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CONTENTS

	<i>Page</i>
Introduction	1
Scope and purpose	1
Background	2
Why is quality assurance needed?	3
Professional motives	3
Social motives	3
Pragmatic motives	4
What are the objectives of quality assurance?	4
Public accountability	5
Managerial improvement	6
Facilitate adoption of innovations	6
How can quality assurance best be introduced at the national and local level?	7
Consider financial and legal incentives and disincentives	7
Develop public support	7
Stimulate professional curiosity	8
Train students	8
Develop supporting materials	9
Develop support among institutional administrators	9
Consider development of legislation	9
What activities should be included in a national quality assurance programme?	10
Monitoring of care	11
Assessment of problems	12

Level of operation 13

Education of health professionals 13

Research and development in quality assurance 15

Information systems development 15

How can quality of services, if found defective, be improved? 16

 Consider reward systems 16

 Be aware of habit patterns 17

 Avoid punitive strategies 17

 Use methods of organizational change 17

Conclusions and recommendations 19

References 21

Annex 1. Participants 23

Summaries in French, German and Russian 25

INTRODUCTION

The Working Group on the Principles of Quality Assurance was convened by the WHO Regional Office for Europe and met from 17 to 19 May 1983 at the Hospital de la Santa Creu i Sant Pau, Barcelona, Spain. The 18 participants and 6 observers included physicians as well as individuals with professional backgrounds in nursing, economics, biostatistics and hospital administration. In addition, there were several government health officials, medical educators and public health educators. Mr Lluís Bohigas, Head of the Service of Health Care Planning, Catalan Ministry of Health was elected Chairman and Dr William Jessee acted as Rapporteur. The list of participants is given in Annex 1.

Scope and purpose

Starting from the assumption that quality assurance is a relatively new but highly desirable concept in the European Member States of WHO, the Working Group was charged with the responsibility of suggesting a strategy for presenting quality assurance to national health authorities, health professionals, the scientific community, and the consumers of health services. The Group attempted to analyse and answer the following questions: why is quality assurance needed; what are its objectives; how can it be best introduced at the national and local level; what activities should be included in a national quality assurance programme; and how can the quality of services, if found defective, be improved? The recommendations the Working Group made should facilitate the ultimate objective of developing comprehensive systems for quality assurance as an essential component of the health care delivery system.

BACKGROUND

Although the World Health Assembly and the Regional Committee have passed no resolutions explicitly mentioning quality assurance, WHO's mandate to consider quality-related issues is clear. Quality of care is implicit in the WHO Constitution, in the Sixth and Seventh General Programmes of Work, and in the many recommendations pertaining to the establishment of norms and standards, and to health services evaluation. There is also clearly a growing interest in quality assurance among the Member States, both in Europe and in other areas.

The current WHO concern with quality assurance is a natural and logical extension of previous activities that have reflected this implicit mandate. The various reports and recommendations of working groups convened by the Regional Office contain increasingly frequent references to the evaluation of the quality of health services and the effective use of available resources. Early in the evolution of WHO, the notion prevailed that every individual was entitled to the best that medicine could offer. Gradually, however, a more resource- and cost-oriented view has emerged emphasizing cost-effectiveness as well as absolute standards of quality.

The WHO Regional Office for Europe has assumed a position of leadership in attempting to facilitate the efforts of the Member States to develop their own approaches to quality assurance in their health care systems. Earlier WHO activities that have addressed this issue have included the publication of a book on quality assurance (1) and the co-sponsorship of a symposium on health care quality assurance methodology in Utrecht, Netherlands, from 18 to 20 October 1982. The present Working Group is a logical extension of these earlier activities. This report is intended to stimulate further the interest of the European Member States and to facilitate communication among workers in quality assurance.

Despite the intense level of interest in quality assurance, the topic remains a novel and often nebulous concept for most European health professionals. Although there is an abundance of American literature on quality assurance methods, the approaches used are often so specific to the American health services system that their translation to the various systems in Europe is difficult or impossible. Accordingly, the Working Group attempted to draw primarily on the experiences of ten European countries, while not ignoring lessons from the American experience, to develop principles for the evolution of improved quality assurance activities in Europe.

WHY IS QUALITY ASSURANCE NEEDED?

The answers to this question are fundamental to establishing the rationale for quality assurance activities in the health care systems of WHO Member States. The answers will vary, however, according to the audience that poses the question. There seem to be three separate sets of motives that require attention, and that individually and collectively answer the question of “why?”.

Professional motives

Professional motives for quality assurance are of key importance in motivating health care practitioners to become involved in quality assurance activities. One of the elements of professionalism is the desire to be self-correcting and self-regulating. In addition, altruistic motives form an important part of the professional ethics of all the health care professions. Accordingly, quality assurance can be seen as an important means for health care practitioners to identify their deficiencies and, therefore, their educational needs. Similarly, participation in quality assurance activities can create an environment of professional challenge and result in growth for health care professionals. The active participation of health care professionals in programmes to improve the quality of services can be an important mechanism for analysing and explaining differences in patterns of practice and results of care. These differences in performance can stimulate the intellectual curiosity of health care professionals, and be a first step towards improving their performance.

Social motives

A second motive for quality assurance activities is the need to be accountable to society for the funds spent to purchase health services. An equally important social motivation is to ensure the safety of the public, and to protect the public from care that is inappropriate, suboptimal, or harmful. A growing body of evidence seems to indicate that the incidence of iatrogenesis is substantial in western nations, possibly as a consequence of the rapid expansion of technology (2,3). Accordingly, quality assurance programmes must be developed so that the risks inherent in modern medical practice can be identified and controlled, thus maximizing the benefits to patients, while ensuring that unnecessary risks are avoided. Some have even suggested that the terms “efficiency” and “effectiveness” of care might be substituted for “quality” of care to indicate the importance of evaluating not only the results achieved, but also the efficient

allocation of financial resources in achieving those results. This, too, forms a rationale for the development of quality assurance systems to assure social accountability.

Pragmatic motives

Finally, a set of pragmatic motives related to the proliferation of information and to the possibility that patients may either be denied available services or injured by excessive or inappropriate services, makes it essential that quality assurance programmes be developed to reduce patient suffering. It is amply consistent with the mission of health care, and with the definition of health contained in the WHO Constitution, to have programmes designed to identify problems and continually to advance the performance of health care systems. This objective of quality assurance programmes can be achieved only with the active involvement of health professionals and the continuous support of health care delivery systems.

The Working Group felt that a major objective of quality assurance activities was to avoid adverse impacts on physical, mental and social wellbeing. WHO could assist by promoting an international comparison of methods in this rapidly developing field. This coordination of information and dissemination of results from the various Member States could help ensure that mistakes are not repeated and that lessons learned are shared. In addition, the involvement of WHO could formalize the interest in quality evaluation and quality improvement that has often been stimulated only by isolated individuals.

One important prerequisite for the further development of quality assurance activities throughout Europe will be the development of a critical mass of interested health professionals and policy-makers in each of the Member States. In this, the support and involvement of WHO will be critical. Finally, the improvement of health care data, especially information used in planning, will be an important side-effect of greater involvement in quality assurance activities and permit health planning to proceed from a more accurate information base.

WHAT ARE THE OBJECTIVES OF QUALITY ASSURANCE?

