Quality of Care Assessment and Assurance

Hirschhorn • Lamstein
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AN ANNOTATED BIBLIOGRAPHY WITH A POINT OF VIEW

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Quality of Care Assessment and Assurance

Introduction

This is a bibliography with a bias. Hundreds of articles, monographs and books have been written about Quality of Care Assessment and Assurance (Q/Caa) in ambulatory medicine. Nevertheless, it is still difficult to know just what good care comprises (*Quality*), how to measure it accurately (*Assessment*), or how to make sure it stays good (*Assurance*). It is especially true of ambulatory care that only tenuous links are found between what is done for a patient, and what finally happens to that person. Yet most Q/Caa schemes continue to examine the specific, technical interactions between a provider and the patient; but they fail to measure, much less assure, quality. Two factors contribute to this failure: 1) medical care is delivered increasingly by organizations with multiple layers of staff and systems; and 2) the scope and complexity of medical services and technology have increased almost beyond control. Whether all this complexity is beneficial is doubtful; that its cost is high is not. Despite medical advances, millions of persons in this country are still unable to get simple, compassionate care, or achieve prevention of serious physical and mental afflictions.

The articles chosen for annotation in this bibliography support the following points of view:

1. Q/Caa must be an organization-wide affair and not simply a review of medical charts.
2. A better Q/Caa system is not enough. It must be tied to an explicit definition of what a particular health care organization is trying to accomplish which, in turn, must be appropriate to the needs of the people served by the organization.
3. While the attributes of appropriate care are still debated, some types of care have been proved to make a difference in the outcome of illness and in the maintenance of health. They are:
   a) removal of subtle as well as obvious barriers to care;
   b) availability and continuity of needed services;
   c) delivery of care in a compassionate and dignified manner;
   d) a minimum of major errors in diagnosis and use of drugs;

e) a strong emphasis on use of proven methods of prevention and screening; and
f) the maintenance of cost-effective and managerially efficient operations.

Other attributes of quality may emerge later to meet the requirements of the time and new knowledge.

4. Each of the attributes mentioned can be expanded into a series of criteria which may be quantified—so much waiting time, so many percent immunized, etc.—and therefore assessed. Operational steps can be taken to assure that targets are either met or revised.
5. It is clear that Q/Caa, to be at all useful in improving health and delivery of health care, must be an integral part of planning and managing health care systems.

This bibliography is organized into four categories and several subcategories. The sequence of the annotations within the categories is a deliberate one; it is intended to lead the reader to the conclusions listed above. We have also not shied from interpreting many of the articles. Our own views are signaled by the word "Comment."

Contents

Philosophy and Review

Definitions of Quality

Hiatt, H. H. "Protecting the Medical Commons: Who is Responsible?" *The New England Journal of Medicine* 293(1975): 235–241.

This article discusses the finite resources available for health and summarizes the choices of medical technology and medical processes which must be made.

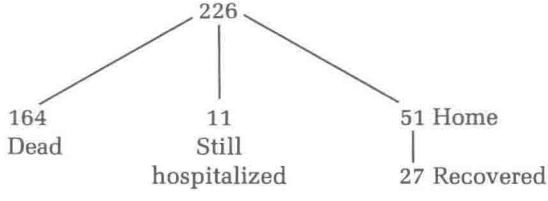
1. Trained prehospital rescue units resuscitated 301 patients with heart attacks. Forty-two left the hospital (5 brain damaged) and survived for a mean of thirteen months. Was it worth it? How do we tell?
2. Nearly a dozen major surgical procedures have been abandoned in recent years because they proved worthless. Ninety percent of the one million yearly tonsillectomies are probably unnecessary. Oral hypoglycemic agents are given to 1.4 million Americans but are probably more harmful than helpful. The treatment of acute pulmonary edema was as successful on a general medical ward as in intensive care and at much lower cost. Coronary angiography leading to coronary artery surgery for every American with heart disease could cost up to 100 billion dollars a year. Even if proved useful, the decision to use such technology must still be made.
3. Carelessness in promulgating simple immunizations and prevention programs is causing an increase or no change in the incidence of polio, measles, dental decay, black lung disease, infant mortality in the poor, and environmentally caused cancer.
4. Poor, underserved children have considerable prevalence of anemia (ages ½ to 3 years, over 25%), poor vision (25%), and middle ear disease (20%) with hearing loss (7%) and poor performance in school.

The individual physician cannot possibly take all factors into account when treating patients. But the standards of therapy must eventually be based on the rational use of all resources, dictated by

continuing research, cost effectiveness, and technical and ethical issues.

Cullen, D. J.; Ferrara, L. C.; and Briggs, B. A. et al. "Survival, Hospitalization Charges and Follow-Up Results in Critically Ill Patients." *The New England Journal of Medicine* 294(1976): 982–987.

These statistics are derived from a one year study of 226 critically ill patients who were admitted consecutively:



Eighty-three percent of blood transfusion costs were spent on the deceased, 17% on the survivors. The use of limited resources for the management of critically ill patients will be controlled either directly or indirectly through medical-governmental policy decisions since the level of intensive care, if applied to all critically ill patients in the U.S., would cost 46 billion dollars per year.

Sidel, V. W. "Quality for Whom? Effects of Professional Responsibility for Quality of Health Care on Equity." *Bulletin of the New York Academy of Medicine* 52(1976): 164–176.

1. "Quality" is in the eye of the beholder, and a professional's view is often inconsistent with the consumer's and is not necessarily correct.
2. A definition of "quality" reflects a statement of goals which in health care often reflects the predominant view of the provider.

