

FMH – Verbindung der Schweizer Ärztinnen und Ärzte

International Review of Quality Management Systems in Outpatient Care

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Abbreviations

AAAHC	Accreditation Association for Ambulatory Health Care, US
AHRQ	Agency for Healthcare Research and Quality, US
AMA	American Medical Association
AMAP	American Medical Accreditation Programme
AQA	Ambulatory Care Quality Alliance, US
BMA	British Medical Association
CME&L	Continuing Medical Education and Learning
CPG	Clinical Practice Guidelines
CPSA	College of Physicians and Surgeons of Alberta, Canada
DRG	Diagnosis related groups
EPP	Evaluation des Pratiques Professionnelles, France
GBA	(German) Gemeinsamer Bundesausschuss, Federal Joint Committee
GP	General Practitioner
HAS	Haute Autorité de Santé, France
HSS	United States Department of Health and Human Services
ICT	Information and Communication Technologies"
JCAHO	Joint Commission on Accreditation of Healthcare Organisations
NCQA	National Committee for Quality Assurance
NHG	Dutch College of Family Physicians
NHS	UK National Health Service
OECD	Organisation for Economic Co-operation and Development
PDCA	Plan-Do-Check-Act
PSO	Patient Safety Organisation
QEP	Quality and Development for Practice, Qualität und Entwicklung in Praxen
QuIC	Quality Interagency Coordination Task Force, US
SCIH	Swiss Centre for International Health
STI	Swiss Tropical Institute
TQM	Total Quality Management
UK	United Kingdom

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Executive Summary

Equity, effectiveness, cost containment and quality of care are primary objectives of health policy and health service delivery. Over the last decades, quality of care management systems have received considerable attention, especially in hospitals settings. In parallel, evidence on quality of care and the related management systems in out-patient settings is scarce. Thus, the objective of this document is to review how quality of care is managed in different countries at national and regional levels, with special consideration of the role of medical associations.

This review was based on documents retrieved from “Medline”, a hand search in three peer-reviewed journals and consultations to various websites, including those of medical associations. Eight countries were included (United Kingdom, Germany, Netherlands, Denmark, France, and the province of Alberta in Canada, Switzerland and United States) and their quality management systems in outpatient care were related to 9 instruments or tools (continuous education, guidelines, audit and practice visits, quality circles and peer-review groups, benchmarking, computer-based clinical decision support, Break-through Series Collaborative, negative incidence reporting and patient compliance systems, and pay for performance). We also included two programs - the Performance Assessment Programmes and European Practice Assessment.

The role of medical associations with regards to the promotion of quality of care in ambulatory care varies greatly across the different countries, reflecting different health system settings. Over the last years, medical associations have undertaken new roles with regard to quality improvement and quality management. Traditionally medical associations were in charge of licensing doctors as specialists, continuous medical education of community-based physicians, and also negotiate service prices with health care financing bodies. Since the 1990s, medical associations have acquired an increasing relevance in the fields of quality assessment, quality management, clinical practice guidelines (CPG), quality control and auditing of medical services. Depending on the country, central or local administrations have created a legal basis to introduce quality management systems (QMS) in ambulatory care, such as in the case of Germany, Netherlands and the UK.

Depending on the policy choices, the role of professional associations has evolved in different ways. In some countries medical associations have generally maintained their traditional roles, with the addition of generating and validating CPGs for the various medical disciplines (e.g. Switzerland, US). In others (e.g. France, Germany) medical associations have formed coalitions with other stakeholders (e.g. health insurances, centres of excellence in health economy or Ministries of Health) to play a leading role in the promotion of quality care. In countries with strong governmental financing mechanisms medical associations have lost this role in favour of regulatory bodies that previously dealt only with financial control such as in the case of the UK NHS trust boards.

Quality of care, its assessment and quality improvements are playing an increasingly relevant in ambulatory care. Following the idea of Quality Management (QM), many of the performance measures go beyond clinical parameters to include organisational variables, access issues (e.g. waiting time for patients, opening hours), interdisciplinary relations (doctors, nurses, midwives), collaboration across system levels (hospital, ambulatory care, rehabilitation).