In attempting to define the objectives of quality assurance programmes, it is important that a consensus should be reached at the outset about what is to be defined as "quality". Although there is extensive literature on approaches to a definition of quality in health services (4), a general consensus has not yet emerged among health professionals regarding an

appropriate operational definition. This has handicapped efforts to develop effective quality assurance programmes, as individual efforts have produced personal definitions that are often incompatible with one another.

Four particular components must be addressed in any effort to develop an effective statement of the objectives or content of quality assurance activities:

- professional performance (technical quality);
- resource use (efficiency);
- risk management (the risk of injury or illness associated with the services provided);
- patient satisfaction with the services provided.

Incorporating these four elements, one might then attempt to define the objectives of a quality assurance programme as:

to assure that each patient receives such a mix of diagnostic and therapeutic health services as is most likely to produce the optimal achievable health care outcome for that patient, consistent with the state of the art of medical science, and with biological factors such as the patient's age, illness, concomitant secondary diagnoses, compliance with the treatment regimen, and other related factors; with the minimal expenditure of resources necessary to accomplish this result; at the lowest achievable risk of additional injury or disability as a consequence of the treatment; and with maximal patient satisfaction with the process of care, his/her interaction with the health care system, and the results obtained.

While an individual quality assurance activity need not necessarily address all four components of this definition, it is important that the overall quality assurance programmes mounted by institutions or countries give equal consideration to the importance of each. Exclusive attention to only one of these four components could lead to invalid conclusions about the quality of service and to faulty programme or policy decisions about the allocation of resources or future directions for the health care delivery system.

Public accountability

One of the principal objectives of quality assurance programmes is to provide a mechanism for the public accountability of the health services delivery system, since substantial proportions of all health services are currently financed from public sources. In every European Member State, it is critical that quality assurance activity should provide objective evidence that funds are being spent both efficiently and effectively. In this

sense, quality assurance activities can focus on both the efficacy and the efficiency of the care provided, to validate the concerns of the public about the expenditure of resources, as well as to improve the operational efficacy and efficiency of the services provided.

Managerial improvement

Public accountability leads to a second important objective of quality assurance programmes: their use as a managerial tool for problem solving in health care organizations. Although considerable jargon has grown up in the quality assurance field, it remains fundamentally a simple process of identifying and solving problems. Accordingly, as part of the managerial process in institutions or multi-institutional systems, one of the principal objectives of quality assurance must be to identify the problems that affect any of the four components of quality noted above (technical quality, efficiency, risk, or patient satisfaction); to assess the nature of those problems and attempt to identify the causes; and finally to facilitate effective managerial actions to reduce or eliminate the problems so identified. In this context, it is clear that quality assurance activities cannot be isolated from the line management functions of health care institutions and organizations. Ideally, quality assurance should be incorporated as an integral management component at each level of organizational function. In particular, it is vital that each clinical department within a health care institution or organization consider quality assurance as part of its general responsibilities, rather than as a merely academic exercise removed from the everyday provision of clinical health services.

Facilitate adoption of innovations

A third objective of quality assurance programmes is to facilitate the process of innovation in health services delivery. Through the process of evaluating the performance of health care professionals and bringing them together to discuss appropriate criteria for assessing the processes and outcomes of health care, innovations (such as technological advances) can be brought to their attention and more rapidly disseminated and incorporated into practice. Similarly, innovations in the organization, administration, and operation of health care facilities and organizations may be propagated through the evaluation of the impact of such activities on patient care outcome, efficiency, risk and satisfaction. Quality assurance activities can facilitate the exchange of information within and among health disciplines.

By using the patient as the unit of analysis, the success of the health care system in achieving the four content components and the various roles and responsibilities of the members of the health care team can be more clearly

identified and their interactions to improve health can be facilitated. Bringing about a clear understanding of the roles of the various disciplines in achieving optimal health care and the contributions they can make can be a critical step towards more comprehensive and effective health services.

HOW CAN QUALITY ASSURANCE BEST BE INTRODUCED AT THE NATIONAL AND LOCAL LEVEL?

The implementation of quality assurance programmes in organizations or throughout health care systems is an innovation that is subject to a variety of types and sources of resistance. Accordingly, it is extremely important that careful thought be given to the strategy and tactics to be used to facilitate the development of such activities at the national level, the local level, and within particular institutions.

Because of the diversity of the organizational models to be found among the health care delivery systems of Europe, no single approach to the introduction of quality assurance activities should be proposed. Rather, each country must move forward gradually, recognizing the political and professional sensitivities involved in evaluating health care quality and making recommendations for change.

Consider financial and legal incentives and disincentives

As part of this gradual process, it must be recognized that among many professionals there is a fear that an explicit definition of standards for health services may lead to litigation if they are not met. The experience in Europe to date has not, however, approached that of the United States in this regard. Further, the different approaches to financing health services mean that the role of financial incentives will vary from country to country. This, then, requires that the specifics of the financing system should also be taken into account in any approach to the development of financial incentives for quality assurance activities.

Develop public support

For many health professionals, there is currently little reward in the active pursuit of quality assurance activities. For this reason, it may be important to mobilize external pressure from consumers or governments or to identify other approaches to internal motivation, in order to stimulate practitioners to become actively involved in quality assurance activities. It must

be recognized, however, that there are risks inherent in moving quality assurance out of the professional arena and into the political arena. Specifically, introducing the elements of government and consumer pressure may result in a substantial loss of professional autonomy and in the development of solutions to quality problems that may not be consistent with the expectations or desires of professional groups.

Legislation to stimulate the involvement of physicians or other health practitioners in quality assurance may have the unplanned opposite effect of decreasing their willingness to participate in these activities in a meaningful fashion. This has been the experience in the United States with the Professional Standards Review Organisation's programme. Conversely, however, legislative efforts have, in some instances, stimulated initially reluctant health professionals to become involved, leading to extremely productive quality assurance activity.

Stimulate professional curiosity

In the professional arena, one of the most valuable strategies to involve health care practitioners in effective quality assurance activities is to show them the differences in performance and in patient care results or outcomes. For example, some of the differences in practice patterns identified through the Bavarian Perinatal Project (5) have stimulated the curiosity of the practitioners involved to learn more about why those differences occur and what is the impact of practice differences on the outcome of patient care. For this reason, data systems may be useful in demonstrating such differences, to the extent that they allow the presentation of practitioner-specific or institution-specific data on process or outcome.

Train students

Another important strategy in the professional realm is to teach the specifics of quality assurance methods and the responsibility of health professionals for quality assurance at every level of their education. There is a great need for effective educational programmes to be developed for medical students, nursing students, and students of the various other health disciplines, and to include the philosophy, knowledge, and skills of quality assurance activities. In addition, these students should be encouraged early in their educational development to participate in the delivery of care and in the joint evaluation of their own performance. Since professional education consists in large part of a process of role modelling, it will be critical for the educational institutions themselves to begin to participate actively in quality assurance so that students in training can see the importance of these activities to the practitioners on whom they model themselves.

Develop supporting materials

To support these efforts, as well as to stimulate the further development of expertise in quality assurance methods among practising health care professionals, publications and other materials on quality assurance need to be developed in each of the Member States. Such publications should be developed for at least four types of audience, each of which requires different types of information. For the public, informational and promotional materials need to be developed to improve their understanding of the need for quality assurance, its potential and its limitations. For health policy-makers and financiers, this information should be expanded with additional material on the social motives behind quality assurance and its role as a means of improving the cost-effectiveness of health services. Health professionals will require materials to stimulate their professional curiosity and to develop positive attitudes towards quality assurance, as well as more technical materials on specific methods for identifying problems in the quality of care, analysing them and solving them. Finally, educators and students will require somewhat different materials, including guidance on the integration of teaching of quality assurance skills and attitudes into the curricula of various health professional education programmes.

