Sonic the Hedgehog was the first computer game I actually managed to complete. Although I may not have collected every one of the rings and I certainly died a lot while trying, I defeated Dr Robotnik in the final scene. Eventually. I felt a brief sense of achievement, but it was followed by a chasm of loss: what now? As I was 12 years old, my sense of purpose was quickly replaced by sports, riding my bike, and Street Fighter II.

A career in medicine can feel rather like a computer game. I used to think that it was something that needed to be completed, that the big boss could be defeated, and that the coins had to be collected along the way. I still think of medicine like a computer game, but in different, important ways.

If Sonic the Hedgehog had been the same on every level—with no hard bits, and no levels that made you shout or swear or think about giving up, with no big boss who felt impossible to beat—it would have been a terrible game. I would have taken the cartridge back to the shop. It was a great game precisely because it was hard and because the levels constantly changed. You had expected and hoped for exactly that.

So too now I expect a life in medicine to be like Sonic. A complaint will come, an exam will be failed, and I will have a terrible day. This is how it is. It is implicit in the game design. If every year were exactly the same as the one before, I would take the cartridge back.

We should still strive for better, but expecting some hard times makes the better times better. It also means that you can plan more effectively for when that tough level arrives and decide how you’re going to deal with it. And you can be there for others when they get to the big boss before you do.

But the game of medicine is also much better than Sonic. Not because of the graphics, or the sound, or the number of rings on offer—but because it doesn’t have an end. There is no big final boss to beat. You can keep playing for as long as you find it enjoyable, remembering that there are other games out there, and you can always go out to ride your bike.

Matt Morgan, intensive care consultant, University Hospital of Wales

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Expecting some hard times makes the better times better
**PERSONAL VIEW  Nigel Edwards**

**NHS political appointees: be careful what you wish for**

The 2021-22 health and care bill gives politicians powers to control how the service runs. But past evidence suggests this may be unwise.

One of the few positives of the former health secretary Andrew Lansley’s 2012 NHS reforms was his determination to remove the health secretary from the day-to-day running of the NHS. But the 2021-22 health and care bill has created some anxiety about a possible attempt by ministers to take more direct control. Shortly before his departure as health secretary, Matt Hancock said that the legislation would give him the power to sign off on senior appointments to local NHS boards. At the same time, in other parts of the public sector, we have seen interest in appointing politically connected people to board positions at institutions such as the BBC and Ofcom.

Now Hancock’s successor, Sajid Javid, begins with a bill that gives politicians powers to control the detail of how the health service is run. An insider recently told me how unsurprising it should be that the government should seek to exert such influence. “Why shouldn’t we seek to appoint Conservatives to positions?” they asked. In this example they weren’t referring to the NHS, however, even if off-the-record briefings have suggested that Simon Stevens, outgoing chief executive of NHS England, was not always compliant with government demands. That Stevens appeared to be more politically skilled than some senior politicians might also have proved irksome.

Labour had a similar view on favourable appointments in the 2000s, but Javid’s advisers should present him with the risks of such an approach and explain why it may not deliver what politicians expect.

The most obvious point is that complex organisations require the best people. Whichever party is in power, the size of its membership constrains the talent pool for recruitment. Appointing people from a wider group known to be sympathetic might get around this problem—but it fails to avoid other problems that are more fundamental.

**Diversity in leadership**

There is a strong argument for more diversity in the leadership of NHS organisations. This is associated with improved organisational performance and innovation. NHS England has made the case strongly, including the important point that it is not reasonable for the boards of NHS organisations to look very different from the population they serve or the staff that work in them.

Mixing political and managerial control can create confusion about where and how decisions are taken. It creates a risk that different messages are transmitted down different routes and reduce transparency. It also cuts across some important principles of good governance. Those responsible for organisations have a key duty of stewardship, safeguarding its long term future.

In countries where key health officials are politically appointed, I have observed a lack of willingness among hospital directors to make difficult decisions and an incentive to postpone anything contentious. As in the UK, hospitals often serve many constituencies, and there is the risk of decisions being distorted by short term political considerations.

Leaders also have an obligation to act as advocates for their organisations and generally take their stewardship role seriously. This can lead to problems for politicians, who may

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**BMJ OPINION  Chris Hopson**

**Tackling demand when capacity is constrained**

The daily case rate for new positive covid tests has now reached around 35 000 a day and the government is predicting it could reach as many as 100 000 a day. The good news is that, for this pattern of variants, vaccines have weakened the link between infection and the high levels of hospital admissions and mortality we saw in previous waves.

But that doesn’t mean the NHS won’t be under huge amounts of pressure. Just focusing on the potential rates of covid admissions completely misses the broader picture. Trust leaders are saying there is a combination of five elements that is causing significant operational problems.

