

Why attitudes to quality of care are changing

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The editorial by Stephen Bolsin is appropriate at this time of change in attitudes to patient safety and quality of health care. Bolsin has indicated one method to monitor the level of care; the recent use of comparative data by anaesthetic specialists. It is interesting to document the factors that have caused this change to collecting clinical indicators. Four seem particularly important to me.:

1. Increased willingness to report comparative information.

When the NSW hospital inpatient data were initially made available to my research group, some 20 years ago, it was on condition that we did not provide to one hospital the summary statistics of another hospital – only comparisons to aggregated hospital data were allowed. This significantly reduces the use of the data for determining the potential to improve, and a recent report of the Australian Council on Healthcare Standards (ACHS) shows the use of reporting hospital specific rates (ACHS and HSRG 2000; Gibberd, Pathmeswaran & Burtenshaw 2000). This report publishes the 20th and 80th centile as well as the mean rate, together with the gains to be made by shifting the mean to the 20th centile.

2. Access to more timely data and reports.

The resources directed to collecting hospital data have, primarily, been for the inpatient data, which in turn has been used for strategic planning of acute care services, resource allocation (Gilbert, Gibberd & Stewart 1992), and to a lesser extent quality. For planning and funding, delays in the reporting of the data were not regarded as a major problem – strategic plans based on data that are a year out of date are not going to create major problems. However, reporting higher deaths rates or returns to operating theatre that are 12 months out of date does present a major problem. This issue can be addressed through developing software that allows reports to be prepared as soon as the data are entered into the computer. The ACHS is developing such software that will be available later in the year.

3. Recognition that the magnitude of error is greater than the public assumed to be the case.

Studies such as the Quality of Australian Health Care Study (Wilson, Gibberd, Runciman et al 1995) are being replicated in other countries and reports show similar findings: namely that 10% or more of admission as associated with an adverse event. It is now recognised that adverse events account for about 10% of the hospital's annual expenditure.

4. The occurrence of poor care at a single institution.

This includes the Bristol Hospital, brought to light by Bolsin, the deaths due to a single GP in the UK, Canterbury Hospital's use of the wrong pharmaceutical product or the Chelmsford Hospital case. The Bristol enquiry will report soon and the recommendations are expected to result in major changes to the NHS. This will also impact on the Australian health system, with one expected feature being the increased use of clinical indicators.

Although the factors 1 to 3 listed above should provide the greatest opportunity for a scientific approach to improving the quality of care, it is a paradox that the one-off events such as those listed in 4 often provide the necessary force to overcome the resistance to change in the health care system. This may be of some concern to pioneers such as Brian Collopy and the Colleges who began developing the ACHS clinical Indicators 10 years ago, without receiving any of the same recognition as Bolsin.

This is not because the removal of two surgeons in Bristol saves more lives than the development of clinical indicators, but rather that the lives lost at Bristol (30 deaths over a 10-year period) are more easily documented and a known cause has been established. In contrast, the ACHS Indicator for death from coronary artery graft surgery shows that, in Australia, the rate has declined from 2.5% (1997) to 2.0% (1999) with a potential to be 1.5% in the near future. The potential number of lives saved as result of this reduction in Australia is 100 over a period of about four years.

The reasons for the decline are complex, and the impact is across all hospitals rather than in a single "bad apple". Further, it can be shown that improving the processes across all hospitals results in a greater gain than targeting a single outlier hospital. Clinical indicators can be criticised as being only a screening tool for measuring the variation in quality, but both risk management and accountability will result in their importance increasing.

Bolsin's success in encouraging anaesthetists to monitor their own performance continues the scientific approach noted in factors 1 and 2 above. The greatest returns will come when all hospitals are able to use a more refined version of that currently in use.

Progress requires three aspects: measurement; comparative analyses (analysed appropriately, using new standard statistical methods) as in ACHS and HSRG (2000) and Gibberd, Pathmeswaran & Burtenshaw (2000) and the scientific use of the results (often called the PDCA cycle). Bolsin is to be congratulated on being able to move from the Bristol case to the scientific approach that he mentions in his editorial.

References

ACHS and HSRG 2000, *Determining the Potential to Improve the Quality of Care in Australian Health Care Organisations: Results from the ACHS Clinical Indicators data 1998-1999*. 2000. ISBN 1 875544 90 9.

Gibberd R, Pathmeswaran A, & Burtenshaw K 2000, Using clinical indicators to identify areas for quality improvement. *J of Quality in Clinical Practice*, Dec 2000.

Gilbert R, Gibberd RW & Stewart J 1992, The New South Wales Resource Allocation Formula: a method for equitable health funding, *Australian Health Review*, vol 15 no 3, pp6-21.

Wilson RM, Gibberd RW, Runciman WB et al 1995, The Quality in Australian Health Care Study, *The Medical Journal of Australia*, vol 163 no 9, pp458-71.