Develop support among institutional administrators

Institutional administrators can play an important role in the stimulation of quality assurance activities by placing a high priority on such efforts in their internal budgeting. The allocation of funds to quality assurance programmes highlights their importance to the institution, and can provide a strong incentive to professionals to become actively involved. In addition, it must be recognized that quality assurance in institutions is an important managerial process that can assist line department managers in identifying and resolving problems in the process of patient care. In this perspective, it may be seen that institutional administrators can play an important role in stimulating the development of other effective quality assurance activities. Towards this end, effective information systems and information management within institutions are also of considerable importance. Such information systems must be planned to include the capability of developing quality assurance data and reproducing these data as reports which are of maximum utility in the quality assurance process.

Consider development of legislation

Some countries may wish to consider the possibility of legislation to stimulate both quality assurance activities and the evaluation of specific

health services programmes. In addition to authorizing legislation, it is critical that adequate financial support be provided for quality assurance activities. The designation of a specific proportion of the national health services budget to evaluative or quality assurance activities is also a strategy worth considering. In the development of such a national strategy, however, it will be important to emphasize the limitations of quality assurance at its current state of development. Over the short term such activities are not likely to improve the general state of health of the population, to reduce health care costs, or to produce major changes in the health care system. They can, however, result in substantial local changes in patterns of care with resultant favourable impacts on both the process of health care and its results. Over the longer term, these apparently small changes may result in substantial health and economic benefits.

Regardless of the approach taken towards implementation of quality assurance activities, both the ethical and legal responsibility for the quality of services continues to rest primarily with the owners or operators of health care institutions. Whether these owners or operators are private or public entities, they must assume the responsibility of assuring their patients that the services they provide meet acceptable standards of quality. For this reason, an appropriate strategy for implementation could be an external system of review and evaluation in the public sector, superimposed on internal systems of review and evaluation, that are professionally organized and run within each health care institution or organization. Such an approach would meet the twin objectives of professional acceptability and public accountability.

WHAT ACTIVITIES SHOULD BE INCLUDED IN A NATIONAL QUALITY ASSURANCE PROGRAMME?

As to specific activities that should be included in actual quality assurance programmes, the consensus seems to be that a pluralistic approach is essential. The current state of the art of quality assurance is such that no single approach can be recommended for all types of facility or all types of health care delivery system. In many instances, the selection of a particular method will depend on the political environment, the level of operation and complexity of the institution or organization, the sophistication of the health care professionals involved in the quality assurance process, and a variety of other environmental factors. It is possible, however, to identify a set of important characteristics of any particular method or activity included in an operational quality assurance programme. In any

such programme, the presence of three components of problem-solving (monitoring, assessment and improvement) will be critical.

Monitoring of care

The first of these is a system for the continuous monitoring of patient care so as to identify potential problems that require intervention. A variety of alternative methods for identifying such problems has been discussed in the literature (6). These alternative approaches to monitoring may be classified into five generic types as follows.

Variation from the norm

Approaches using this method are based on the assumption that care that departs from the norm (mean) is different and may be indicative of a possible problem in quality. It must be emphasized, however, that this method does not take account of the fact that the norm may represent either suboptimal or superior care, nor does it allow for the possibility that departures from the norm may in fact be better than care that is normative. For this reason, great care is required in the interpretation of statistical information.

Criteria-referenced screening

This method of identifying problems bases the definition of potential problems on a departure from explicit definitions of desired processes or outcomes of care. Such explicit definitions or criteria are developed by peer professionals in advance and the actual care provided is then compared with these explicit criteria. Departures from criteria are identified as potential problems requiring further assessment and possible intervention.

Multifactorial indices

This rather complex method involves the development of indices of quality, which may combine both normative and criteria-referenced information. While there is some available literature on the development of multifactorial indices of quality, the method is complex and the use of this approach in operational programmes, as opposed to research programmes, has been quite limited.

Small group methods

Since the health professionals involved in the provision of health services are generally in the best position to be able to identify problems in patient

care, the use of structured small groups to elicit such information and determine priorities for intervention can be very valuable. Such methods as the nominal group technique (6) have proved valuable in identifying problems in the quality of care even in the absence of either normative or criteria-referenced data.

Surveys

Formal surveys of health workers, including physicians, nurses and other health professionals, have proved to be effective mechanisms for identifying quality of care issues. In addition, surveys of patients can be very valuable in identifying problems both in technical quality and in patient satisfaction.

In any approach to problem identification, it will be important for the subjects of quality assurance activities to be issues in which qualitative improvement is likely. Further, subjects that are highly prevalent, that require high resources, and in which there is good professional consensus about the appropriate process or outcome tend to be most productive as the focus of quality assurance activities.

Assessment of problems

The second key component of problem-solving that must be included in a national quality assurance programme is the assessment of actual or suspected problems identified through the monitoring process. Many assessment methods have been developed and a rather large literature has grown up explaining them (7). They share, however, a common dependence on the use of explicitly written criteria to define acceptable or expected performance and to serve as a point of reference in comparing the actual care provided.

Assessment methods may be based on a variety of data sources, as well. Some of these data sources will be patient records, but increasingly such methods as direct observation, interviews and computerized patient information systems are becoming of value in conducting assessment studies. Regardless of the method selected, or the data sources employed, the result of the assessment must be a clear understanding of whether or not there is in fact a problem and what the causes of that problem are. This then can serve as the focus for the third essential function, *improvement* in the quality of services. This third component is discussed in greater detail on pp. 16-19.

Level of operation

It may be of value in developing the specific activities to be included in an operational quality assurance programme to consider a three-dimensional matrix defining the functions, content, and level of operation of quality assurance within the health care system. Such a matrix defines 48 discrete cells, which any country's health care delivery system must be concerned with in developing effective quality assurance activities. As depicted in Fig. 1, the functions of quality assurance (monitoring, assessment and improvement) are first superimposed on the four content areas (professional performance, resource use, risk, and patient satisfaction).

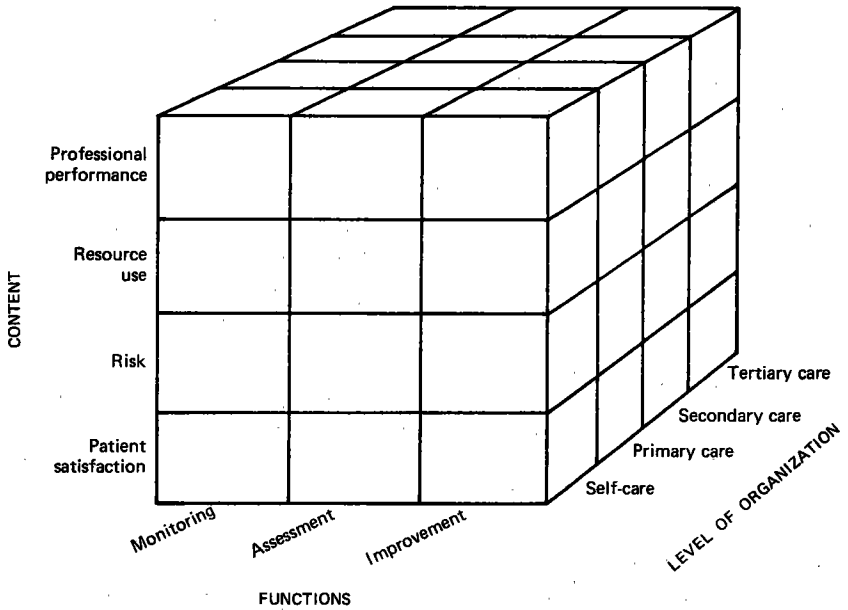
Each of these cells may then be seen as existing at one of the four levels of organization of the health care delivery system (self-care, primary care, secondary care and tertiary care). In making an inventory of the approaches to be taken in a national health care system for improving health care quality, it will be critical for each of the 48 cells to be carefully considered, and for appropriate activities to be developed in each. For instance, this matrix stimulates one to ask questions such as: what activities in a national health system have been developed for monitoring professional performance at the secondary care level; or what activities or mechanisms exist for improving the use of resources at the tertiary care level? Questions of such a specific nature are more readily addressed within the context of the social and political environment in a national health care system than are more global issues such as how quality is maintained. Accordingly, such a matrix may be of great value in facilitating the development of a specific mixture of quality assurance activities in a national health programme.

