QUALITY ASSURANCE IN HEALTH CARE

WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

Institut für Gesundheits-System-
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TARGET 31

Ensuring the quality of services

By 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems.

Index:

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QUALITY ASSURANCE IN HEALTH CARE

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Note

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Introduction

The Working Group was composed of 27 individuals from 11 countries in Europe and from the United States. They included physicians, nurses, administrators, medical sociologists and health care information specialists, all of whom are concerned with developing effective means to measure and improve the quality of care in both hospitals and primary care settings.

The charge of the Working Group was to discuss how to introduce and organize quality assurance in hospitals and primary health care settings. Building on the results of a WHO working group on the organization of quality assurance, held in Copenhagen in May 1987, on the work carried out in the WHO programme on quality of care and technologies and on experiences already gained in different countries, this Working Group was to develop models for quality assurance in hospitals and primary health care, and specifically to look at such issues as:

- how to motivate administrators and health care providers to adopt quality assurance;
- the role of different personnel categories in quality assurance;
- how to finance quality assurance;
- what kind of care to assess;
- what kind of bodies to set up;
- the terms of reference and composition of such bodies;
- reward systems for quality assurance;

- the implementation of corrective action; and
- the evaluation of the outcome.

Discussion

The motivation to involve health professionals and managers of health care organizations is critical to the success of any quality assurance programme. While external motivation such as laws and financial penalties may stimulate activity, meaningful changes in practitioner performance and institutional effectiveness are likely only when quality assurance is undertaken by health professionals for reasons of self-improvement. Data demonstrating variations in performance may be useful tools for stimulating professional interest in quality assurance activities. These variations could include differences in the indications for surgery, drug use or other treatment, in outcome and cost, in the rates of infection or other complications, in the level of accuracy of diagnoses, in mortality rates and in other patient care outcomes including patient satisfaction.

The roles of personnel and the organization of quality assurance bodies are closely intertwined. Quality assurance is most effective when it is integral to the existing management of the health care organization. Accordingly, each department of a hospital and each organizational unit of a primary care organization must define its own structure and personnel roles in quality assurance. (It is clear that the manager or head of each department is ultimately responsible for quality assurance in that department. Others in that department may participate as members of a departmental committee or task force, or as individual quality reviewers.) It is essential, however, that the selection of quality indicators be based on international experience, and take into account the opportunities for data collection, analysis and action. Follow-up should be clearly

defined: some results will only be relevant to the unit itself, while others may usefully be compared routinely with other health care services with similar health care problems.

At the hospital level, there should not be a quality assurance structure that competes with the existing management structure. A group or committee of representatives from each department should, however, be charged with overseeing and coordinating the hospital's quality assurance activities. This group must include at least physicians, nurses and administrators.

Since complete and accurate medical care information is an essential prerequisite for quality assurance, skilled medical records (documentation) personnel and information system/data analysis experts are also essential.

In an ideal world, quality assurance would be entirely an internally motivated, continuous management activity for health professionals and health care organizations. Realistically, however, the quality assurance process must occur at several levels of activity, in order to ensure feedback of the relevant comparative information on quality, to address issues that cut across organizational units and to provide for public accountability.

Health care professionals, in collaboration with quality assurance bodies within hospitals or primary care organizations, must be responsible for deciding what aspects of care should be monitored, choosing the quality indicators to be used, interpreting the collected data and acting on the problems identified. External bodies should ensure that quality monitoring is being done, that the results of these activities and the interpretation of the data are valid, that corrective action is taking place, and that the outcome of care is indeed improved as a result. In addition, external bodies can identify

certain broader quality indicators that should be uniformly defined and monitored in all hospitals or primary care organizations. Thus, the internal quality assurance bodies would receive regular, systematic feedback on comparative quality performance and outcome. They can then ensure that they are achieving acceptable results according to these broader quality indicators.

Extreme care must be taken to assure a proper blend of intramural and extramural activities. Extramural, punitive approaches to quality problems are unlikely to produce change in individual or organizational behaviour. Further, comprehensive external quality monitoring would be prohibitively expensive. Conversely, isolated, episodic internal studies are likely to miss important interdepartmental or interhospital problems, do not permit feedback of data on interorganizational quality performance and outcome measures, and are unlikely to satisfy public demands for accountability for the quality of care provided.

