When big isn't beautiful: lessons from England and Scotland on primary health care organisations

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ABSTRACT

- United Kingdom primary care trusts resembled the primary health care organisations (PHCOs) that have been proposed for Australia — for example, Medicare Locals.
- They resulted in a loss of innovation, creativity, motivation and morale among general practitioners and other front-line staff.
- English primary care trusts are being abolished and £80 billion will be handed over to GP commissioners.
- Management theory and practical experience shows repeatedly the dangers of reorganising into larger units.
- Lessons for Australia are to defer deciding on the size of PHCOs until their purposes are clear, to enshrine the principle of subsidiarity, and to opt for networking of the current Divisions of General Practice over mergers.
- So far, debate on the functions and structures of PHCOs has been muted. It is now time for vigorous debate.

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The Department of Health and Ageing has consulted on the role, function, governance, membership and proposed boundaries of primary health care organisations (PHCOs), such as Medicare Locals, which may lead Australia to repeat the experience of New Zealand and the United Kingdom with PHCOs.[1,2] In 1997, the UK government abolished general practitioner fundholding and moved towards primary care commissioning. In England, primary care groups were formed and later became primary care trusts. Scotland went straight to primary care trusts but abolished them in 2004 by unifying acute and primary care trusts under 14 health boards. The effects of these changes — a loss of innovation, creativity, motivation and morale among GPs and other front-line staff — highlight the consequences of progression to ever larger organisations in both countries.[2]

In this article, I review English and Scottish evidence and experience concerning the performance of PHCOs over the past 15 years. Information and viewpoints were gathered from health professionals who were active in primary care before the formation of PHCOs and were initially supportive of PHCOs. In-depth interviews with seven key informants (who have backgrounds in general practice, pharmacy, public health and health policy) and a focus group with five founder members of the Dundee Alliance, the UK's PHCO prototype, were conducted. The Dundee Alliance operated from 1997 to 1999; it then merged with the Tayside Community Health Care Trust to form the Tayside Primary Health Care Trust, which was disbanded in 2004. As the Dundee Alliance received substantial support for organisational development, its founder members were keen judges of the link between organisational and clinical success and quotes from some of them are presented here.

What works?

A feature of health reform in the United States and Europe is "systems thinking" — the process of understanding how a system's components influence each other and influence the overall system. Health care systems consist of people, structures and processes working together to create health outcomes. When applied to health reform, systems thinking is a problem-solving approach that goes beyond looking at a list of components and considers interdependent relationships between components of the whole system.

"Clinical microsystems" are the places where patients, families and care teams meet; they are the building blocks of health care that join to form a continuum of care. Each general practice is a clinical microsystem. Leaders at all levels of a health system need to know how to create conditions of excellence in clinical microsystems because these are the places where quality and safety are built.

Clinical microsystems are not freestanding and are usually part of a larger organisation — a macrosystem. Ultimately, the outcomes of a macrosystem can be no better than the outcomes of its microsystems. The relationships between microsystems and macrosystems are important. Successful health services are therefore characterised by:[3]

- leadership of the clinical microsystems
- macrosystem support for the clinical microsystems
- focus on patients
- focus on staff
- interdependence of care teams
- adequate information and information technology
- widespread process improvement
- focus on performance results.

Historically, Australia's Divisions of General Practice have provided support for general practice, including local clinical leadership and change management. Missing from Australian primary care is the specific training of clinical leaders, widespread process improvement and a focus on performance results.[1]

> We need to increase advocacy, support an innovative service and developing clinical leadership.
>
> — GP

What doesn't work?

Reorganisation

The disadvantages of reorganisation are now thought to be greater than the advantages.[4] Fewer than one-third of mergers succeed. Savings are, at best, modest and less than expected. They are also outweighed by dysfunctional effects, including loss of focus on services, delays in improvements, loss of organisational memory and inter-organisational relationships, and difficulties in transferring good practice.[5,6] Reorganisation results in decreased morale, with clinical staff feeling that managers — whose main motives to support reorganisation are perceived to be opportunities for higher

salaries or better retirement packages — have become even more remote.[4,7]

> I'm not against change. What I am against is irrational change, ill thought-out change, change that's demoralising — and change that is changed back 5 years later.
>
> — GP

Paradoxically, this poor performance often leads to another reorganisation and a spiral of increasing organisational dysfunction.

Reorganisation is based on a formal, hierarchical and mechanistic view of how organisations work. This downplays the importance of culture, norms, values and relationships.[8] Reorganisation fails to understand the complexity of issues that can lead to unintended consequences. The metaphor of reassembling a machine is less accurate for successful reorganisation than the metaphor of tending a garden.

Large organisations

Psychologists and sociologists have consistently warned of the dangers of large organisations.[9,10] It is a common experience to feel like a small cog in a vast machine, where human relationships are superfluous and rules reign. Lifeless orderliness and increasing centralisation stop innovation and creativity.[11]

> Rather than a system which is about encouraging lots of little things to flourish down here, it's a system which comes down very heavily and does not tolerate variances particularly well.
>
> — GP

Perverse incentives abound. There are disincentives to "rocking the boat". Politicians interfere. The purpose of an organisation is lost.[11,12]

Management by mistrust

Centralist-planned, "command-and-control" organisations manage by targets, which may work in the short-term but can lead to medium-term problems. Targets discourage continuous quality improvement because, once the target is achieved, there is no incentive to improve further.