In addition to the various operational activities defined by the matrix in Fig. 1, in order for a national quality assurance programme to be successful three other categories of activity are essential: education, research and development, and information systems.

Education of health professionals

One of the major difficulties that has handicapped the development and dissemination of quality assurance programmes has been the lack of education among health care professionals and health care students in the nature, objectives, and methods of health care quality assurance. Unless this deficiency is remedied, efforts to develop quality assurance programmes will continue to be handicapped. Accordingly, a key component of any national effort to develop effective quality assurance activities will be the development of curriculum and training activities for health care students at all levels of their education, as well as the development of continuing education programmes in quality assurance for practitioners currently providing services.

Fig. 1. Three-dimensional matrix illustrating the components of an operational national quality assurance system



In addition, educational strategies for the public and for political figures in every country will be the key to developing the type of public and government support necessary for quality assurance initiatives to survive. Currently, the public in most countries has unrealistic expectations of the capability of medical care to cure illness. For quality assurance initiatives to begin to have some impact, it will be essential for the public to gain a better understanding of the limitations of medical care, of their responsibilities for their own health, and of the need for continuous evaluation and improvement in the services provided by health care institutions as a mechanism for maximizing efficacy and efficiency. Similarly, key political figures in every country must better understand the importance of quality assurance and evaluation activities if the resources necessary for these activities are to be forthcoming.

Research and development in quality assurance

In a similar fashion, it will be critical that resources for research and development programmes on quality assurance be routinely included in the health budgets of every country. The designation of a specific percentage of the national health budget for research and development in evaluation and quality control is a reasonable approach towards improving the quality of services and developing more effective programmes for their delivery in a particular sociopolitical environment. If improvements are, indeed, to be made in the quality of health services, it will be essential for adequate research to be conducted into the development of more efficient and effective mechanisms than are currently available for quality assurance. While some of the methods that have been used to date have been effective, others have been relatively ineffective. It is only through careful research and evaluation into such complex issues that better means of identifying and resolving problems in the quality of care may be developed.

Information systems development

Finally, as an important component of the development of quality assurance systems, it will be critical for countries to develop information systems that provide the kinds of data that are critical to quality assurance. Unfortunately, most information systems that have been developed for use in health care organizations or systems are not sufficiently specific or comprehensive to be of value in quality assurance. Many of them are oriented strictly towards productivity or financial information, and omit many of the clinical data that are of key importance in quality assurance. Further, even among those that do include clinical information, there are often high rates of error in data collection, and difficulties in linking

patient-specific data across levels of care. If these problems can be resolved, it will greatly facilitate the use of health information systems as a quality assurance tool, as well as providing a tremendously valuable resource for research into more effective means of health care delivery.

HOW CAN QUALITY OF SERVICES, IF FOUND DEFECTIVE, BE IMPROVED?

The third and final functional component of a national quality assurance system is the improvement of health care. If this component is missing, or underdeveloped, then energy and resources devoted to the first two functions will have been wasted. Unfortunately, improvement in services is often the most difficult of these three functions to perform. Because health care is a complex undertaking, often conducted in institutions of substantial organizational complexity, by autonomous professionals, and involving scientifically complex activities, it may be exceedingly difficult to produce change.

Nonetheless, change can be effected through the use of principles of individual and organizational behaviour. One of the major barriers, at present, to effective improvement is the lack of an attitude among health professionals and health care organizations that is receptive to the initiatives for change that grow out of quality assurance programmes. This problem has been discussed earlier (pp. 3 and 6-7). If this problem can be effectively addressed through education at every level of the health manpower development process, it will be a major step towards improving the efficacy of a variety of quality improvement activities throughout the health care system.

Consider reward systems

Individual health care practitioners resist efforts to modify their behaviour for a variety of reasons. One of the most important is related to the reward systems that operate in particular health care delivery systems. Accordingly, if efforts at improvement are to be effective, it will be essential to consider the economic and other incentives in the delivery system that may influence the behaviour of practitioners. It will be futile to attempt to make changes that run contrary to economic incentives, unless there are substantial economic or political sanctions available. Since most Western European countries probably prefer not to use such sanctions, it will be critical that economic motivations or other reward systems are identified.

Be aware of habit patterns

In addition, it must be kept in mind that the behaviour of health care practitioners is often conditioned by a long and complex set of behavioural stimuli that have produced a set of conditioned responses to particular clinical situations. If these habitual responses are suboptimal, they may pose particularly difficult obstacles to efforts to produce change. Most adults, however, can be motivated to change even the most complex of behaviour patterns if they can see it to be in their best interests. Health professionals, in addition, may often be motivated by discovering that a new pattern of behaviour is in the best interest of their patients. Professional altruism is an important positive force in the improvement of the quality of care and must be recognized and used wherever possible.

Avoid punitive strategies

One of the major failings in many initiatives to improve quality, however, has been the use of punitive approaches that immediately provoke defensive responses among practitioners. Human nature dictates that when the professional performance of an individual is attacked, he or she will defend the *status quo*. Accordingly, it will be critical that effective mechanisms be developed for bringing to the attention of practitioners those areas in which improvements can be made, in such a way that they do not feel that it is necessary to defend their current behaviour. Experience has shown that person-to-person discussions are much more effective in this regard than are written communications, which tend to become officious and to connote official sanction. Further information on individual strategies for change should be developed through effective research programmes as part of the research and development initiatives discussed on pp. 10–16.

Use methods of organizational change

Within health care organizations, initiatives for change may often be met with a variety of organizational strategies for resistance. An extensive literature on organizational change (8) can be a valuable resource in improving the efficacy of institutional quality assurance initiatives. The larger and more complex the organization, the more successful it tends to be in resisting change. Quality assurance, however, must be seen as an agent of institutional change, if it is to be effective. Accordingly, institutional quality assurance programme staff will need to develop extensive skills in the identification of the causes of resistance to change in organizations, and in strategies and tactics of organizational change.

Four categories of strategy for change have been identified in the literature (9). These include re-education, facilitation, persuasion and power.

Re-education

Re-education is the process by which the organization and its members learn new and, hopefully, better ways of doing things. This approach is based on the principle that reasonable individuals will react reasonably when they are given information that allows them to conclude that change is appropriate. In this capacity, it is critical that the information be presented in a non-threatening fashion. Hence, the availability of information systems for quality assurance will be a key component.