First, trusts are working flat out to tackle the backlog of care. Trusts are operating at maximum capacity to tackle the backlog of elective procedures, including extended use of theatres and weekend working. It’s also important to remember there are other backlogs too—in cancer care, but also in community and mental health services.

Second, trusts are experiencing extreme pressure in urgent and emergency care. We understand that in many instances this reflects an increase in the complexity and severity of some patients’ conditions, as well as pressures on primary care. Everywhere you look, the NHS is seeing demand not just return to pre-covid levels but, often, exceed it.

The third factor is the continuing loss of capacity as a result of the need to protect patients and staff from nosocomial infection. Staff capacity, the fourth factor, has been
find that the people they appointed because they were thought to be sympathetic to
government policy have gone native and are now using their political skills to oppose it.

Where appointees do follow the party line, they risk losing credibility with staff
and stakeholders by failing to advocate effectively for the organisation. It is unwise
to create a culture of compliance in which there is no challenge, and this has been at
the heart of many of the biggest errors made by governments over the years.

Introducing local politicians into elements of NHS governance is often helpful in
ensuring plans are locally sensitive and that links are made between different public
sector plans. But that is very different from politicising key appointments in the system.

Political oversight of publicly funded institutions is legitimate and unavoidable.
The machinery for accountability is already in place, and confusing political and
managerial control is unwise, unnecessary, and potentially damaging.

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Could separate hot and cold sites work?

I

Is it realistic to think of separating NHS hospital sites more effectively for “cold” (elective) and “hot” (acute
and urgent) care, so that outbreaks or seasonal surges don’t lead to elective care being cancelled or delayed?
This month over five million people were waiting for planned care and outpatient appointments in
England—the highest figure on record.

After previous successful drives to tackle waiting lists, waiting times for elective care had been deteriorating in the years before
the pandemic because of staffing pressures, financial constraints, and insufficient beds, clinics, or diagnostic services.
The pandemic massively accelerated worsening waiting time performance and has set back any improvement for years.

Although we often discuss such care as “routine” to differentiate it from acute care, in reality many of the people on ever
longer waiting lists are frightened and in deteriorating health, their quality of life impaired. And those waits include “urgent
elective” delays for suspected or confirmed cancer. In turn, professional leaders, the media, and the public have expressed
concern about mortality and morbidity and the secondary harms of gearing up NHS services to cope with covid surges in
people with other conditions. Government officials, campaigners, researchers, and commentators argue that we’ve overvalued
covid at the expense of all other conditions. Government, media, and the public have expressed

Health policy and management experts and clinical leaders have argued that if we could separate “cold” and “hot” hospital sites the
capacity in elective care wouldn’t be affected by pressures on acute care, including from infectious diseases.

NHS general hospitals have made serial attempts to “ringfence” elective inpatient and day surgery beds to prevent
cancellations. These are often over-ridden under severe pressure on acute admissions
and emergency department waiting times. Again, we saw this during the pandemic.

Using dedicated “cold” elective care centres could enable much more intensive
use, as every bed and theatre space can be occupied efficiently and appropriately. In
a pandemic, such centres would also be easier to protect from outbreaks and the
associated bed closures, cancellations, and hospital acquired infections.

However, such facilities often don’t have the same access as general hospitals to
critical and intensive care, 24 hour onsite emergency cover, or specialist acute input.

As things stand, I see no prospect of a major increase in elective capacity or
workforce, let alone a major building programme. Elective care and its patients
will remain vulnerable to the fallout from acute demand surges, as well as pandemic
or seasonal viruses, even if we catch up on the big and growing backlog.

The line between acute and elective care can be blurred

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Will a restructure help patients?

Another health and social care bill is on its way through parliament, changing again the way decisions are made. Do many doctors or patients really care who sits at the top table making commissioning decisions, as long as services continue to be provided free at the point of care? Should we be concerned about this bill?

The most positive aspect of this bill is the removal of the requirement for competitive tendering. This was brought in with the last set of reforms (the 2012 Health and Social Care Act), the aim being to improve quality and reduce prices using the mechanisms of the market. There isn’t much evidence that this has been achieved. Collaboration is now the flavour isn’t much evidence that this has been achieved. Collaboration is now the flavour.

Clinical commissioning groups are being merged and their functions taken over by integrated care boards (ICBs), which will include representatives of hospital trusts, local authorities, general practice, and other stakeholders. The inclusion of private sector providers on ICBs has led many campaigners to ring alarm bells. If a company has a commercial stake in how services are commissioned and designed, should it have a say in those decisions? Can we be confident a company will prioritise providing the best possible care over maximising returns to its shareholders?

