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Quality improvement: time for radical thought and measurable action

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Last week's 3rd Asia Pacific Forum on Quality Improvement in Health Care, which attracted leading overseas commentators and around 900 participants, is evidence of the momentum building around healthcare quality in New Zealand. Specific initiatives in recent years include the Health and Disability Services (Safety) Act 2001, professional-led credentialling of senior medical staff,[1] and sentinel events reporting.[2]

The momentum received a further boost during the conference with the release of the report 'Improving quality: a systems approach for the New Zealand health and disability sector'.[3] Health professionals should not underestimate the importance of this report. If you are going to read one 'policy' document this year – or at least the executive summary – make it this one.

The 'Improving quality' (IQ) report is the result of a robust process, led by the Ministry of Health. A working group with wide representation provided guidance and a draft was circulated to the sector for comment. The report builds on advice to the Minister of Health from the National Health Committee (NHC),[4] and a discussion paper on quality improvement in hospitals.[5] The NHC advice drew on a review of international experience,[6] discussions from two national workshops,[7] consultation with a wide range of health and disability providers, input from consumers and Maori organisations, and submissions on a discussion document.[8]

The IQ report identifies key dimensions of quality: people-centred, access and equity, safety, effectiveness and efficiency (Figure 1). The report also advocates a systems approach to healthcare quality, not as an end in itself but as a means to enhance services for people. Thus, quality must encompass all levels of the system – individuals, teams, organisations, subsystems – as well as interactions between different levels. Quality is the responsibility of all people working in healthcare, but these people must be supported by a system that places a high priority on safety and enables ongoing quality improvement.

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Figure 1. Quality dimensions for the New Zealand health and disability system

The language of quality can be confusing, but quality activities fall into two broad camps: quality assurance and quality improvement. Quality assurance is about setting expectations (standards), their implementation, and measurement of performance against them. Quality assurance is essential and we need to do it well to maintain the safety of our healthcare system. However, international evidence increasingly suggests that a sole focus on quality assurance is not enough.[3]

Quality improvement is where we need to head – combining quality assurance activities with an explicit concern for quality and continuous improvement. Quality improvement is underpinned by incremental change where all individuals, teams and organisations (from small providers to the Ministry of Health) critically evaluate their practice, incorporate new learning into their work and, importantly, share their learning with others. This is not a simple linear process with a beginning and an end, but an ongoing cycle of reflection and action. A quality-improvement approach calls for us to examine not just what we are doing (outputs), but also how we are doing it and what we are getting – the outcomes.[9] This implies monitoring the total process of care, and measurement of outcomes rather than outputs.

In addition to incremental changes in practice, more radical change is required, and herein lies the challenge. There needs to be a fundamental shift in our attitude towards quality improvement. As stated unequivocally by the NHC, quality improvement should be the prime focus of healthcare delivery if we are to achieve the best possible outcomes. Quality must no longer be seen as of interest just to those people with 'quality' in their job title, but needs to become the responsibility of everyone.

Not surprisingly, most doctors and other health professionals maintain that they already have a focus on quality as part of their work. We do always strive to do the best for patients and families, and there are many existing activities that demonstrate a commitment to quality.

But in reality how often do we follow routine audit with decisive action and ongoing evaluation? Do we analyse the accessibility of our services? Do we assess our competence in working with people from cultures other than our own? What processes do we use to critically assess emerging evidence to ensure new

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interventions are safe and actually improve outcomes for patients at a reasonable cost – both to the public purse and to individuals? Do we measure and analyse the outcomes of our practice and, even more importantly, present this information to the people seeking our advice?

International quality expert Dr Donald Berwick, who spoke at the Auckland conference, has written movingly on his wife's personal experience within the health system to reflect the crisis facing healthcare around the world, and to suggest ways to address this crisis and improve quality of care.[10] The crisis he describes is not one of funding or unlimited demand, but a crisis in the way that healthcare systems deliver care.

Berwick argues that to improve quality we need a new approach that faces the reality of the current problems and involves leadership, teamwork, integration and good communication. It calls for innovative approaches that may not necessarily use the 'tools' that we are used to. Berwick challenges us to think outside the square, and to question whether our traditional thinking and practices are helping us to improve healthcare.

While Berwick's experience lies within the US healthcare system, any clinician reading his account will instantly recognise many of the small and large failures in the care received by his wife. The errors were not rare; they were a daily occurrence. If they are chillingly familiar to us, they must be more so for the numerous people worldwide whose care is affected by such failures. However, even more alarming is the obvious conclusion that many of these failures are easily preventable and that their prevention would actually save rather than cost money.

Key to a change in thinking must be a strong emphasis on being 'people-centred'. The genuine placement of people at the centre of healthcare decisions at all levels is a prerequisite for improving the outcomes of healthcare. In particular, cultural competence at all levels of the system is crucial. Cultural competence in healthcare requires us to understand social and cultural factors that influence patients, and devise interventions that take these factors into account.[11] Cultural competence is a necessary skill for health professionals and an essential part of effective care.[12] In New Zealand we have a particular obligation to understand relevant Maori cultural issues and to apply that understanding in practice.

As health professionals we have an important part to play in improving quality – in particular as leaders and role models – but we need to be clear on what this means in practice. The challenge to improve quality demands that we revolutionise our thinking about quality, moving from a focus on quality assurance to a model of quality improvement that routinely involves different professionals and people who use our services. On a practical level, we can begin now by making incremental, evidence-based changes for better outcomes. Both radical thought and measurable action are called for.

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