3. Current measurements of "quality" are difficult in terms of precision, reliability, and replicability. Sometimes only easily measured indicators are measured, whether relevant or not.
4. The process to outcome link is often nonexistent.
5. Audits can detract time from service delivery; an emphasis on technical aspects subtly decreases accessibility.
6. Measurement of short-term outcomes can lead to a short sighted view of health care.
7. A definition of "quality" should take into account the barriers that keep consumers from playing a role in health care systems:
   a) the heterogeneity of the urban community;
   b) ignorance of personal fitness;
   c) feelings of powerlessness; and
   d) feelings of intimidation by professionals.

Navarro, V. "The Underdevelopment of Health of Working America: Causes, Consequences and Possible Solutions." *American Journal of Public Health* 66(1976): 538–547.

A Marxist view of ill health: social class correlates with morbidity and mortality in the U.S.; the working class is in a much worse situation. These findings are attributed not to perverse life-styles but to occupational hazards, alienation, boredom, and powerlessness. Dwelling on life-styles is a rationale used by those in power (upper-classes) to divert attention from the social/political causes of illness.

Conover, P. W. "Social Class and Chronic Illness." *International Journal of Health Services* 3(1973): 357–368.

The relationship between social class and illness has been subject to several different and opposing interpretations. Taking

data from the 1965–1967 National Health Survey, the author elucidates several aspects of this relationship:

1. There is a strong association between income and measures of chronic disease. The poorest group demonstrates a 50 to 100% greater incidence of chronic illness and resulting disability.
2. Age is an overriding cause and correlate of chronic illness.
3. Approximately half the population of the United States and 85% of people over 65 have some chronic illness.
4. Limitation of activity resulting from chronic illness is minor in most instances.
5. Differences in incidence of chronic illness are strongly related to income, but not racial groupings.
6. These differences are not, as some observers have claimed, due to a tendency of lower classes to "overreact" to chronic illness, but simply to poverty, lack of access to health services, and to fewer amenities (health insurance, sick leave) to ameliorate ill health.
7. These relationships are true for twelve selected chronic conditions, none of which are commonly thought of as class-related. These findings clearly have implications for national health policy.

Carter, J. E. Speech on Preventive Health Care. Presented to American Public Health Assoc., 19 October 1976, at Miami Beach, Florida.

President Carter's health care goals for the United States are:

1. preventive programs, especially oriented to neighborhoods and communities;
2. national health insurance stressing both catastrophic and prenatal/infant care benefits;
3. health and nutrition education in public schools;
4. attack on environmental carcinogens;
5. more biomedical research;
6. bureaucratic streamlining;

7. alternative delivery systems (HMOs, rural group practices);
8. cleanup of Medicaid mills; and
9. scholarships to women, minorities, and poor people so that they will pursue careers in medicine and thereby promote inner city and rural practice.

"National Health Planning and Resources Development Act of 1974." Public Law 93–641, 93rd Congress, S.2994, January 4, 1975.

Public Law 93–641 passed by Congress in 1974 is known as the "National Health Planning and Resources Development Act of 1974." National Health priorities (Section 1502) promulgated by this law (to be translated into quantifiable targets) are linked to the three overall purposes of Public Law 93–641 which are equal access, improved quality of health care, and cost constraint. The priorities and linkages are:

The Section 1502 Priorities	Equal Access	Quality of Care	Cost Constraint
1. Primary care for the underserved	X		
2. Coordination of health services		X	X
3. Medical group practices		X	X
4. Physician assistants	X		X
5. Sharing of support services			X
6. Improving quality		X	
7. Appropriate levels of care	X	X	X
8. Disease prevention	X	X	X
9. Uniform reporting systems			X
10. Health education	X	X	X

Comment: Since the priorities are to be specified by operational terms and numerical targets, they will increasingly form the basis of Quality of Care Assessments.

Chamberlin, R. W., and Radebaugh, J. F. "Delivery of Primary Health Care—Union Style. A Critical Review of the Robert F. Kennedy Plan for the United Farm Workers of America." *The New England Journal of Medicine* 294(1976): 641–645.

This is a sharply focused article on the attributes of quality of care as defined by a militant rural labor union.

First, the road to health is defined in societal terms:

"People are healthy not because of good hospitals or good doctors or good medicine . . . A healthy body demands that you have decent living conditions and decent working conditions. '(Ill health is) a symptom of poverty and powerlessness.'"

Second, the activities of health clinics stress self-sufficiency, primary preventive care, health education, outreach and active involvement in environmental improvement and union activism. Medical technology is kept to a minimum and folk medicine is interwoven. Third, a strong emphasis is placed on the family health worker, an outreach social activist and ombudsman. Fourth, physicians and nurses are entirely subordinate to the union lay committees, earn little money, work long hours, and do many housekeeping chores. Fifth, the clinics operate to eliminate cultural, economic, and physical barriers to access.

The clinics are greatly successful in acquiring the support and approval of their clients. However, they are not adequately responsive to the needs of professionals. Professionals do not have power, a voice in decisions, and an option to continue their education. They suffer from low pay, long hours, and "incompetent practices due to understaffing."

Comment:

1. The health philosophy and goals stated in this article are reminiscent of those of the Settlement Houses in our big cities

in the early twentieth century. This period was before medical technology became dominant.

2. "Quality" takes on a markedly different face when defined and controlled by consumers with a political focus.
3. Is provider control necessary to keep a health system working? Or must the government intervene?