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Ensuring the quality of health care

醫護服務的質素保證

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The importance of high standards and striving for excellence in the Hong Kong health care system have been affirmed in the debate following release of the Harvard Report. This paper reviews the issue of quality in health care and recommends a triad quality framework to achieve this, consisting of enhancing professional practice, empowering patients, and providing a facilitative environment in which quality of care is encouraged.

自哈佛報告開始的有關醫護改革的辯論，確認了香港醫護體制追求卓越及維持高水準服務的重要性。本文總結了醫護服務中的質素問題，建議了一個包括加強專業水平、加強病人參與、及營造有利環境的三合一框架以保護醫護質素。

Introduction

In their assessment of the health care system in Hong Kong, the Harvard Team expressed concern about the highly variable quality of health care in the Territory.¹ Their assertion of substandard practice in parts of the medical sector, however, was strongly challenged by local professional bodies, including the Hong Kong Academy of Medicine.² These divergent views were reported widely by the local media, subjecting health care quality to intense public debate. In the subsequent public consultation on the Harvard report, the maintenance of high standards and the constant striving for excellence, both cornerstones of quality, were emphasised as areas for enhancement in future health care reform.

This emphasis of placing quality at the heart of health care leads naturally to the question of how this may be achieved. The current paper reviews general issues of health care quality and considers a broad framework for ensuring the quality of care in the Hong Kong health care system.

What is quality?

In 1980, Donabedian,³ building on his highly regarded health services research work, articulated a patient-centred concept of quality of health care. Donabedian³ defined quality care as care which is expected to maximise patient welfare, after taking account of expected gains and losses attending the process of care in all its parts. This perspective was broadened by the Institute of Medicine in 1990 to include the population at large, the health system, and prevailing professional standards. In this context, quality health care was defined as the degree to which health services for individuals and populations increased the likelihood of desired health outcomes and was consistent with current professional knowledge.⁴ Another widely quoted definition of quality health care is the one formulated by Maxwell,⁵ who identified six different aspects comprising quality health care:

Key words:

*Outcome assessment (health care);
Patient participation;
Professional competence;
Quality assurance, health care;
Total quality management*

關鍵詞：

結果評估(醫療護理)；
病人參與；
專業能力；
質素保證，醫療護理；
總體質素管理

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- (1) Access to service;
- (2) Relevance to need (for the whole community);
- (3) Effectiveness (for individual patients);
- (4) Equity;
- (5) Social acceptability; and
- (6) Efficiency.

The concept of health care quality is thus both diverse and complex. For the purpose of this paper, care of high quality is regarded as that type of care which is provided professionally in all respects and which is patient-centred. The former concerns delivering the most appropriate care using updated knowledge and skills to achieve optimal health effects, whereas the latter places emphasis on considering the patient first. To ensure quality of health care, the authors suggest that a triad quality framework, consisting of enhancing professional practice, empowering patients, and providing a facilitative environment, should be in place.

Quality framework

Maintaining and enhancing professional practice

Maintaining and enhancing professional practice is fundamental to providing care of high quality. As custodians of a specialised body of knowledge and skills, health care professionals have a tendency to view quality in terms of technical excellence. Technical excellence encompasses the appropriateness of services provided and the skill with which appropriate care is performed.⁶ High technical quality consists of 'doing the right thing right'. This requires that practitioners make the best decisions about care for each patient (high-quality decision-making), and requires skill, judgement, and timeliness of execution (high-quality performance).⁷

The most elementary measure to ensure quality of professional practice is to maintain a statutory register of professionally qualified health care practitioners. Only those with appropriate qualifications are allowed to practise, thereby protecting the public from unqualified and ineffective practitioners. Statutory registers of doctors, nurses, and allied health professionals, differentiate the qualified from the unqualified and certify that the former have attained a certain professional standard.

With the biomedical knowledge base currently doubling every 19 years,⁸ however, medical knowledge will increase four-fold during the course of an individual's professional life. The importance of keeping practitioners up-to-date is increasingly recognised,

and life-long learning is now accepted universally as the key to maintaining and improving standards. This has resulted in a global increase in continuous professional development (CPD) offered by academic and professional institutions. The concept of CPD is generally regarded as broader than continuing education in that it is not only concerned with personal growth but also satisfaction with professional work.⁹

The notion that what is learned should be applied in practice and what is practised should be in accordance with research evidence has yielded another movement, called evidence-based practice. This requires practitioners to focus on the evaluation and use of evidence from clinical research, rather than traditional factors such as clinical intuition and experience.¹⁰ Evidence-based medicine helps enhance professional standards by facilitating the incorporation of research findings into daily practice, and through the formulation of clinical guidelines to assist clinical decision-making on appropriate care. The process of translating evidence into practice, however, is complex, as it requires changes in both the attitude and behaviour of health care practitioners. In this respect, work in applied psychology and communications theory has provided a wide range of techniques to help improve performance.¹¹ To facilitate behavioural change, it is also necessary to address factors such as the relevance and appropriateness of the new practice or innovation, the use of communication mediums, and the availability of opinion leaders and networks.¹²