It’s not clear that the middle of a pandemic is the right time to make sweeping changes, but many NHS issues need urgent attention. We have a huge workforce problem and a crisis in social care, widening health inequalities, and inadequate funding. Unfortunately, nothing in the bill tackles these. There’s also no sign of public accountability: we should have a right to scrutinise how decisions to spend our money are reached.

There is, however, a remarkable power grab by the health secretary, who seems to have the right to intervene if an appointment—or decision—made by an ICB is not to his or her liking. The BMA has rightly cried foul and suggested the government think again.

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ANALYSIS

Aiming beyond equality to reach equity: the promise and challenge of quality improvement

Improving services must move beyond only measuring average quality to focus on equity to support achieving effective universal health coverage, argue Lisa Hirschhorn and colleagues

Close to 20 years after the seminal Institute of Medicine report Crossing the Quality Chasm, the Lancet Global Health Commission on High Quality Health Systems found that poor quality care accounts for more deaths than lack of access to care. The most disadvantaged populations have the worst outcomes, reflecting how much work is needed.

We use the Institute of Medicine definition of quality, which emphasises equity as one of the six dimensions of quality, to call for the quality improvement (QI) community to include equity more effectively as we work to ensure the quality needed to achieve the promise of universal health coverage. We believe that QI can be a powerful tool to achieving equitable high quality healthcare, but better methods and focus are needed.

The World Health Organization defines equity as “the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.”

But equity is often forgotten or not explicitly measured and targeted in interventions for health system improvement. Experience shows that traditional QI methods can maintain or worsen health inequities across subpopulations. These failings are exposed by the current covid-19 pandemic, where, unsurprisingly, inequities intrinsic in health systems and society are magnified for the most disadvantaged populations.

There can be three possible outcomes of QI on equity: improvement for all but maintenance of the quality gap (equality in improvement); improvement more in the disadvantaged population (decreasing the gap); or improvement more in the advantaged population (widening the gap). QI initiatives must prioritise equity in how they design and measure change among disadvantaged subpopulations and strengthen the evaluation needed to know which of these three outcomes they have achieved.

For example, the US based Diabetes QI Collaborative improved care for white but not Latino patients, worsening inequity and widening the gap. Analysis found flaws in the programme design contributing to this outcome, such as English-only communication, absence of interventions to deal with barriers specific to the Latino population, and no disaggregation of data to detect changes by ethnic subgroup. Similarly, pay-for-performance initiatives, which have gained popularity with global funders, can also result in worsening equity. For example, Medicare’s Hospital Readmissions Reduction Program was associated with higher rates of readmission among black people for conditions not targeted by the financial scheme in safety net hospitals but not in more resourced hospitals.

How can we do better?

These examples underscore the importance of proactive identification of drivers of inequities, and QI designed with clear equity related aims. This intentional integration into QI aims, intervention design, and programme evaluation is required to reduce inequities as quality is improved. This work will require expanding interventions to include the underlying political, social, and structural causes of health inequities.

National health systems, payers such as insurance and donors, and QI implementers must also expand their scope to identify and tackle these factors outside the individual provider or facility, such as social determinants of health, governance, and health system design, which can happen only by engaging communities more deeply in identifying solutions.

Work is also needed to tackle the intrinsic and extrinsic biases within the health system and in the community, which can underlie ineffective QI design and implementation. Increasing the involvement of patients and community members in QI design, raising their expectations of health system performance, and prioritising measurement of patient reported outcomes and experiences are also improvement strategies needed to achieve equity.

We also recommend that designers incorporate planned data disaggregation upfront to look at changes among commonly affected population groups.

KEY MESSAGES

- Poor quality care accounts for more deaths globally than lack of access to care
- Work to achieve universal health coverage therefore needs to consider effectiveness and equity
- Without prioritisation of equity, population level improvements in healthcare may mask those left behind because of economics, gender, ethnicity, or location
- We suggest five key areas where strategies for quality improvement need to tackle inequity: stakeholder engagement, measurement, design, improvement work, and learning
disadvantaged subgroups such as wealth, race, and location. Measurement should include implementation outcomes such as acceptability and adoption and data elements needed to understand the underlying factors associated with success or failure in reducing inequity as quality improves. Disciplines such as implementation sciences and disparities research offer tools and frameworks that can accelerate this work.11,12

While this broader approach to QI may seem daunting, we describe an initiative led by two of the authors (HM and AK) in Ethiopia and lessons learnt to inform how we can improve the way we design, implement, and define success of QI.

Equity focused QI: the Ethiopia healthcare quality initiative

The Ethiopia healthcare quality initiative began with the Institute for Healthcare Improvement supporting development by the Ethiopia Ministry of Health of a national healthcare quality strategy in 2015, setting the vision and leadership for a high quality equitable health system and the high priority interventions and policies needed to translate the strategy into action. This was supported by the building of QI competency at all levels of the health system to create local champions, who served as Ministry of Health employed QI experts, to sustain capability building in the country.