The financing of quality assurance activities must be an integral component of the budget of the health care organization. Effective quality assurance requires adequate fiscal resources for the personnel and information systems necessary to manage the process. An investment of several per cent of the institution's budget would be consistent with the level of financial commitment to quality assurance found in other industries.

Services or conditions that pose a high risk to the patient or which are known to be or suspected of causing quality problems should also be high priorities for monitoring. Some examples in hospitals might include:

- the use of high-volume or high-risk drugs such as antibiotics, sedatives and narcoleptics;

- the use of blood;

- hospital-acquired infections;
- the use and interpretation of radiograms;
- the use of specific surgical procedures; and
- the nursing care of patients at risk of embolism.

In primary care, similar high-priority examples could include:

- immunization practices and outcome;
- the management of highly prevalent chronic conditions such as diabetes mellitus and hypertension; and
- screening for and follow-up of treatable diseases.

Reward systems for quality assurance should focus on evidence of improvement in quality, as measured by health outcome or the reduced use of resources. Positive incentives for improvements are more important than punishment for poor quality. Such incentives need not be purely monetary, although budgetary incentives for quality improvements may be useful. Public recognition before professional bodies, the recognition of individuals being considered for management posts or for promotion, and prizes or simple letters of commendation for quality assurance work that successfully identifies and solves quality of care problems are all likely to be effective in developing enthusiasm for continuous quality improvement.

Finally, corrective action taken on identified problems must be appropriate to the true cause of the problem. Most health care quality problems require changes in the care system, or care process, rather than new knowledge on the part of practitioners. The Working Group agreed that simple feedback of comparative data on performance, outcome and cost to individuals,

organizational units and organizations, at regular intervals, may itself serve as a powerful tool for corrective action.

Recommendations

1. Member States contemplating a national quality assurance programme must give careful attention to:

- adequate medical records systems;
- the development of a uniform minimum data set of important quality indicators that can be used by health professionals and health care organizations to make a comparative evaluation of performance, using a variety of process and outcome measures of quality, including both human and monetary costs; and
- the commitment of the fiscal resources necessary for personnel and data systems to conduct effective quality assurance activities.

2. Health professionals and health care organizations must integrate systematic quality monitoring and development into the management and professional governance of each hospital and primary care organization.

3. Quality assurance systems should achieve continuous improvement through the regular, systematic feedback of data on important process and outcome measures to individuals, organizational units and organizations. These systems should also incorporate positive incentives for solving problems, so as to produce demonstrated improvements in the outcome of patient care.

4. The principal focus of quality assurance activities must be within individual hospitals or primary care organizations and within their organizational units.

External agencies should serve primarily as resources for training, data collection and feedback, and for monitoring the effectiveness of the internal quality assurance system.

5. Any Member State contemplating a national quality assurance programme should recognize the need for a national coordinating organization to:

- educate health professionals in quality assurance methods;
- assist in defining quality indicators;
- develop a uniform data set of important quality indicators;
- collect and feed back data on such indicators to each institution involved; and
- monitor the effectiveness of each institution's attempts to improve its internal quality.

Such coordinating organizations are most likely to be effective if they have the active participation and support of professional and hospital associations.

Annex 1

WORKING PAPERS

ICP/HSR 031/6	Quality assurance in hospitals - state of affairs in Europe, by Dr Evert Reerink
ICP/HSR 031/7	Quality assurance in hospitals - state of affairs in the USA, by Dr William F. Jessee
ICP/HSR 031/8	Quality assurance in primary health care - state of affairs, by Dr Heather Palmer
ICP/HSR 031/9	Review of country experiences in the Federal Republic of Germany, by Professor Hans-Konrad Selbmann
ICP/HSR 031/10	Review of country experiences in the United Kingdom, by Dr Nick Black
ICP/HSR 031/11	Review of country experiences in Yugoslavia, by Professor Viktorija Cucic
ICP/HSR 031/12	Hospital infection surveillance, by Dr Anne Marie Worning
ICP/HSR 031/13	Ensuring quality of care by introducing systems of continous surveillance and feedback, by Dr Kirsten Staehr Johansen

Annex 2

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