Funding of QM measures in ambulatory care depends on the organisation of care in each country. In general, quality assessment programmes are performed at the expense of the practice

owner, who can have a variety of indirect benefits. In France, for example, certification of a private practice owner may lead to a reduction in professional liability insurance fees; in Germany certified practices may negotiate better prices for services with the insurances. In countries with strongly regulated national health care systems (e.g. UK), there are generally subsidies from the health care financing organisations that set the standards for QM measures and goals, after negotiations with the other stakeholders.

There are many different instruments and tools for quality control used in ambulatory care across the different countries reviewed. They range from patients' questionnaires, doctors' self-assessment instruments and auditing, peer reviews or quality circles to total quality management schemes or accreditation procedures. Considerable research has been devoted to generate specific quality assessment tools for ambulatory care, such as the Quality and Development for Practice (QEP, Qualität und Entwicklung in Praxen) in Germany. Depending on the organisation of care in each country, independent organisations have to undertake these assessments, establish benchmark systems, elaborate quality standards, and provide information and learning opportunities for participants.

The document outlines three options for the Swiss medical association (FMH) on how to move forward in the area QM systems in ambulatory care:

- Focus on the current “core business”; in other words, CME, curricula development, promoting scientifically evident procedures and practices. This option has the advantage that strengthens areas where the institution is already good in. However, there is the risk that other players will fill the gap in field of institutional quality management systems and consequently the Swiss medical association would lose some of its influence.
- Focus on the role of a moderator of change; in other words, introducing continuous quality improvement measures, such as quality circles, peer audits, self assessment to certification. This option has the advantage that the Swiss medical association would have a neutral institutional standpoint, thereby providing reliable information for decision making at the level of its members. This would, at the same time, go along a limited influence on shaping the regulatory and practical working environment.
- Focus on a pro-active role with regard to QM systems improvement. This option would entail the establishment of partnerships with other actors for the development of QM improvement strategies and/or the mutual creation of institutions in charge of quality assessment. This option would allow the Swiss Medical association to maintain a high influence on regulatory environment and the introduction of QM measures. However, there is a risk of having limited capacity and many additional tasks, as well as the loss of the neutral position for its members and of the current visibility.

Doctors have a central role in quality of care. However, doctors cannot anymore justify quality care on the sole grounds of continuing medical education and/or licensing. In an era of increasing health care costs, the other stakeholders are more and more concerned about documenting of quality care. Therefore, medical associations cannot continue to rely only on their classical role if they want to play a central role in the promotion of quality care in the near future. An increasing transparency in the evaluation of quality, stronger interdisciplinary collaborations and integration of client expectations are needed. Furthermore, the lobbying on the policy level on the one side, and promoting the idea of QM to its members on the other side, will be essential. In countries where the national health care system is not too strongly regulated at a central level, the medical associations have this opportunity and they should make use of it.

Zusammenfassung

Die Qualität ärztlicher Leistung ist eine zentrale Zielsetzung bei der Erbringung von Gesundheitsdiensten. In den vergangenen Jahren haben Qualitätsmanagementsysteme, insbesondere im Spitalbereich, grössere Aufmerksamkeit erhalten. Gleichzeitig sind wissenschaftlich belegte Erkenntnisse zu Managementsystemen in der ambulanten Versorgung limitiert. Ziel dieser Arbeit ist es mittels einer Literaturrecherche publizierte Evidenz zu Qualitätsmanagementsystemen in der ambulanten Versorgung in verschiedenen mit der Schweiz vergleichbaren Ländern zusammen zu tragen. Dabei findet die Rolle von Fachverbänden spezielle Berücksichtigung.

