

PMO526

Assessing and Improving Health Care Systems

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Introduction

As we have seen throughout this course, most of the issues facing the United States health care industry overlap and are very complex. Fundamental changes in the health care industry need to involve the laws of our country, our ideals of equality, private business, national, state and local governments, and our economy. Diverseline's discussions about improving the safety and effectiveness of health care in the U.S. found these common threads engrained in this issue of quality.

In this paper we will share our opinions about the international assessment of the U.S. health care system. We offer some suggestions for improving the safety and effectiveness of health care delivery and identify some of the issues associated with our suggestions.

Quality of U.S. Health Care

Although many of us were not aware of the World Health Organization's (WHO) rankings of the U.S. health care system, we were not surprised by the rankings after we examined the definitions that were used.

As pointed out in the readings, the WHO organization could have chosen many different measures of health care quality. The definition of quality can differ greatly depending on the perspective. Diverseline's discussions exemplified this with real life assessments of quality from the patient perspective and from the provider perspective. An example of quality from the patient perspective, is receiving treatment that helps the patient feel better in a timely and pleasing manner. The patient has a cold or flu and wants an antibiotic treatment and the patient receives it and gets better. Quality from a provider perspective looks at whether the treatment was appropriate, was an antibiotic necessary or sufficient. Would the same outcome have been achieved with a less expensive treatment?

The divergence on patient and provider perspectives on quality illustrates how hard it is to develop a common and comprehensive definition of quality. The inability to define quality will make it even more difficult to measure.

Suggestions for Improving Quality

Diverseline discussed many of the suggestions found in the readings and we also discussed some of things that were touched upon in previous modules. The following is a discussion of five of our suggestions for improving quality and the important issues associated with the suggestion.

1. Guidelines: Clinical guidelines for care are seen as having potential for improving the quality of care. Clinical guidelines should be based scientific or evidence based information. The use of clinical guidelines can improve the quality of care by ensuring everyone receives the most up-to-date treatments.

Developing uniform clinical guidelines is a very daunting task. Clinical guidelines are already being employed to some degree in many health care settings. The problem is that the guidelines may not have been objectively developed. For example, a treatment guideline may state that antibiotic X should be used rather than antibiotic Y, which is recommended by a different health care provider. Who is right? Is either guideline based on contracts with a drug company? For reasons like this, it is important, but difficult, to establish guidelines that are applied everywhere. Reaching consensus on such guidelines in today's structure of U.S. health care seems impossible.

In addition to clinical guidelines, the system must remain flexible enough to allow physicians to make case-by-case decisions about the appropriate treatment for a patient. Although clinical guidelines will help keep the system current on recommendations, the provider has to have the ability to do something different if it is warranted. This is a tough balancing act.

2. Information/Education: This is related to clinical guidelines but oriented more toward informing the consumers of health care services. Diverseline discussed the benefit to the patient to be able to educate herself about health care services she may be receiving. Empowering the patient/consumer to obtain and evaluate health care information that is applicable to his personal life is a measure of quality to the patient.

Potential hazard areas of information and education are similar to those discussed for the clinical guidelines. It is important to know the source of the information you are using and the motives for providing the information. Patients who are equipped with information about their health care will be in a better position to be their own advocate and defender, possibly resulting in better outcomes or improved safety. Alternatively, too much information can also be a hazard to a patient. Many patients are not always equipped to assess conflicting information and make a decision. As our discussion showed, patients are not always the best judge of appropriateness and quality of care.

3. Group Practice: Diverseline discussed the benefits that group health care practice can have on quality. It was pointed out that a solo or isolated health care practice does not benefit from the depth and variety of knowledge, and peer review and consultation that can be obtained from a group practice. For a solo practitioner, a returning customer is a satisfied customer and the measure of quality. However, as demonstrated by our example of patient assessment of quality, just because a patient is happy doesn't mean that treatment was appropriate. It was speculated that the movement toward managed care and group practice over the past 20 years, although motivated by cost, has been a good thing for improving quality by encouraging and allowing communication among health professionals.

It is important to note that the creation or increase of provider consultation could negatively impact quality by prolonging the treatment process and thereby decreasing access to care. From a foundation of good training and current clinical guidelines, well managed peer consultation can be improve the quality of care.

4. Electronic Medical File: The benefits and difficulties of developing an electronic medical file were address in the previous discussion. The electronic medical file was brought up again here as something that could contribute to the quality of health care. Having portable, accessible information about a patient (past conditions, treatments, medications, family history) could go a long way toward improving the safety of health care. A simple example of the benefits would be in knowing what medications a patient has taken in that past, the dosage and if there were any side effects. Armed with this information, a doctor may be able to provide a faster, more accurate treatment thus improving quality from both the patient and provider perspectives.

5. Legal Reform/Error Reporting: The readings make a compelling argument for the reform of the system and laws that are used to report errors and make restitution. The Diverseline discussions recognized the conflict with equating bad outcomes to poor quality of care. In either situation, bad outcome or poor quality, both need to be fully examined in the health care environment. We will not learn from our experiences if we are unable to openly discuss them. Unfortunately, openness on these subjects brings with it the thorn of scrutiny by others who are not capable of separating bad outcomes and poor quality of care.

Conclusions

The safety and effectiveness of health care in the United States can be improved. As we have discussed throughout this course, improvements in cost, quality and access are all intricately related to each other. Unfortunately, our current health care structure is one of many micro-systems that are not well integrated. In order to achieve real gains in quality, a comprehensive approach will needed to institute things like an electronic medical record, and clinical guidelines. This comprehensive approach will require unprecedented cooperation and coordination among the current micro-systems or a movement toward a national system. A statement in "A User's Manual for the IOM's 'Quality Chasm' Report," by Donald Berwick summarizes the WHO rankings of the U.S. health care system, "our awesome capacity for biomedical innovation has no match in our level of investment for delivery system redesign."