Facilitation

Facilitative strategies are those that attempt to assist the organization in changing itself. These include a variety of methods developed by social scientists, including organizational psychologists, such as team building, conflict resolution, consensus building, and other small group methods for facilitating the process of organizational change.

Persuasion

Persuasion strategies will rely on the ability of a respected member of the organization, or an outsider of influence, to stimulate consideration of a new or different approach to organizational performance. This mechanism is most effective early in the process of change and requires that other methods be available to continue to solidify the process once change has begun.

Power

Strategies for change based on power are often used in organizations, but have several undesirable characteristics. Power is an external motive for change, and often produces surface compliance with initiatives for change, while stimulating deeper resistance to long-lasting change. Power can serve as a successful external motivator, but must be supplanted by another mechanism for solidifying and internalizing the new behaviour thus created. Nonetheless, the exercise of effective power strategies for change by those who have power within the organization, or the power to affect the organization from outside, can be extremely valuable mechanisms for initiating the process of change.

In the area of improvement, there is also a clear need for additional research so that more cost-effective means may be found for facilitating improvements in care. Many of these improvements may involve the very

nature of health services in the developed countries, particularly our current reliance on curative medicine and sophisticated technology. It may well be demonstrated that one of the most effective mechanisms available for quality improvement would be to stimulate greater reliance on the prevention of illness and on the personal and individual responsibility of the public for its own health. In any event, there will continue to be a need for effective mechanisms for identifying and solving patient care problems; accordingly, the need for quality assurance in health care will persist.

CONCLUSIONS AND RECOMMENDATIONS

WHO must play a leading role in facilitating the development, promotion, and implementation of effective mechanisms for quality assurance in the European Member States. Although the nature of the specific activities to be conducted by each country will vary with its social, political and professional situation, seven major principles can be enumerated to serve as guidelines for WHO and the European Member States in working towards an effective and efficient approach to quality assurance in health care.

1. The methods employed must lead to the identification and resolution of problems in the provision of health services and to the identification of opportunities for improvement in health care, so as to have positive effects on the physical, mental and social wellbeing of patients.
2. Quality assurance activities should include consideration of efficiency and risk, as well as effectiveness, in order to promote care that achieves optimal benefits, at minimal cost, with minimal risk of further injury or disability.
3. Consideration must be given to developing programmes that encompass the emotional and social aspects of health care quality, as well as the scientific and technical aspects.
4. Quality assurance activities must be integrated into the direct clinical and institutional management functions of health professionals and health care institutions, rather than separated or isolated from those activities. Accordingly, quality assurance should become an operational responsibility of line management personnel, both clinical and administrative, at all levels of health care. Adequate resources and support to facilitate and coordinate quality assurance activities should be provided by the administration of each health care organization.

5. The appropriate locus of quality assurance activities extends across every organizational level in health care, from the individual interaction between patient and provider through institutional subunits, institutions and regions, to countries.

6. All health professions have a public obligation to participate in quality assurance activities. Because the provision of health services requires the coordinated efforts of a variety of health disciplines, evaluation and improvement of the quality of health services should also be performed through interdisciplinary coordination of the professionals involved in care.

7. Because health care is a rapidly changing field, and health care quality assurance methods are still in a period of experimentation and development, any approach chosen for quality assurance in the Member States should maintain the flexibility to change as the state of the art of quality assurance continues to evolve.

These principles should provide important signposts for the development of quality assurance activities at the national level. In order to facilitate the further development and implementation of quality assurance programmes consistent with these principles, the Working Group made the following recommendations.

1. A comprehensive plan should be developed and implemented for the collection and dissemination of information on quality assurance methods, activities, and results in the Member States. The development of informational, motivational and technical publications on quality assurance should be included in this plan for such audiences as the public, health policy-makers, health professionals, health services financiers, and educators.

2. Organizations of health professionals in the Member States should be encouraged to plan and implement programmes to increase the motivation of their members to be actively involved in quality assurance activities.

3. Each Member State should, as a component of its national health plan, define the organization(s) responsible for quality assurance activities and establish mechanisms for assuring the public that those responsibilities are met.

4. Member States should be encouraged to allocate a percentage of their financial resources for health services to quality assurance research, development, education, and implementation.

5. Educational institutions in the Member States should develop programmes for training all health care students in quality assurance, such that the attitudes, skills and knowledge necessary for effective quality control are developed in each individual. In addition, appropriate post-graduate or continuing education programmes should be developed to foster these attitudes, skills, and knowledge among practising health professionals.

6. Where necessary and appropriate, Member States should develop legislation to implement the recommendations outlined above.

The Working Group recognized that the principles and recommendations it had enumerated were ambitious. It was further recognized that efforts to implement these recommendations must of necessity be gradual and that the areas of emphasis will vary among the Member States. Nonetheless, the Working Group felt that the principles and recommendations should serve as a long-range framework within which WHO and its individual Member States could work towards the ultimate objective of a comprehensive system for quality assurance as an essential component of the health care delivery system. The Working Group concluded that as health professionals, health care institutions, governments and the educational system work together towards this goal, the public they serve will benefit from effective, efficient health services that maximize the opportunity for each individual to enjoy good health.

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RESUME

Introduction

Les quinze membres du groupe de travail sur les principes de l'assurance de la qualité et les quatre observateurs présents étaient notamment des médecins, des fonctionnaires d'administration sanitaire, des enseignants en médecine et des enseignants en santé publique représentant des domaines professionnels divers (soins infirmiers, sciences économiques, biostatistiques et administration hospitalière). Ils venaient des pays suivants : République fédérale d'Allemagne, Belgique, Espagne, Etats-Unis, Finlande, France, Italie, Pays-Bas, Royaume-Uni, Suède et Yougoslavie.

Partant de l'hypothèse selon laquelle l'assurance de la qualité est un concept nouveau mais qu'il est souhaitable de mettre en œuvre dans les Etats Membres de la Région européenne de l'OMS, le groupe de travail devait suggérer comment présenter ce concept aux autorités sanitaires, aux professionnels de la santé, à la communauté scientifique et aux consommateurs de services de santé. Il a essayé d'analyser et d'apporter une réponse aux questions suivantes :

- pourquoi l'assurance de la qualité est-elle nécessaire ?
- quels sont ses objectifs ?
- quel est le meilleur moyen de l'introduire aux niveaux national et local ?
- quelles activités doit comporter un programme d'assurance de la qualité ?
- comment améliorer la qualité des services dans le cas où ceux-ci sont considérés non satisfaisants ?

Information de base

Bien que ni l'Assemblée mondiale de la santé ni le Comité régional n'aient adopté de résolutions mentionnant explicitement l'assurance de la qualité, l'origine de ce concept apparaît clairement : la qualité figure implicitement dans la Constitution de l'OMS, dans les sixième et septième programmes généraux de travail et dans de nombreuses recommandations concernant la fixation de normes et de critères ainsi que l'évaluation des services de santé. Il est également clair que l'intérêt pour l'assurance de la qualité est de plus en plus net dans les Etats Membres.

L'intérêt que l'OMS porte actuellement à cette question découle naturellement et logiquement de ses activités antérieures qui ont reflété ce mandat implicite. Si l'on regarde les rapports et recommandations des groupes de travail réunis par le Bureau régional, on s'aperçoit en effet que le concept de l'assurance de la qualité apparaît de plus en plus fréquemment au cours des discussions sur l'évaluation des services de santé et l'utilisation efficace des ressources disponibles.

