglas Black (the Black Report). London: DHSS 1980.
[20] Cary L (Viscount Falkland) (1641). A speech concerning Episcopacy, printed in A discourse of infallibility, 1660.
[21] White, KL. Letter in *Lancet* 1995; 346.