For a variety of reasons, some practitioners have encountered difficulty in continuing to maintain a high standard of practice after qualification.¹³ The 'Bristol case' in the United Kingdom was perhaps the most extreme example of this in recent years. The case centred on the death of 29 babies and children after heart surgery, for which three doctors were subsequently found guilty of serious professional misconduct.¹⁴ Care of inadequate quality, such as this, is wholly unacceptable, and has led to the proclamation that the case will transform the practice of British medicine in the future.¹⁵ For its part, the General Medical Council of the United Kingdom has announced its intention to introduce a system of regular mandatory revalidation for all doctors, to be implemented over a period of 2 years.¹⁶ The system will involve local profiling of a doctor's performance, external peer review of the profiling process, and submission of evidence of a doctor's fitness to practise.¹⁷ Failure of revalidation may cause a doctor to be removed from the medical register. This system will, thus, explicitly link the statutory process of registration and revalidation to CPD,

making the latter a compulsory rather than a voluntary requirement.

The need to provide evidence to demonstrate maintenance of professional standards is a global trend. In the United States, most doctors have to renew their specialist licences every 7 to 10 years and should they fail to do so, can lose admission rights to hospital, effectively losing a means to earn their livelihood. In Canada and Australia, maintenance of certification requires evidence of continuing medical education (CME). This trend has also been extended to other health care professions. For instance, the British government has proposed the formation of a single professional body for the nursing profession, to enable registration, discipline, training, and maintenance of standards in day-to-day practice, to be closely linked.¹⁸

Involving and empowering patients

Berwick,¹⁹ a contemporary expert in health care quality and safety, has suggested that the ultimate measure by which to judge quality of care is whether it helps patients and their families, according to their own perceptions.¹⁹ This underscores the importance of involving patients in the quality framework. Unlike professionals, however, patients tend to take for granted a practitioner's technical excellence. Rather, they consider factors such as access and convenience, staff attitudes and empathy, respect for their dignity and rights, information and explanations, the environment and hygiene, as well as channels for feedback and complaints, as important aspects of quality care.

Traditionally, complaints procedures are deployed to utilise the patient's perspective to improve quality. Complaints made by patients about their care present a means of learning about deficiencies in quality of care which can be translated into quality improvements. While having a good complaints system is important, it is nevertheless reactive in nature, and represents fixing the 'defects' after they have come to light.

In this context, two alternative methods of involving patients in quality improvement have been advocated—a proactive stance, and a dynamic approach.²⁰ The former seeks actively to listen to patients/clients using active feedback channels, such as regular unstructured consumer surveys, telephone 'hot lines', and help desks. The latter involves the organisation endeavouring to understand client expectations. A systems-wide approach is taken, and issues identified in one department are reviewed for relevance to other parts of the organisation. Specially designed surveys

and focus groups are examples of this approach in action. The issues identified through these methods are then addressed systematically, ensuring continuous quality improvements.

Apart from soliciting patient views, empowering patients is the other major approach to patient involvement in quality improvement. At its most basic, this entails making appropriate information available to facilitate informed decision-making by patients. At the patient-practitioner level, this involves engaging patients in medical decision-making through the provision of health information, explanations of treatment side-effects, and advice on relief of pain and emotional distress. Evidence supporting this practice suggests that better informed patients have better coping skills and better clinical health outcomes.²¹

A more controversial method of patient empowerment is in the publication of comparative information on outcomes of care. This is more common in the United States, where the reporting of statistics such as mortality from coronary heart disease treatments, has occurred. The rationale for this practice rests on the belief that the public release of data on performance will lead to behavioural change and hence, quality improvement. Research has shown that clinicians do take note of such data but that changes in behaviour can occur in unintended ways. Green and Wintfeld,²² for example, showed that clinicians changed their coding practices as a result, leading to a dramatic increase in recorded comorbidities among patients undergoing bypass surgery. In so doing, practitioners could improve risk-adjusted mortality figures.

In the United Kingdom, patient empowerment has been addressed by the Patient's Charter.²³ This was specifically designed to enable patients to understand what they could expect from the health service by making explicit their rights and service standards. The challenge here is to balance the patients' rights with their responsibilities—tipping the balance either way will raise unrealistic expectations, or arouse hostility among patients and practitioners, respectively.

Providing a facilitative environment

Quality care is not an additional technique or task to be completed. It is a philosophy which is embodied in every aspect of the organisation's work. Providing an environment which facilitates quality of health care, thus, forms a vital part of the framework. Such an environment enables practitioners to perform optimally. Donaldson²⁴ has suggested that this can be achieved by having strong leadership, creating the

right culture, communicating effectively, providing information support, aligning individual and organisational goals, and facilitating education and training. The role and contribution of health care management was particularly emphasised.