Die Methode der Literaturrecherche beruhte auf formalen Suchtechniken innerhalb von elektronischen Datenbanken, der manuelle Sichtung von drei Fachzeitschriften und der Konsultation von Internet-Plattformen. Acht Länder wurden bei der Studie berücksichtigt: das Vereinigte Königreich (von England), Deutschland, Holland, Dänemark, Frankreich, die Provinz Alberta in Kanada, die Schweiz und die Vereinigten Staaten von Amerika. Dabei fanden acht Instrumente der Qualitätssicherung (Weiterbildung, Richtlinien, Audit und Praxisbesuche, Qualitätszirkel, Peer-review Gruppen, „Benchmarking“, Computer gestützte klinische Entscheidungshilfen, „Break-through series collaborative“, Anonymes Critical Incident Reporting und Patient Fehlermeldesysteme) sowie zwei Programme (Performance Assessment Programmes und European Practice Assessment) Berücksichtigung.

Die Rolle von medizinischen Fachverbänden bei der Qualitätssicherung in der ambulanten Versorgung variiert innerhalb der Länder. Innerhalb der letzten Jahre haben Fachverbände neue Funktionen bei Qualitätsmanagementsystemen wahrgenommen. Ursprünglich hat sich deren Rolle auf die Zulassung von Ärzten als Spezialisten und Weiterbildung beschränkt. Seit den 90er Jahren des letzten Jahrhunderts hat die Bedeutung von Fachverbänden bei der Qualitätssicherung zugenommen insbesondere im Bereich der Ausarbeitung von klinischen Standards („clinical practice guidelines“) und des Audits von medizinischen Diensten. Je nach Land, wurden rechtliche Grundlagen zur Qualitätssicherung erarbeitet. Dies trifft insbesondere für Deutschland, Holland und das Vereinigte Königreich zu.

Je nach Land haben politische Entscheide den Fachverbänden verschiedene Rollen zu geordnet. In Ländern wie der Schweiz oder den Vereinigten Staaten, haben Fachverbände ihre historischen Aufgaben bewahrt. In anderen Ländern wie Frankreich oder Deutschland haben Fachverbände Koalitionen mit anderen Interessensgruppierungen wie Krankenkassen oder Kompetenzzentren in Gesundheitsökonomie gebildet um eine Schlüsselrolle bei der Etablierung von Qualitätsmanagementsystemen wahr zu nehmen. In Ländern mit einer starken Rolle des Staates innerhalb des Gesundheitssystems, wie zum Beispiel im Vereinigten Königreich, verloren Fachverbände ihre ursprüngliche Rolle bei der Qualitätssicherung zu Gunsten von neu etablierten Institutionen.

Allgemein kann festgestellt werden dass die Qualitätssicherung in der ambulanten Versorgung an Bedeutung gewinnt. In Anlehnung an eine Grundidee der Qualitätssicherung stehen dabei nicht nur klinische Parameter sondern auch organisatorische Fragen wie die der Zugang zu Gesundheitsdiensten (zum Beispiel Wartezeiten) und die interdisziplinäre Zusammenarbeit zwischen verschiedenen Berufskategorien im Vordergrund.

Die Finanzierung von Qualitätssicherung in der ambulanten Versorgung ist abhängig von der Organisation eines Gesundheitssystems. Typischerweise werden Qualitätssicherungssysteme von den Leistungserbringern finanziert, die dafür im Gegenzug Vorteile erhalten. In Frankreich

zum Beispiel ist die Zertifizierung von ambulanten Versorgern an eine Reduktion von Versicherungsprämien gekoppelt. In Deutschland ist es für zertifizierte Praxen möglich bessere Preise mit Krankenkassen zu verhandeln. In Ländern mit einem stark regulierten Gesundheitssystem (Vereinigtes Königreich) gibt es Unterstützungen durch die Finanzierungsinstitution(en) die gleichzeitig die Standards bei der Qualitätssicherung setzen.

Die Instrumente die bei der Qualitätssicherung benützt werden variieren je nach Land. Dabei geht das Spektrum von Patientbefragungen, Selbst-Evaluation von Ärzten und Audits über Qualitätszirkel bis hin zu Akkreditierung. Die Erstellung dieser Instrumente war in einigen Fällen mit grösseren Forschungsvorhaben verknüpft wie im Beispiel der „Qualität und Entwicklung in Praxen“ („European Practice Assessment“) in Deutschland und in einem geringern Ausmasse der Schweiz. Je nach Land wurden unabhängige Organisation mit der Aufgaben betraut, diese Evaluation vor zunehmen, und Qualitätsstandards oder Benchmarkings aus zu arbeiten.