> The Quality and Outcomes Framework has moved us from lots of good activity to a standardised system of care which improves health but … only on a bronze level.
>
> — GP

Targets also lead to gaming, including downright manipulation of figures. Targets demoralise and demotivate managerial and clinical staff.[13] The National Health Service (NHS) in England is moving away from targets, which imply mistrust of staff.[14]

What size is best?

The Australian General Practice Network (AGPN) has proposed a decrease in the number of Divisions to fewer than half, to cover populations of 500 000. Evidence suggests that the minimum population coverage of 100 000 is large enough for GP commissioning of health services without excessive risk from the cost of expensive conditions.[15] Australian PHCOs will not be commissioning in this risky environment. Therefore, the population covered could be fewer than 100 000. The current shortage of staff able to carry out health needs assessments and assist with population health programs (including data analysis required to support them) could be solved through networking. Until the purpose of PHCOs is known, size should be left undecided because current sizes may prove to be optimal.

How will Australian PHCOs work with state health services?

A possible purpose of Australian PHCOs will be to coordinate care, especially for patients with complex conditions.[1,2] How this will happen in the absence of GP commissioning is unclear. The proposed funding for hospitals perpetuates the perverse incentive against moving resources into the community by reducing hospital activity. It will result in a disadvantageous power imbalance between PHCOs and the state health services, perpetuating a stalemate.[2]

Worse still, Gresham's Law may apply: the bad may contaminate the good.[16] New South Wales and Queensland health services are extreme examples of the problems of large organisations, with inquiries having been highly critical of their command-and-control policies and clinical disengagement.[17-20]

Clinical networks and clinical senates are partial but largely unproven solutions.[21] State politics are likely to become involved in PHCO–hospital negotiations to the detriment of equity, efficiency and effectiveness. To centralist planners, it may seem sensible for PHCOs and regional state health services to share boundaries, but this is fraught with danger. Shared boundaries are particularly unsuitable for rural and remote Australia.[22]

What next in the UK?

Based on the evidence that GP fundholders were able to improve services in England,[23] the UK government is abolishing English primary care trusts in favour of allocating £80 billion to GP commissioning.[13] Size, organisation and structure will be for GPs to decide. Targets will be abolished and trust restored. A number of pathfinder projects will start before full implementation. Until recently, these proposals have had the support of all the major health policy organisations and of most GPs.[24] At the moment, there are no plans for reorganising the Scottish health system.

What are the lessons for Australian PHCOs?

At the end of the consultation period, the proposed new PHCOs and their organisational design must be clear. A compelling narrative that justifies the move from the status quo will be necessary. The change in New Zealand from independent provider associations to primary health organisations shows the damage that excessive government and health bureaucrat interference can do.[25] Pathfinder projects should be given 3 years in which to demonstrate their success. If reorganisation of the Divisions is required to allow specialist population health functions and service delivery, the AGPN's proposal of "branch offices"[1] is not adequate for protecting against the dangers of large organisations. The principle of subsidiarity (matters should be handled by the smallest competent authority) must be enshrined in constitutions of Medicare Locals[11] — the head office must not absorb the functions of the branch offices on the assumption that the head office is wiser and will fulfil these functions more efficiently. Better still, the current divisional networks should be built on. Divisions in the first wave would be wise to set up their PHCOs as shell companies so that they can maintain divisional subsidiarity.

> There has to be a balance between the freedom to innovate and the ability to control and this comes down to the contract structure, which needs to be incentive-based, which in turn leads to less need for control.
>
> — primary care manager

Subsidiarity protects clinical microsystems.[2,3,11] Each current Division should be a quasi firm with a large amount of freedom and the greatest possible opportunity to innovate and improve. Accountability should be by light touch, lest it interfere with creativity. Each Division should have control of its own budget. Incentives and motivation should take precedence over rules and orderliness. The ability to balance the antinomy of order and freedom should be a selection criterion for chief executive officers of PHCOs.[11]

The Victorian Healthcare Association has stated that "the implementation approach taken by the Department of Health and Ageing, Australian General Practice Network and some divisions of general practice will not achieve the aims of national health reform".[26] Victorian Minister for Health David Davis commented that "There are many more people who are opposed to the proposed changes than are for them".[26] These commentators are correct. There has been a paucity of debate, with many of the crucial issues unidentified and unresolved. Lessons from overseas have not been learnt. The dead hand of bureaucracy and the importance of strengthening the negotiating position of primary care over hospitals has not been grasped. England is attempting to solve these two problems with £80 billion of GP commissioning. Organisational culture is closely linked with safety and quality.[27] We should not risk everything that is good about Australian general practice without vigorous debate. The *Heads of Agreement — National Health Reform*, signed at a recent Council of Australian Governments meeting, should be the opening for this debate.[28]

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Competing interests

Before taking up my current post in 2002, I was a founder member of the Dundee Alliance and the inaugural Medical Director of the Borders Primary Care NHS Trust.

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