These steps were important in facilitating the co-design and testing with the Ministry of Health of a district-wide approach to managing and improving quality explicitly to support populations with the worst maternal and newborn health system experience and outcomes and show the impact of QI on maternal and newborn health.

The Institute for Healthcare Improvement worked with the Ministry of Health to include equity in site selection, which led to inclusion of pastoralist communities, given their worse maternal and newborn health outcomes. This intentional inclusion of some of the hardest to reach and underserved ethnic groups deepened understanding of diverse population needs, preferences, and health system challenges and their impact on quality.

The initiative also prioritised broad stakeholder engagement, leveraging QI expertise and leadership within the federal and regional governments in the country. These strategies resulted in a cadre of embedded improvement leaders, trained to prioritise equity, who will continue the work beyond partner engagement. Federal and regional leaders supported district level leadership to build a culture of learning through improvement collaboratives and identification of local contextual factors that needed to be tackled.

Key stakeholders across the health system, including patients, community health workers, clinical providers, and data managers, convened in learning sessions to empower frontline providers with QI methods and to use their own data to identify problems in inequity of quality and access, create and test solutions, and spread positive change quickly.

Measurement and feedback were designed to increase the input of patients and communities as core to increasing equity by ensuring that they informed problem prioritisation and solutions. Patient experience was put at the centre of the improvement process through community engagement in the collaboratives and inclusion as a performance measure. In addition, government quality unit leaders trained providers to use data to advocate effectively for solutions identified through this engagement but beyond their immediate resources, further increasing the involvement of patients and communities.

The Ethiopian healthcare quality initiative resulted in improved quality overall, with two thirds (67%) of facility QI teams reporting over 90% adherence to all labour and delivery bundles and almost 75% of these teams reporting improvement in at least one outcome of maternal and neonatal service coverage.14 Importantly, inequity of quality was reduced for indicators such as antenatal care (equity gap reduced from 15 to 8 percentage points) and similar improvement was seen for new measures across regions, with some of the largest improvements found in the traditionally disadvantaged pastoralist areas.

How can the QI community increase equity of QI focus and outcomes?

We make the following recommendations, including which data we use and how we use them and how QI is designed, implemented, and monitored, to help accelerate the work to improve inequities through QI.5,7 The appendix on bmj.com gives further details on how these recommendations were applied in the Ethiopia healthcare quality initiative.

Engage better

Ensure that you have identified your key stakeholders in and beyond the QI team to understand the root causes from perspectives within and external to the health system. This should include people representing the lived experience of inequities in quality and policy makers able to facilitate the system changes needed. Keeping these individuals as active participants as you design, test, and refine the QI will increase your understanding and more effectively tackle quality and inequity.

This strategy was important in Ethiopia and has been seen in other improvement work. For example, participatory women’s groups—used to identify and convene women often from marginalised subgroups—support their prioritisation, and problem solving at the household level has been effective in reducing neonatal mortality and reducing inequities.15 While this approach may not be traditionally categorised as QI, the purposeful engagement of these women to join in a structured...
process of problem identification and resolution is an area where QI can increase impact on inequity.

Measure and use data better
Design and use your data to identify inequities from the start. In many contexts, the lack of relevant data may be part of the problem of continued neglect, implicit bias, and structural inequities. Programme designers may need to look beyond traditional health metrics, including qualitative measures to iteratively identify disparities and underlying causes, to inform the work to improve quality and close the equity gaps.

Planning for disaggregation from the start, similar to that planned in the work in Ethiopia, is also critical. For example, the English NHS has included health equity indicators to identify disadvantaged neighbourhoods and impact of expanding primary care in equity of access. Through disaggregation, covid-19 research has rapidly identified disparities in outcomes and identified the need to design QI to tackle underlying determinants as well as quality of care received.

Design better
Prioritise tackling barriers identified through your stakeholders of groups least served by the health system. Reaching the most disadvantaged will take innovations in strategies and learning from other groups already showing progress in these areas. For example, the role of patient navigators to improve uptake of cancer screening among African American women has now been expanded to increase access and uptake in settings across Africa, Asia, and Europe for other conditions.

The use of community health workers to improve access and uptake of interventions to reduce child mortality among those in more remote areas is another example of equity focused interventions.

Improve better
Move beyond conventional ways for improvement to include areas outside the scope of traditional QI and take a “whole quality management” approach. The work requires quality planning and leadership that intentionally prioritises equity; tackling gaps in the health system structure such as human resources, systems, health financing, and governance associated with disparities; and moving beyond the health system to include social determinants of disease and factors such as female empowerment and education associated with better access and survival.