Diese Studie zeigt der Verbindung der Schweizer Ärzte und Ärztinnen (FMH) drei Möglichkeiten auf wie Qualitätsmanagementsysteme in der ambulanten Versorgung weiter aufgenommen werden können:

- Fokus auf das gegenwärtigen Aufgaben, mit anderen Worten Weiterbildung, Curriculum Entwicklung und der Förderung von wissenschaftlich abgestützten Abläufen. Diese Variante bietet den Vorteil sich auf die derzeitige Kernkompetenzen der FMH ab zu stützen. Gleichzeitig besteht das Risiko dass andere Akteure die Lücke im Bereich von Institutionen mit dem Mandat der Qualitätssicherung füllen. Dadurch könnte die FMH ein Teil ihres derzeitigen Einflusses verlieren.
- Fokus auf die Rolle eines Moderators von Änderungen. Dies würde es mit sich bringen dass Instrumente der Qualitätssicherung wie Qualitätszirkel, Audits durch Berufskollegen oder Selbstevaluationen systematisch durch die FMH als Standart propagiert würden. Dies würde für der FMH die Möglichkeit eröffnen eine neutrale Rolle ein zu nehmen dabei aber gleichzeitig Informationen zur Entscheidungsfindung ihren Mitgliedern zur Verfügung zu stellen. Gleichzeitig wäre die Einflussnahme auf das gesetzliche Umfeld begrenzt.
- Fokus auf eine pro-aktive Rolle bei der Verbesserung von Qualitätsmanagementsystemen. Diese Option würde die Etablierung von Partnerschaften mit anderen Akteuren beinhalten und/oder die gemeinsame Etablierung von Institutionen die mit der Qualitätssicherung beauftragt sind. Dies würde der FMH erlauben weiterhin einen starken Einfluss auf das gesetzliche und regulatorische Umfeld zu bewahren. Gleichzeitig besteht das Risiko dass die derzeitigen Kapazitäten der FMH nicht ausreichen um zusätzliche Aufgaben wahr zu nehmen. Im Weiteren würde die FMH ihre neutrale Position bei der Qualitätssicherung aufgeben und allenfalls ein Teil ihres Profils durch Partnerschaften verlieren.

Ärzte spielen eine zentrale Rolle bei der Qualitätssicherung. Gleichzeitig genügt es im heutigen Umfeld nicht mehr Qualität alleine auf Weiterbildung und Lizenzierung zu begrenzen. Im Zeitalter der „Kostenexplosion“ im Gesundheitswesen, ist es für viele Akteure von grosser Wichtigkeit dass der Qualitätssicherung eine zentrale Rolle zufällt. Dementsprechend können sich Fachverbände nicht damit begnügen ihre klassischen Aufgaben wahr zu nehmen falls sie weiterhin eine zentrale Rolle spielen wollen. Transparenz bei der Evaluation von Qualität, stärkere Zusammenarbeit über verschieden Berufskategorien und die Aufnahme der Erwartungen von PatientInnen sind notwendig. In Ländern in denen das gesetzliche Umfeld nicht sehr stark reguliert ist, haben Fachverbände die Möglichkeit eine konstruktive und pro-aktive Rolle bei der Ausgestaltung von Qualitätsmanagementsystemen zu spielen.

1 Introduction

Historically quality management systems emerged from the industry and services-related activities. Through the enforcement of appropriate principles of quality management, the industry increased the quality of their products and services and simultaneously reduced costs by decreasing waste, rework, staff attrition and litigation, and increased customer loyalty. Over the time, two prominent concepts emerged: Continuous Quality Improvement (CQI), which focuses on industrial methods, and Total Quality Management (TQM), which more is management oriented. However, in practice these terms are frequently used interchangeably because they share common principles. Although 'control' and 'inspection' can both help to identify standard products and services, these activities are not enough by themselves to raise the level of quality. In order to improve quality, it has to be integrated into the production processes from the very beginning, so as not only to exert remedial action but also, or even mainly, to prevent quality related issues in the first place. Three major elements characterise this approach: (1) the use of continuous measurements of quality, (2) a client satisfaction focus and (3) the empowerment of employees through teamwork and shared decision-making.