To continually orientate the organisation towards achieving quality, Peters and Waterman²⁵ have also stressed the importance of focusing on the McKinsey 7-S variables:

- (1) Strategy (providing a clear direction and a coherent set of actions);
- (2) Structure (showing how tasks are divided up and integrated);
- (3) Systems and procedures, guiding concepts and innovations;
- (4) Shared values;
- (5) Staff capabilities;
- (6) Styles of management; and
- (7) Skills contained within the organisation.

These variables are interdependent and should not be considered in isolation. A common mistake is the tendency to pay more attention to the so-called 'hard Ss' or physical environment—strategy, structure and systems—with less consideration being given to the so-called 'soft Ss' of style, staff, skills, and shared values. An appropriate structure showing clear lines of accountability and responsibility helps to avoid confusion of who is doing what. The systems, consisting of the processes and procedures, in turn help to govern the ways quality initiatives are implemented, whereas pace and atmosphere are determined by the leadership and staff.

Modern quality of care philosophy advocates the adoption of total quality management. This approach attempts to involve the entire workforce in achieving the optimum, the first time, and every time. This represents a paradigm shift in quality management away from inspection for the purpose of finding defects. Berwick²⁶ referred to this latter as the 'bad apple approach' and suggested that dealing with the tail of the normal distribution of care patterns, is not as effective as shifting the whole curve to the desired direction of improvement (that is, focusing on the whole organisation).

Moss and Garside²⁷ has summarised the characteristics of total quality management (Box). Using clinical case studies, they highlighted the importance of cultivating an organisational culture of quality, which strives to meet the needs of both the external and internal customers, and which encourages staff to

Box. Characteristics of total quality management

- Making customers' needs a priority for everyone
- Defining quality in terms of customers' needs
- Recognising the existence of internal customers and suppliers
- Examining the process of production, rather than individual performance for explanations of flaws or poor quality
- Using sound measurement to understand how to improve quality
- Removing barriers between staff, and promoting effective team work
- Promoting training for everyone
- Involving the entire workforce in the task of improving quality
- Understanding that quality improvement is a continuous process

function as a team. Emphasis was also placed on the need to have good, reliable data on the processes of work—for detecting problems, for identifying faults in processes, and for assessing progress.

In creating a facilitative social environment for quality care, there is a need to shift away from a culture of blame and punishment when errors are made. Berwick²⁸ comments that all modern, effective systems to assure quality and improve safety, involve a culture in which the reporting of error or apparent error is a valued positive act, leading not to blame, but to curiosity and study. Berwick and Leape²⁹ further assert that fear, reprisal, and punishment, produce not safety and quality, but rather defensiveness, secrecy, and enormous human anguish. Hence, the focus of a conducive environment in which to achieve quality care, is on the proper design of equipment, jobs, support systems, and organisations.

Quality tools

Although the issue of measuring health care quality is beyond the scope of this paper, the authors nevertheless reiterate the importance of collecting relevant and objective data, proxy or otherwise, on quality of care. There are many tools available for this purpose, including performance indicators, benchmarking, clinical audit, quality circles, and accreditation. It is emphasised, however, that these tools remain instruments to provide information on the quality of care in the health service. Used in isolation, they will never ensure quality of care.

Lessons for Hong Kong

What then are the lessons for Hong Kong? This is perhaps best considered using the triad quality framework already discussed.

With regard to enhancing professional practice, it is noted that the Hong Kong Academy of Medicine and its constituent colleges are spearheading the drive to promote CME and CPD. One major difficulty relates to practitioners falling outside the sphere of influence of the Academy. Although the Hong Kong Medical Association has come in to fill this gap, it remains uncertain what proportion of local practitioners are still outside these initiatives and continue to practise without participating in formal CME or CPD. How this will be resolved is unclear. Questions as to whether CME and CPD should be made compulsory or should be linked to registration, revalidation, and recertification will no doubt be raised.

In terms of improving quality by empowering patients, a local patient's charter stressing both rights and responsibilities currently exists, although the balance remains delicate. Many organisations and groups also provide patient and general public health information, either as leaflets or on the internet. There are also efforts to enhance complaints procedures and move the emphasis upstream to complaints prevention, through better staff training in communication skills and the provision of patient advocates. Given the overseas experience in providing comparative information on outcome of care, initiatives of that kind should be handled with caution.

On providing a facilitative environment, it is recognised that parties with a substantial role to play include the government, professional bodies, and service providers. Educators also have a role in changing attitudes, and leadership is important. Where organisation exists, structure and systems can be put in place. Culture and commitment can also be nurtured and cultivated. A particular challenge, however, relates to solo practices. Putting in place a system to ensure quality of care in these practices will obviously be more difficult, not least because of the economy of scale. Solutions to this challenge will contribute further to quality enhancement.

Conclusion

Ensuring the quality of care is a worthy objective for any health service. To work towards this aim, a triad quality framework of enhancing professional practice, empowering patients, and providing a facilitative environment is suggested. Achieving quality is the concern and responsibility of all those who are associated with the health system. Ensuring that quality care is continually pursued, in addition, requires that reliable data be made available to

identify problems, suggest solutions, assess progress, and monitor trends.

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