The work will require new partnerships and interdisciplinary approaches to deal with the often vast quality gaps and where root causes also go beyond the health sector.

Learn better
A robust internal learning system is required to monitor QI implementation to iteratively adjust to ensure equity while increasing impact. Lessons from disciplines such as implementation science, disparities research, realist evaluation, and patient centred outcomes research to better understand contextual factors will need to be applied during QI, and those that will influence implementation strategies will also strengthen equity targeted QI.

For example, in Bangladesh, recognition that strategies that improved access to family planning were ineffective owing to systems and culture barriers informed adaptation to strategies and improved uptake. More effective dissemination of results of equity focused QI is also needed to move the focus beyond the already broad literature describing existing disparities. This approach will also help the QI community understand and learn how and why QI did or did not improve quality and if disparities were reduced or eliminated.

Conclusion
QI impact is challenged by approaches that can ignore or even worsen inequities. As illustrated by the Ethiopia initiative, a participatory strategy to improve the design and implementation of solutions needs to go beyond the traditional clinical and individual focus and QI methods to include the broader systems, governance, and intersectoral responses needed to tackle underlying social determinants of access and health and structural inequity. Intentional stakeholder engagement from leadership through to frontline providers and, critically, the patient and community is needed to inform the design, ensuring the QI tackles root causes within and beyond the health system and support work throughout its implementation. Investment in measurements to monitor equity and increase patient involvement through experiential quality and patient reported outcomes is also needed.

Changing what and how we measure will need commitment from funders, insurers, multilateral and bilateral institutions, policy makers, and other leaders who define metrics for accountability and payment, and will need to increase community engagement in this process.

A multidisciplinary approach including implementation science, patient centred outcomes, and research can offer additional tools to QI to better understand context, strengthen stakeholder engagement, and create more generalisable knowledge to accelerate scale and adapt quickly to meet the needs of the most disadvantaged. While goals of scale and equity often conflict, health system leadership must act to transform this dynamic and achieve high quality care for all.

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Defining covid-19 elimination
Having zero tolerance for new cases is achievable and should not be confused with eradication

Throughout the pandemic, the word “elimination” has been used in different senses. Many confuse elimination with eradication, which normally means permanent reduction to zero of the worldwide incidence of an infection—as was achieved for smallpox. This confusion helps to make the idea of eliminating covid-19 seem impossible and not worth pursuing. Elimination is variously defined but stops short of permanent eradication of infection. Countries pursuing an elimination strategy have experienced less disruption and economic damage than those that have focused on mitigation to protect health services. A comparison of five member countries of the Organisation for Economic Cooperation and Development that aimed for elimination with 32 others that opted for mitigation indicated that elimination creates the best outcomes for health, the economy, and civil liberties. The authors defined elimination as “maximum action to control SARS-CoV-2 and stop community transmission as quickly as possible.” This is an action oriented definition, which acknowledges that some community transmission of the virus will occur after importation, though steps will be taken to extinguish it. A similar approach was advocated by the head of the New Zealand health service, who declared that elimination focuses on zero tolerance towards new cases, rather than a goal of no new cases.

No agreed definition
The World Health Organization has defined elimination of tuberculosis as a reduction in prevalence to below one case per million population. A WHO definition for the elimination of measles in a country allows for importation of cases, as long as endemic transmission of the measles virus strain does not continue for more than 12 months. So far, there is no internationally agreed definition for the elimination of SARS-CoV-2.

Several countries, mainly in the Asia-Pacific region, have adopted an elimination strategy for controlling SARS-CoV-2. They have experienced relatively small burdens of covid-19 disease and relatively few deaths, but none has had “zero covid” for a prolonged period. Even with border restrictions and strict quarantine, incursions of the virus occur from time to time, leading to clusters of infections and occasional large outbreaks.

The likely consequences of not aiming for elimination have been detailed by leading researchers Christopher Murray and Peter Piot, who predicted that SARS-CoV-2 may become a recurrent seasonal infection in the US, requiring health system change and “profound cultural adjustment for the life of high risk individuals in the winter months.” Moves in some countries, including England, to relax public health and social measures for controlling the virus in partially vaccinated populations might drive the emergence of new variants that are resistant to current vaccines. If such variants caused severe disease, the case for an elimination strategy would become compelling.

The emergence of more transmissible variants presents challenges for controlling SARS-CoV-2 by conventional public health measures. Yet stamping out most covid-19 should be more feasible with the advent of highly effective vaccines—if current problems of global scarcity and inequitable distribution can be resolved.