In the early 1980s, the American health care industry started to focus on quality management in order to insure the delivery of quality care at a reasonable cost. However, major differences between the health care sector and industrial production have limited the widespread use of these management principles. Among other problems, the 'technical' quality in health care cannot be judged easily by the patient, or the consumer, due to the limited amount of information. Customer satisfaction is thus a specific criterion as it reflects mainly perceptions about health services. For these reasons, some authors have seen "Total Quality Management" as a comprehensive approach facing the challenges described above and taking into account the more traditional approaches to quality of care –such as licensing, accreditation, and setting standards (Morgan and Murgatroyd, 1994).

Pressure from health insurance bodies, policy makers and the general public for cost containment in the health sector, together with the ageing of the population and the emergency of new drugs and medical technologies, are altogether the driving forces for the increased attention being given to quality of care and related management systems. In consequence, and since the 1990s, hospitals have been under pressure for better accountability and transparency (Wagner et al., 2006) and several quality management systems have emerged.

In the health sector, quality of care management systems can be defined as:

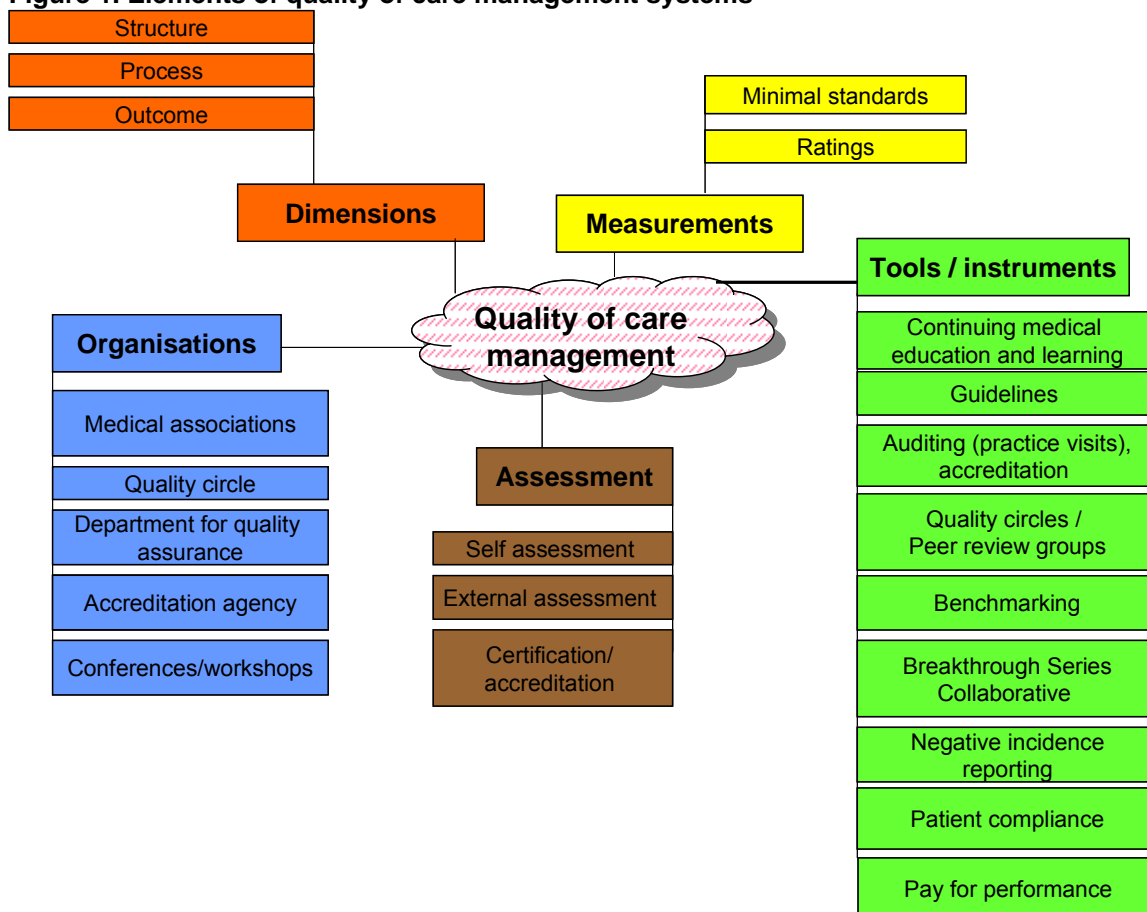
A set of integrated and planned activities and measures at various levels in the health care organisation, aimed at continuously assuring and improving the quality of patient care (Council of Europe, 1997).