Thèmes de discussions et conclusions

Le groupe a essayé de définir plus clairement les caractéristiques souhaitables des programmes d'assurance de la qualité dont la nécessité ne fait plus de doute. Comme dans le cas des procédés industriels, il est essentiel d'intégrer à tout système de prestations des mécanismes efficaces d'évaluation et d'amélioration des soins de santé. Devant la complexité et la technicité croissantes des systèmes de services de santé des pays développés d'Europe et d'autres régions du monde, les anciennes méthodes (telles que la certification du personnel et d'institutions) ne permettent plus de contrôler de manière satisfaisante la qualité des soins. Il faut donc élaborer de nouveaux mécanismes et méthodes pour garantir la responsabilité des professionnels de la santé et des institutions de soins à l'égard du public qu'ils servent.

Le groupe de travail a conclu que l'OMS devrait montrer la voie à suivre pour faciliter la conception, la promotion et l'application de mécanismes efficaces d'assurance de la qualité dans les Etats Membres de la Région européenne. Bien que la nature des différentes activités que réaliseront les divers Etats sera fonction du contexte social, politique et professionnel, le groupe de travail a fixé sept principes directeurs qui devront permettre à l'OMS et aux Etats Membres de la Région européenne d'aborder avec efficacité et efficience la mise en place d'activités d'assurance de la qualité des soins de santé.

1. Les méthodes utilisées doivent conduire à l'identification et à la solution des problèmes posés par la fourniture de services de santé et à l'identification des possibilités d'amélioration des soins pour accroître le bien-être physique, mental et social des patients.
2. L'assurance de la qualité ne doit pas être seulement efficace, mais également efficace et tenir compte des risques, c'est-à-dire déboucher sur des soins d'une qualité optimale, pour un coût minimum et qui réduisent au minimum les risques d'aggravation des traumatismes ou des handicaps.
3. Il faut chercher à élaborer des programmes qui tiennent compte, outre des aspects scientifiques et techniques, des aspects sociaux et affectifs de la qualité des soins de santé.

4. Les activités d'assurance de la qualité ne doivent pas être isolées ou séparées des fonctions cliniques et de gestion des professionnels et des institutions de santé mais y être directement intégrées. L'assurance de la qualité doit donc dépendre du personnel chargé de la gestion des soins comme de l'administration, à tous les niveaux, y compris au niveau des soins de santé primaires et des institutions. Le responsable de chaque organisation prestataire de soins de santé devrait fournir les ressources et l'appui nécessaires pour faciliter et coordonner les activités d'assurance de la qualité.

5. L'assurance de la qualité doit englober tous les niveaux des soins de santé, depuis la relation entre le patient individuel et le prestataire de soins jusqu'au niveau de l'institution, de la région et de la nation.

6. Toutes les professions de santé ont l'obligation, vis-à-vis du public, de participer aux activités d'assurance de la qualité. La fourniture de services de santé supposant les efforts coordonnés de diverses professions de santé, l'évaluation et l'amélioration de la qualité de ces services doivent également être le résultat d'une coopération interdisciplinaire des professionnels concernés.

7. Etant donné que les soins de santé sont un domaine en évolution rapide et que les méthodes d'assurance de la qualité des soins sont encore au stade de l'expérimentation et du développement, toute approche choisie par les Etats Membres doit être suffisamment souple pour pouvoir être modifiée et améliorée.

Recommandations

Afin de faciliter l'élaboration et l'application de programmes d'assurance de la qualité conformes à ces principes, le groupe de travail a formulé les recommandations suivantes :

1. L'OMS devrait élaborer et mettre en œuvre un plan général de collecte et de diffusion d'informations sur les activités d'assurance de la qualité, les méthodes utilisées et les résultats obtenus par les Etats Membres. Ce plan devrait également inclure la préparation de publications techniques, d'information et d'encouragement à l'application de l'assurance de la qualité et destinées aux responsables de la santé publique, aux professionnels de la santé, aux financiers des services de santé et aux enseignants en soins de santé.

2. Les organisations professionnelles sanitaires des Etats Membres devraient être encouragées à concevoir et à mettre en œuvre des programmes destinés à motiver davantage leurs membres à prendre une part active à l'assurance de la qualité.

3. Chaque Etat Membre devrait, dans le cadre de son plan sanitaire national, définir la ou les organisations responsables des activités d'assurance de la qualité et mettre en place des mécanismes afin de montrer au public qu'il s'est acquitté de ses responsabilités.
4. Il faudrait encourager les Etats Membres à affecter une part de leurs ressources financières à la recherche et au développement de services d'assurance de la qualité, à l'application de ces services et à leur enseignement.
5. Les centres d'enseignement des Etats Membres devraient définir des programmes de formation des étudiants de toutes professions sanitaires à l'assurance de la qualité afin que chacun ait les attitudes, les compétences et les connaissances nécessaires à un contrôle efficace de la qualité. De plus, il faudrait mettre en place des programmes appropriés de formation permanente pour permettre aux professionnels de la santé déjà en activité d'acquérir ces attitudes, compétences et connaissances.
6. Si cela est à la fois nécessaire et possible, les Etats Membres devraient élaborer une législation pour mettre en œuvre les recommandations exposées ci-dessus.

ZUSAMMENFASSUNG

Einleitung

Die fünfzehn Teilnehmer und vier Beobachter der obigen Arbeitsgruppe umfaßten mehrere Ärzte, Beamte des Gesundheitswesens sowie Lehrkräfte aus dem medizinischen Bereich und dem öffentlichen Gesundheitswesen; an Fachbereichen waren vertreten: Krankenpflege, Wirtschaft, Biostatistik und Krankenhausverwaltung. Die Teilnehmer kamen aus den Ländern Belgien, Bundesrepublik Deutschland, Finnland, Frankreich, Italien, Jugoslawien, Niederlande, Schweden, Spanien, USA und Vereinigtes Königreich.

Ausgehend von der Annahme, daß Qualitätssicherung ein neues, anstrengenswertes Konzept der europäischen Mitgliedstaaten der WGO ist, wurde die Arbeitsgruppe beauftragt, eine Strategie für die Einführung dieser Disziplin bei Gesundheitsbehörden, Gesundheitsfachkräften, in wissenschaftlichen Kreisen und bei den Empfängern von Gesundheitsleistungen zu entwerfen. Die Arbeitsgruppe bemühte sich um die Untersuchung und Beantwortung nachstehender Fragen:

- Warum benötigt man die Qualitätssicherung?
- Welches sind ihre Ziele?
- Wie kann sie am besten auf nationaler und lokaler Ebene eingeführt werden?
- Welche Tätigkeiten soll ein reelles Qualitätssicherungsprogramm umfassen?
- Wie kann die Qualität der Dienstleistungen, falls sie nicht zufriedenstellend ist, verbessert werden?

Allgemeines

Obwohl die Weltgesundheitsversammlung und das Regionalkomitee keine Resolutionen über die Qualitätssicherung als solche verabschiedet haben, liegt trotzdem eine klare Aufgabenstellung vor: Die Forderung nach Qualität ist implizit in der WGO-Verfassung, dem Sechsten und Siebenten Allgemeinen Arbeitsprogramm und in den zahlreichen Empfehlungen enthalten, die sich auf die Erstellung von Normen und Standards und die Bewertung der gesundheitlichen Dienstleistungen beziehen. Außerdem nimmt offensichtlich das Interesse der Mitgliedstaaten an der Qualitätssicherung zu.