Ambition, leadership
The effects of high vaccination coverage in Israel show what can be achieved and that vaccination must be combined with other measures including widespread testing, isolation of cases, contact tracing, and social measures such as mask wearing. This requires political leaders capable of convincing citizens of the huge benefits of stopping community transmission. That will be difficult in places where citizens are already wearied by the faltering control efforts of the past year.

An unduly strict interpretation of elimination may discourage countries from adopting this ambitious approach. Instead of being equated with “zero covid,” elimination of SARS-CoV-2 in a population could be defined as “achievement of a situation in which outbreaks of covid-19 are extinguished eventually, with no continuing widespread transmission.”

The Independent Panel for Pandemic Preparedness and Response has urged WHO to develop a road map to guide efforts towards ending the covid-19 pandemic within countries and globally. In doing so, WHO should set out and promote a realistic definition of elimination in the context of SARS-CoV-2. This would encourage ambition, rather than defeatism, in confronting the coronavirus causing such havoc around the globe.

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Primary services have key role in end-of-life care

Higginson and colleagues emphasise the need for high quality, community end-of-life care as an ongoing concern for the NHS (Editorial, 19 June). The role of primary care in end-of-life care needs much more attention, as reported by The BMJ over the past two decades.

Primary care has had a key role in the delivery of end-of-life care to patients dying at home during the covid-19 pandemic, adapting rapidly to meet increased need. Clinicians and managers from primary care and specialist palliative care have worked collaboratively to identify concerns and find timely solutions. District nurses, alongside care home staff, have delivered most of the face-to-face end-of-life care in the community. They report feelings of isolation, however, as other services increased remote consultations. Reducing face-to-face contact with dying patients caused moral distress for general practitioners. Primary care services managed patients with increasingly complex needs and saw a large number of rapid deaths, particularly in care homes. For many patient-facing community professionals, there has been a significant emotional impact.

Higginson and colleagues highlight the lack of systematic evidence to understand the quality of end-of-life care delivery during covid-19. The role of primary care in end-of-life care is vital but has received little attention. There are renewed calls for funding for palliative care services. As healthcare services move through the next phases of the pandemic without new funding, more community focused, collaborative approaches are needed. Specialist and generalist professionals are united in their desire to tackle longstanding inequities in access to palliative and end-of-life care. Primary care has the potential to deliver high quality community end-of-life care for all who need it.

Sarah Mitchell, GP and Yorkshire Cancer Research senior research fellow; Helen Chapman, district nurse head of integrated community care; Iolanthe Fowler, GP clinical director of integrated community services; Laura McTague, community consultant in palliative medicine, Sheffield

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COVID-19 LEADERSHIP FAILURES, NATIONAL AND GLOBAL

No veterinarians on the Italian covid-19 committee

Smyth cites ‘long overdue structural reform’ as a factor in the disintegration of Northern Ireland’s secondary care services (This Week, 19 June). For decades, reform has been proposed as the solution to a serially underfunded NHS and social care system.

McKinsey model solutions—stratification of care and pathways, further reductions in hospital capacity, down-skilling of staff, outsourcing and privatisation of services, increasing restrictions to accessing care—have been implemented. But the problem has worsened to a dangerous degree.

Consolidation is a corporate solution, not a medical one. It depends on cuts, and it invariably reduces access and quality of end users’ experiences. Spare capacity should be seen as essential—a huge asset and useful for future planning with flexibility.

Without the basics in place, the rest is just more unpalatable hubris. The NHS never was ‘unsustainable,’ as Smyth implies, but the lie that more reform is the solution somehow prevails.

Nick Mann, GP, London

Cite this as: BMJ 2021;374:n1763

SEVEN YEAR WAIT IN NORTHERN IRELAND

More “reform” is not the solution

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Nick Mann, GP, London

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WHEN DID YOU LAST SEE YOUR DOCTOR?

The NHS is close to the edge

Salisbury draws our attention to the excessive demands that UK GPs now face (Helen Salisbury, 19 June). Perhaps we should go further and acknowledge just how close to the edge our chronically underfunded NHS has been running. A lack of beds, a lack of psychiatry support, growing waiting lists, more treatments, and now an entirely new disease with its various facets—something’s got to give.

Primary care takes the brunt. Do we blame our colleagues for using the simplicity of the phone consultation to achieve a more efficient and less emotionally taxing clinical interaction? And perhaps losing the perception of efficacy is better than losing efficacy itself. We should be clear about why appointments are difficult to get and why we have to cut short our interactions—if the public doesn’t demand more NHS resources, then why would their elected officials be bothered to provide them?