Assessment of quality of care can be addressed to three dimensions of the health care system (Donabedian, 1966; Donabedian, 1980): structure, process and outcome. 'Structure' refers to the environment in which health care is being provided (e.g. infrastructure of the facilities, equipment, staff qualification), 'process' refers to what is actually done when delivering care (e.g. timelines, continuity, adherence to standards) and 'outcome' to the resulting effect on the health of the patients (e.g. survival, functional status, quality of life, patient satisfaction).

Quality of care management systems in the health sector is characterised by various elements as shown in Figure 1. Quality of care has to be measured in order to determine to which extent improvement has taken place. 'Improvement', though, has to be relevant to 'quality of care' as

defined by health care providers or health insurance bodies, but also taking into account patients' perspectives and societal aspects, such as demographic trends at population level. In other words, depending on the importance conferred to equity, accessibility, acceptability, comprehensiveness, effectiveness, efficiency or sustainability in a health care system, greater or lesser importance will be assigned to the different dimensions of quality of care in a given system. (Woodward, 2000:4).

Figure 1. Elements of quality of care management systems



This report provides an **overview on the quality of care management systems in outpatient care** in different countries of Europe and America, with a specific focus on the role of professional organisations (national or regional medical associations) and the instruments used to measure the quality of health care. Unlike hospital and large institution settings, in which quality management has been important for long, quality of care management systems in outpatient care settings has received less emphasis until recently, partially due to conceptual issues in the definition of quality and the availability of information to assess quality at that level. Under the pressure of health insurance bodies and policy-makers to contain health care costs, there is an increased pressure on health care providers of any type to justify the quantity and quality of care they deliver.

Ambulatory care is delivered in many different ways ranging from general practitioners or family doctors in single or group practices, up to specialist doctors operating in single or group setting. Hospitals do offer outpatients services as well; for example ambulatory surgical procedures. Outpatient care may be episodic or continuous, such is in the case of chronic conditions like diabetes or rheumatism. Ambulatory care may involve multiple providers and specialties, and

may give variable emphasis to person-centred approaches in dealing with patients and problems in the context of the patient's particular circumstances.

In outpatient settings of many countries, Continuing Medical Education and Learning (CME&L) measures, such as the participation in congresses and workshops and self-studying were until recently the only system used to guarantee that high-quality care was being delivered to patients. Such a system focused only on increasing the knowledge of doctors, and do not warrant that inefficient, unnecessary and potentially harmful care is completely avoided.

As the Swiss Medical Association (FMH) is interested to carry forward the discussion and possibly the implementation of managements systems of quality of care in out-patient settings the agency commissioned this review. **The aim of this report is to:**

- Review how quality of care is managed in different at least partly comparable countries at national and regional levels with special consideration of the role of medical associations.

In the first section, there is a description of the approach and methods used in this review. The following sections present the quality management systems in a selected number of countries (Canada, Denmark, France, Germany, Netherlands, Switzerland, United Kingdom and the United States) with a strong emphasis on the role of medical associations. Next, the approaches to quality management used in those countries are described. The conclusion provides an outlook of the roles of and advantages of medical associations in promoting quality management systems.

2 Approach and methods

In the period April to October 2007, we undertook a systematic review of the literature using a standard methodology. Thereby the review was restricted to information sources published in English, French and German. Quality of care management was defined for this review as a “set of integrated and planned activities and measures at various levels in the health care organisation, aimed at continuously assuring and improving the quality of patient care” (Council of Europe, 2000).