Das gegenwärtige Engagement der WGO bezüglich der Qualitätssicherung ergibt sich automatisch aus früheren Tätigkeiten, die implizit die genannte Aufgabenstellung enthalten. Bei Durchsicht der Berichte und Empfehlungen im Zusammenhang mit Arbeitsgruppentagungen, die vom Regionalbüro veranstaltet worden sind, stößt man bei Behandlung der Evaluierung der Gesundheitsleistungen und bei der Besprechung einer effektiven Nutzung der vorhandenen Ressourcen in zunehmendem Maße auf Fragen der Qualität.

Besprechungsthemen und Schlußfolgerungen

Die Arbeitsgruppe bemühte sich um eine klarere Festlegung der Merkmale, die ein Qualitätssicherungsprogramm haben sollte. Daß Qualitätssicherung benötigt wird, steht fest. Wie bei industriellen Prozessen werden auch bei der Leistungserbringung im Gesundheitssektor effektive Mechanismen zur Beurteilung und Verbesserung der Gesundheitsversorgung absolut benötigt. In dem Maße, wie die Komplexität und technologische Verfeinerung des Gesundheitsdienstes in den Industrieländern Europas und anderen Bereichen der Welt zunehmen, werden frühere Praktiken der Qualitätskontrolle (z.B. Zulassungsbestimmungen für Personal und Institutionen) überholt und können dem Zweck der Qualitätskontrolle nicht mehr gerecht werden. Es müssen also neue Methoden und Verfahren der Qualitätssicherung eingeführt werden, damit die Gesundheitsberufe und die Institutionen der Gesundheitsversorgung ihre Pflicht gegenüber der Öffentlichkeit erfüllen können.

Die Arbeitsgruppe kam zu dem Ergebnis, daß die WGO hinsichtlich der Ausarbeitung, Förderung und Umsetzung effektiver Mechanismen der Qualitätssicherung in den europäischen Mitgliedstaaten eine führende Rolle übernehmen solle. Auch wenn die spezifischen Aktivitäten jedes Landes entsprechend den sozialen, politischen und beruflichen Gegebenheiten von denen anderer Länder abweichen werden, sollten nach Meinung der Arbeitsgruppe hinsichtlich eines effektiven und effizienten Ansatzes für die Qualitätssicherung für die WGO und ihre europäischen Mitgliedstaaten sieben Grundsätze gelten:

1. Die anzuwendenden Methoden müssen bewirken, daß die Probleme beim Leistungsangebot identifiziert und gelöst und die Möglichkeiten einer Verbesserung der Gesundheitsversorgung erkannt werden; auf diese Weise wird das körperliche, geistig-psychische und soziale Befinden der Patienten positiv beeinflusst.
2. Bei der Anwendung der Qualitätssicherung müssen auch Effizienz, Risiken und Effektivität berücksichtigt werden, damit bei minimalen Kosten und der geringstmöglichen Gefahr weiterer Gesundheitsschäden oder einer Behinderung ein optimaler Nutzen erzielt wird.

3. Bei der Ausarbeitung der Programme ist darauf zu achten, daß auch die emotionellen und sozialen Aspekte der Versorgungsqualität sowie die wissenschaftlich-technischen Aspekte mit einbezogen werden.
4. Die Qualitätssicherung muß in die direkten klinischen und institutionellen Managementfunktionen der Gesundheitsfachkräfte und Versorgungseinrichtungen eingebaut und darf nicht von ihnen abgetrennt werden. Dementsprechend sollte die Qualitätssicherung in den betrieblichen Verantwortungsbereich des klinischen und administrativen Managementpersonals auf allen Stufen der Gesundheitsversorgung fallen - dies sowohl in der Primärversorgung als auch im Bereich der institutionellen Betreuung. Die Verwaltung jeder Gesundheitsversorgungsstelle sollte für ausreichende Ressourcen sorgen und die Tätigkeiten der Qualitätssicherung erleichtern bzw. koordinieren.
5. Der Anwendungsbereich der Qualitätssicherung erstreckt sich auf alle organisatorischen Ebenen des Versorgungswesens und erfaßt den gesamten Bereich von der Wechselbeziehung zwischen Einzelpatient und Leistungserbringer bis hin zu institutionellen Teilbereichen, Institutionen, Regionen und Staatsebene.
6. Alle Gesundheitsprofessionen unterliegen einer öffentlichen Verpflichtung zur Anwendung von Qualitätssicherungsmaßstäben. Da die Erbringung von Gesundheitsversorgungsleistungen den konzertierten Einsatz verschiedener Gesundheitsdisziplinen voraussetzt, sollte auch die Evaluierung und Qualitätssteigerung hinsichtlich der Gesundheitsgüter im Rahmen einer interdisziplinären Zusammenarbeit der entsprechenden Fachbereiche erfolgen.
7. Da die Gesundheitsversorgung einer laufenden Änderung unterliegt und sich die Qualitätssicherungsmethoden noch im Stadium der Entwicklung befinden, sollte man beim Einschlagen eines bestimmten Weges zur Durchführung der Qualitätssicherung in einem Mitgliedstaat eine gewisse Flexibilität bewahren, damit man sich dem jeweiligen Entwicklungsstand dieses Fachgebiets anpassen kann.

Empfehlungen

Um die Ausarbeitung und Umsetzung von Qualitätssicherungsprogrammen gemäß diesen Prinzipien zu ermöglichen, empfiehlt die Arbeitsgruppe folgendes:

1. Die WGO sollte einen umfassenden Plan zur Erfassung und Verbreitung von Informationen über Methoden, Tätigkeiten und Ergebnisse der Qualitätssicherung in den Mitgliedstaaten ausarbeiten und verwirklichen. Der Plan sollte auch die Erstellung von informatorischen, motivierenden und technischen Schriften berücksichtigen, die an Entscheidungsträger des Gesundheitswesens, Gesundheitsfachkräfte, Stellen der Gesundheitsverwaltung und Lehrkräfte zu verteilen sind.

2. Die Verbände der Gesundheitsfachkräfte in den Mitgliedstaaten sollten ihre Mitglieder zur Mitarbeit an Qualitätssicherungsprojekten anregen.
3. Jeder Mitgliedstaat sollte im Rahmen seines nationalen Gesundheitsplans die Stelle (oder Stellen) festlegen, die für die Qualitätssicherung zuständig ist (sind) und Verfahren entwickeln, damit die Öffentlichkeit überzeugt sein kann, daß man seiner Verantwortung nachgekommen ist.
4. Die Mitgliedstaaten sollten dazu angehalten werden, einen gewissen Teil des Gesundheitshaushalts für die Forschung, Entwicklung, Unterweisung und praktische Durchführung der Qualitätssicherung abzublocken.
5. Die Lehranstalten der einzelnen Länder sollten in ihren Ausbildungsplan auch die Qualitätssicherung aufnehmen, damit der einzelne sich die richtige Haltung, das entsprechende Können und Wissen aneignen kann, um eine effektive Qualitätssicherung zu ermöglichen. Um den praktizierenden Gesundheitsfachkräften die entsprechende Haltung, das Können und Wissen beizubringen, sollte man außerdem nachuniversitäre Kurse und Fortbildungsprogramme einrichten.
6. Gegebenenfalls sollten die Mitgliedstaaten gesetzliche Vorschriften zur Verwirklichung der obigen Empfehlungen erlassen.