Daniel K Goyal, consultant physician, Inverness

Cite this as: BMJ 2021;374:n1709
OBITUARIES

Geoffrey Baum
GP (b 1928; q Birmingham, 1952; DOBST RCOG), died from covid-19 on 14 January 2021
Geoffrey Baum (“Geoff”) was the quintessential and totally committed family GP, working singlehanded in Hounslow from 1959 until 1998, when his niece, Mandy Baum, joined him and took over as senior partner. Geoff retired in 2004. He was always determined that every patient should have the best possible care. His particular interest was in obstetrics. Geoff was elected a fellow of the BMA in January 1991 and was a highly active member of what was then called the South West Middlesex Division. He served for many years as social secretary and then as chairman. He was chairman of the local medical committee and on the area committee for the Royal College of General Practitioners as well as various other committees related to general practice. Any spare time was spent playing golf and bridge. He leaves his wife, Shirley; two children; and five grandchildren.
Michael Baum
Cite this as: BMJ 2021;373:n1142

Hakim BenYounes
Consultant surgeon and chief of medical services University Hospital Wishaw (b 1959; q Al-Fateh University Medical School, Tripoli, Libya, 1983; FRCS (Edin), FRCS (UK)), died from complications relating to major cardiac surgery on 3 November 2020 Hakim BenYounes travelled to Scotland in 1987, planning to sit the fellowship examination for the Royal College of Surgeons and return to Libya. But when working at Law Hospital, Carluke, in 1988, he met Susan, a medical registrar, who was later to become his wife. His academic research gained him a training number in Aberdeen, which he took up in 1996. In 1998 he was appointed consultant surgeon at Law Hospital. He was appointed as associate medical director in June 2011, before accepting the post of chief of medical services at Wishaw General Hospital. Hakim leaves his wife, Susan; his family from home and abroad; and his many friends and colleagues.
Gavin Bryce
Cite this as: BMJ 2021;373:n1149

Corinne Alison Rees
Associate specialist community paediatrician Bristol (b 1952; q Oxford/ Bristol, 1976; MA (Oxon), FRCP, Hon FRCPCH), d 15 December 2020 Corinne Alison Rees (née Illingworth) came from a medical family. She did her clinical years in Bristol, spent her elective period in Tanzania, and graduated with several prizes and distinctions before embarking on a career in paediatrics. Appointed as an associate specialist in 1991, Corinne relished not being a consultant: she could do the job she loved without being overburdened with administrative responsibilities. She had a special gift for engaging with children and took on national roles relating to adoption services. Corinne devoted much of her last two decades to the care and support of her daughter, who had become increasingly physically unwell from the age of 8. This gave her insights into the challenges and priorities in managing chronic illness. She leaves Gareth; two children; and two grandchildren.
Gareth Rees
Cite this as: BMJ 2021;373:n1145

Anna Rachel Lewis
Specialist trainee in geriatric medicine (b 1980; q Sheffield, 2005; MRCP UK, geriatric medicine), d 10 February 2021 Anna Rachel Lewis completed her core medical training at Sheffield Teaching Hospitals, before going travelling with her sister in 2010. By 2012 she was working as a medical registrar at Tauranga Hospital, New Zealand. She returned to the UK in 2014 to specialise in geriatric medicine. She was an excellent clinician and an inspiration to those junior doctors following in her footsteps. As part of her training rotation in the East Midlands, Anna undertook the first specialist geriatric oncology post at Nottingham University Hospitals NHS Trust. Subsequently she had a key role in managing end-of-life covid patients in the hospital. Anna was at her happiest when travelling. She leaves her parents, Len and Kath; sister, Kate; brother, Richard; and innumerable friends and colleagues from all over the world.
Kath Shakespeare, Kate Lewis, Ruth Willot
Cite this as: BMJ 2021;373:n1144

Antony Graham Davies
Medical physiologist (b 1933, q St Andrews, 1958; MD, PhD), died after a fall on 23 February 2021 Antony Graham Davies (“Tony”), a committed Quaker Christian, refused military conscription but joined the British Antarctic Survey in 1959-62. His studies gained him a doctorate in 1963. He worked at Birmingham Women’s Hospital and the university from 1968 to 1983. Driven by a deep concern about injustice and a compassion to help those in the most deprived situations, he worked for 10 years in Africa. Through many visits up to 2016, he supported the Palestinian people and their impoverished medical college. He was a staunch pacifist and active campaigner against nuclear weapons. His simple lifestyle, practical compassion, quiet determination, and faith were an inspiration and challenge to those around him. He leaves his wife, Vivienne; four children; grandchildren; and great grandchildren.
William A M Cutting, Stephen Rigden-Green
Cite this as: BMJ 2021;373:n1143