Several information sources were identified, as shown in Figure 2. We searched index terms and key words in “Medline”, scrutinised references from the retrieved articles and conducted a hand search for tools or measures used in quality management systems in three journals focusing on quality of care: (1) International Journal of Health Care Quality Assurance, (2) Quality and safety in healthcare, (3) Journal for Healthcare Quality. Thereby we used the key word quality management and related it to tools/instruments listed below. We then screened the abstract of identified references and decided on the relevance for inclusion in the review.

In addition, we looked up at various relevant internet sites to review evidence on quality management systems:

- United Kingdom: British medical association¹
- Germany: German “Bundesärztekammer”²
- Netherlands: Dutch College of General Practitioners³
- Denmark: Danish Ministry of the Interior and Health⁴
- France: Haute Autorité de Santé⁵
- Canada (Alberta): Alberta Medical Association⁶ and the Canadian Federal department of Health⁷
- United States: American Medical Association⁸ and US Department of Health & Human Services⁹
- Switzerland: Swiss Medical Association¹⁰, swisspep¹¹

For the review of tools or measures used to document quality of care in these different countries, we selected nine tools or interventions: a) continuing medical education, b) guidelines, c) audit et practice visits, d) quality circles and peer-review groups, e) benchmarking, f) Break-through Series Collaborative, g) negative incidence reporting, h) patient compliance systems, and i) pay for performance. We also included two measuring systems: the Performance Assessment Programmes and European Practice Assessment.

