Editorial

Nationwide quality improvement—how are we doing and what can we do?

Quality improvement frameworks and methods have developed over the last 100 years.

Ernest Codman developed his End Result System at the beginning of last century, suggesting that all patients should have their outcomes evaluated at discharge and one year after [1].

In the 1920s, Flexner evolved his Hospital Standardization Program, which in 1951 developed into the foundation of Joint Commission of Healthcare Organizations, which now accredit more than 85% of all health organizations in the United States and conduct a remarkable share of accreditation in other parts of the world[2]. Lembcke described audit methods in the 1950s, suggesting medical auditing using scientific methods [3].

Avedis Donabedian, the founder and father of modern quality improvement, described and developed in the 1960s most of the framework that we use for quality improvement [4]. Heather Palmer has updated and developed quality improvement frameworks and explored different methodologies since the 1970s [5]. At the same time, Robert Brook introduced epidemiologic methodologies and thinking in quality improvement in terms of indicator monitoring in outcomes assessments and appropriateness studies [6].

So in conclusion: the methods are there, and we have used them to explore and assess the medical technical aspects of care in terms of prevention, diagnostics, treatment, care, and rehabilitation; the organization of care in terms of continuity and coordination of care, and patient centeredness in terms of patient priorities and satisfaction.

The question is then: how are we doing?

The literature indicates that, that there is [1] lack of documentation of the quality of care for most important diseases in most health care systems [2]. Few goals for treatment of important diseases. In other words, it is unclear what we actually want to achieve when treating patients with even important diseases and conditions [3]. Lack of resource evaluation. What do tax payers get for their money and investment in health care [4]? Huge variations have been identified at local, regional and national levels. Variations in health care is the rule rather than the exception [5]. Lack of outcome assessment [7]. For most patients, we will never know which outcomes our patients have achieved, because we never do systematic assessments of patient outcomes.

The documentation that we do have about the quality of care indicates serious quality problems. McGlynn has documented that US adults receive half of recommended care for common acute and chronic conditions as well as for key preventive services in different cross-sectional studies [8]. These findings are consistent with the findings of Mainz et al. in a nationwide indicator program [9].

But there are few studies describing the quality of care on a national level, and most of them are cross-sectional studies that can only paint a picture at a certain time. Few countries are in fact able to document the quality of their health care system. There is a lack of documentation. A lack of measurement.

The question is then: what can we do?

A precaution for quality improvement is documentation of the quality of care. We need to know our base line at national level. Globally speaking, we need to move from the micro perspective, with quality improvement activities only at local and regional level, to the macro perspective of quality improvement with national and international quality measurement systems and comparisons.

There is evidence indicating that quality measurement and quality monitoring combined with feedback, auditing, and public disclosure of measurement data lead to improvements of the quality of care. So, investments in quality measurement and reporting systems would substantially increase the opportunities for quality improvement and to share and learn from cross-national and international comparisons.

In fact, performance and outcome measurement using indicators represent the only way to obtain quantitative data on the quality of care for quality improvement [10].

Extensive research into quality of care in different countries yields no conclusive findings that one system is better or worse than others. Quality does not necessarily vary with financing mechanisms, and the quality is not directly related to the amount spent on healthcare, because the highest-spending countries do not have measurable better outcomes [9]. So, it seems there is no perfect health care system [11]. All countries need to improve their quality of care according to their measurement and track the quality of patient care [9]. There are attempts to develop global systems, but in most countries there is no mandatory national system to track the quality of care delivered to the citizens [12].

Quality improvement methods and frameworks are here to stay, but at national and international level we have to invest in quality measurement systems. The literature indicates that it will get paid in terms of improvements of patient care.

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References