Keith Glennie-Smith
Consultant anaesthetist, Poole General Hospital (now Poole Hospital NHS Foundation Trust) (b 1927; q St Thomas’ Hospital Medical School, London, 1951, FFARCS), died from covid-19 followed by pneumonia on 27 February 2021 In 1963 Keith Glennie-Smith was offered the position of consultant anaesthetist at Poole General Hospital, where he practised until his retirement. He developed a keen interest in acupuncture, and in 1977 he set up an experimental acupuncture clinic at the hospital. A year later, the clinic was granted official status, with the proviso that the application of acupuncture must be primarily for the relief of pain. During his medical career, Keith was approached by a team from the anaesthetic department and the Bournemouth Ambulance Service, to produce a film promoting the advanced training for ambulance men. Keith was a talented musician, watercolour artist, and photographer. He leaves his wife, Celia; four children; and seven grandchildren.
Janet Oliver
Cite this as: BMJ 2021;373:n1148

Kath Shakespeare, Kate Lewis, Ruth Willot
Cite this as: BMJ 2021;373:n1144
Talking to his houseman on a plane flying home, Harith Lamki suggested the young man make a career in obstetrics and gynaecology. Jim Dornan took the advice and, Lamki says, “The rest is history. He bloomed!”

Dornan was chair of fetal medicine at Queen’s University Belfast; he set up the research charity Northern Ireland Mother and Baby Appeal (NIMBA, now TinyLife); and was a leading figure at the Royal College of Obstetricians and Gynaecologists. In a career spanning four decades, his research into detecting high risk babies in low risk mothers helped change the landscape of obstetrics, saving many babies from stillbirth.

Early life and career
Dornan was born in Holywood, County Down. His father—also Jim—was the general manager of the Incorporated Cripples Institutes (now HarmonI), where the family lived and where his mother, Clare, practised as Northern Ireland’s first occupational therapist. Dornan and his two sisters, Carole and Debbie, spent their childhoods in 1950s rural Ireland. They also absorbed the ethics of their father, a staunch Methodist and ecumenist who strongly believed in giving back to society. In 1960 Dornan went to Bangor Grammar School, where he revelled in debating and acting. He was particularly proud of playing Falstaff and Lady Macbeth.

In 1967 Dornan won a place to study medicine at Queen’s University Belfast and was smitten by his first delivery, saying, “When you first see a birth, it just changes you.” He later said he was even more captivated when the first ultrasound arrived. “Suddenly, instead of communicating with the baby through the mother, you were communicating directly with the baby.” After a year in Kingston, Ontario, Canada, working for Knox Ritchie, Dornan returned to Northern Ireland in 1977 and decided that obstetrics—with its mix of surgery, general medicine, and psychology—was the right choice for him.

In 1986 Dornan became consultant at the Royal Victoria and Royal Maternal hospitals in Belfast and in 1993 director of fetal medicine. In 2003 he was appointed professor of health and life sciences at the University of Ulster and in 2005 professor of fetal medicine at Queen’s University. Colleagues describe him as quick and deft, carrying a little notebook to jot down the ideas that poured from his fertile mind.

But amid the research and high level meetings, Dornan never lost sight of his patients. He had a particular interest in psychology, and his colleague obstetrician Carolyn Bailie said, “In fetal medicine there’s a lot of giving bad news to parents, and Jim had a humanity about him. He was always able to find the right words when parents were distraught.”

Family life and wider interests
In 1970 Dornan’s eye was caught by nurse Lorna Jordan at the side of the university swimming pool. They married five months later, and had three children: Liesa, Jessica, and Jamie. Lorna died from pancreatic cancer in 1998 and to raise awareness of the disease Dornan’s research into detecting high risk babies in low risk mothers helped change the landscape of obstetrics
Dornan became president of the charity NIPanC. Cancer would affect the family a second time, when aged 57 Dornan found himself unaccountably tired walking home and diagnosed himself with leukaemia. Nevertheless, he managed to continue to work and became prominent in the Royal College of Obstetricians and Gynaecologists, where he was a fellow on the council for 12 years and senior vice president from 2004 to 2007. In 2002, Dornan married Samina Mahsud, a fellow gynaecologist and obstetrician. Her career took her to Dubai and, to be closer to her, Dornan accepted a job in early 2020 as head of department in the Royal College of Surgeons Ireland in Bahrain. He continued to maintain his active research network, contributing to projects he was passionate about including a cross border perinatal health project in Ireland.

Throughout his life, Dornan was close to his family. He supported his actor son Jamie’s career, taking great delight in acting alongside him in The Full, as well as taking a cameo role in the TV drama Marcella. With his daughter Jessica he set up Afterbook, a website for recording memories of loved ones. Dornan enjoyed sailing and golf, and in anticipation of hosting family in his Connemara home in the summer of 2021 he decided to have knee surgery. It was a success, but shortly afterwards he caught the coronavirus and died aged 73.

He leaves Samina, three children, and seven grandchildren.

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Cite this as: BMJ 2021;373:n909