РЕЗЮМЕ

Введение

В совещании Рабочей группы по принципам обеспечения качества приняли участие 15 участников и 4 наблюдателя с профессиональной ориентацией в области сестринского дела, экономики, биостатистики и больничного обслуживания. Среди них были врачи, работники официальных органов здравоохранения, преподаватели медицинских наук и общественного здравоохранения. На совещании были представлены Бельгия, Италия, Испания, Нидерланды, Соединенное Королевство, Соединенные штаты Америки, Федеративная Республика Германии, Финляндия, Франция, Швеция и Югославия.

С учетом того, что обеспечение качества является новым и в то же время желательным принципом деятельности европейских государств – членом ВОЗ, перед Группой была поставлена задача разработать стратегию разъяснения этого принципа среди представителей органов здравоохранения, медработников, научной общественности и пациентов. Участники Группы попытались проанализировать и дать ответ на следующие вопросы.

- Почему следует обеспечивать качество?
- Какие цели при этом преследуются?
- Каковы оптимальные пути внедрения этого принципа на национальном и местном уровнях?
- Какие мероприятия должны войти в практическую программу обеспечения качества?
- Как можно повысить качество обслуживания, если это необходимо?

Исходная информация

Хотя Всемирная ассамблея здравоохранения и Региональный комитет не принимали каких-либо резолюций, в которых конкретно упоминается вопрос обеспечения качества,

необходимость в проведении этой работы очевидна: вопрос обеспечения качества нашел четкое выражение в Уставе ВОЗ, Шестой и Седьмой общих программах работы, во многих рекомендациях, касающихся разработки норм и стандартов, а также оценки деятельности служб здравоохранения. Государства-члены все в большей степени проявляют очевидный интерес к вопросам обеспечения качества.

Внимание, которое сейчас ВОЗ уделяет обеспечению качества, является естественным и логичным следствием мероприятий, проведенных ранее, с учетом выполнения четко поставленной цели в этой области. Из анализа отчетов и рекомендаций рабочих групп, созывавшихся Региональным бюро, видно, что концепция качества все больше становится предметом дискуссий по вопросам оценки служб здравоохранения и эффективности использования имеющихся ресурсов.

Темы дискуссий и выводы

В ходе состоявшихся дискуссий участники Группы попытались более четко определить оптимальные характеристики программ обеспечения качества. Был сделан вывод о необходимости обеспечения качества. Как и в условиях производства, эффективные механизмы оценки и совершенствования качества медико-санитарной помощи являются существенными компонентами любой системы здравоохранения. С усложнением характера и укреплением технических возможностей систем медико-санитарных служб в развитых странах Европы и других районах мира стало очевидным, что существующие методы контроля качества (такие, как выдача соответствующих разрешений персоналу и учреждениям) не могут обеспечить надлежащий контроль за качеством обслуживания. Поэтому возникла необходимость в новых методах и механизмах обеспечения качества для того, чтобы население могло контролировать деятельность медицинского персонала и учреждений здравоохранения.

Рабочая группа пришла к заключению о том, что ВОЗ должна играть ведущую роль в деятельности, способствующей разработке, укреплению и внедрению эффективных механизмов обеспечения качества в европейских государствах-членах. Хотя характер конкретных мероприятий, которые будут проводиться странами, зависит от преобладающей в них

социально-политической обстановки и наличия персонала, Рабочая группа считает, что следующие семь основных принципов могут быть использованы ВОЗ и европейскими государствами-членами в качестве рекомендаций при организации работы, связанной с разработкой эффективного и действенного подхода к обеспечению качества медико-санитарной помощи.

1. Используемые методы должны способствовать определению и решению проблем организации служб здравоохранения, определению возможностей совершенствования обслуживания в целях обеспечения физического, психического и социального благосостояния пациентов.

2. Меры по обеспечению качества должны разрабатываться с учетом таких понятий, как действенность, риск и эффективность в целях содействия развитию помощи, позволяющей достигнуть оптимальных результатов при минимальных затратах и с минимальным риском нанесения большего ущерба здоровью больных.

3. Следует уделять внимание разработке программ, включающих эмоциональные и социальные аспекты качества медико-санитарной помощи, а также научно-технические аспекты.

4. Меры по обеспечению качества должны стать составной частью деятельности клиницистов и работников стационаров, а также учреждений здравоохранения, их не следует проводить отдельно или изолированно. Соответственно, обеспечение качества должно стать оперативной задачей линейного руководящего персонала, как клиницистов, так и администраторов на всех уровнях медико-санитарной помощи, включая первичную медико-санитарную помощь и стационарное обслуживание. Администрация каждого учреждения здравоохранения должна обеспечивать необходимые ресурсы и поддержку с тем, чтобы содействовать проведению мер по обеспечению качества и координировать их.

5. Меры по обеспечению качества должны занимать соответствующее место в деятельности каждого организационного уровня медико-санитарной помощи, начиная с отношений между пациентом и врачом и кончая стационарными отделениями, учреждениями, регионами и странами.

6. Все специалисты здравоохранения обязаны участвовать в мероприятиях по обеспечению качества. Поскольку медицинское обслуживание требует координации усилий ряда специалистов, оценка и повышение качества деятельности медико-санитарных служб также должны проводиться на основе междисциплинарного сотрудничества медицинских работников различных специальностей.

7. Учитывая, что в здравоохранении происходят быстрые изменения, а методы обеспечения качества медико-санитарной помощи все еще находятся в стадии апробации и развития, любой подход к обеспечению качества в государствах-членах должен обеспечивать возможность проведения изменений в свете развития методов обеспечения качества.

Рекомендации

Рабочая группа выработала следующие рекомендации с тем, чтобы содействовать развитию и реализации программ обеспечения качества, основанных на указанных принципах.

1. ВОЗ должна разработать и осуществить всесторонний план сбора и распространения среди государств-членов информации о методах обеспечения качества, деятельности в этой области и полученных результатах. В рамках этого плана следует подготовить информационные, мотивационные и технические публикации по вопросам обеспечения качества для таких групп читателей, как руководящие работники здравоохранения, профессиональные работники здравоохранения, сотрудники, занимающиеся вопросами финансирования здравоохранения, и преподаватели.

2. Следует содействовать тому, чтобы профессиональные организации медицинских работников планировали и выполняли программы, которые имеют целью стимулирование и участие их членов в активной деятельности по реализации мер, связанных с оценкой качества.

3. Каждое государство-член должно в рамках своего национального плана здравоохранения определить организации, отвечающие за проведение мероприятий по обеспечению качества, и создать механизмы, позволяющие населению контролировать ход их выполнения.

4. Следует поощрять государства-члены к тому, чтобы они финансировали за счет средств, выделяемых на здравоохранение, проведение мероприятий, связанных с научными исследованиями, развитием, просвещением и реализацией мер в области обеспечения качества.

5. Учебные заведения государств-членов должны разработать программы подготовки студентов всех медицинских специальностей в области обеспечения качества в целях развития у них необходимых навыков, отношения и знаний, позволяющих обеспечивать эффективный контроль качества. Кроме того, следует разработать надлежащие программы постдипломного и непрерывного обучения для содействия распространению среди медиков-практиков указанных знаний, отношения и навыков.

6. Там, где это необходимо и целесообразно, государства-члены должны разработать законоположения, предусматривающие выполнение изложенных выше рекомендаций.