¹ <http://www.bma.org.uk/ap.nsf/content/splashpage>

² <http://www.bundesaerztekammer.de/>

³ <http://www.onderzoekinformatie.nl/en/oi/nod/organisatie/ORG1237274/>

⁴ <http://www.im.dk>

⁵ http://www.has-sante.fr/portail/display.jsp?id=j_5

⁶ <http://www.albertadoctors.org/>

⁷ <http://www.hc-sc.gc.ca/>

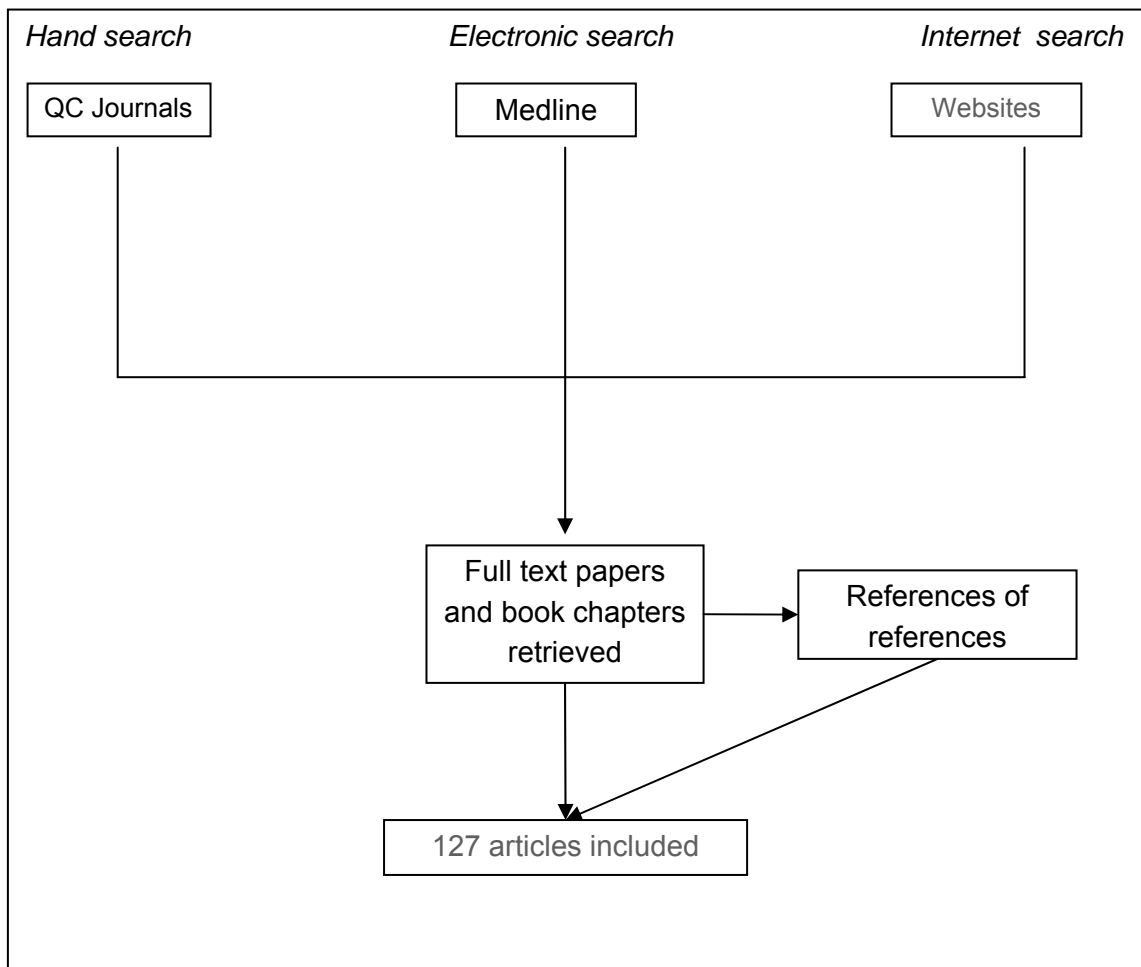
⁸ <http://www.ama-assn.org/>

⁹ <http://www.ahrq.gov/>

¹⁰ <http://www.fmh.ch/de/>

¹¹ <http://server40.hostpoint.ch/~swisspep/index.php>

Figure 2. Summary of sources contributing to the systematic review



3 Quality management systems in selected countries

3.1 The United Kingdom

The National Health Service (NHS) in UK is a complex organisation with several different sub systems. To mention some of them: health prevention and promotion; ‘first contact’ services such as General Practitioners, pharmacies and NHS Direct; community and intermediate care; acute care in hospitals; specialist services. In 1989 Margaret Thatcher’s Government introduced regulations which promoted the development of an “internal market” within an essentially tax-funded system. In practice, this meant that district health authorities – the bodies appointed by the Government to run local health services– became purchasers of services for their communities. Most of the hospital and community health services are currently run by self-governing NHS trusts, leaving the district health authorities to concentrate on their purchasing role. One of the long term results of these changes was the current “postcode lottery” situation, whereby the quality and even the availability of services varies according to the area of residence. Citizens can only change their health authority if they are in a position to change their residence and they can only seek care elsewhere if they use a private health insurance scheme.

The country is now entering another decade of health and social welfare reforms, involving restructuring and substantial investments in the health system. For all health services, the objectives are to (DH Departmental Report, 2006):

- improve health/wellbeing, reduce health inequalities and social exclusion;
- secure access to a comprehensive range of services;
- improve the quality, effectiveness and efficiency of services;
- increase choice for patients and ensure a better experience of care through greater responsiveness to people’s needs; and
- achieve best value within the resources provided.

3.1.1 Quality Improvement

Clinical Governance: At the heart of quality management systems in the National Health Service lies a systemic approach to improve processes known as “Clinical Governance”. The most widely cited formal definitions describe it as:

A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. (Scally and Donaldson, 1998).

This definition is intended to embody three key attributes: (1) recognisably high standards of care, (2) transparent responsibility and accountability for those standards, and (3) a constant process of improvement.

Prior to 1999, the principal statutory responsibility of UK NHS Trust Boards was to ensure proper financial management of the organisation and an acceptable level of patient safety. Trust Boards had no statutory duty to ensure a particular level of quality. Maintaining and improving the quality of care was understood to be the responsibility of the relevant clinical professions – such as the British Medical Association (BMA). As of 1999, Trust Boards assumed a legal responsibility for quality of care equal in measure to their other statutory duties. Clinical Governance is the mechanism by which this responsibility is assumed and contains the following in-

struments: (*) Education and Training (Continuing education), (*) Clinical Audit, (*) Clinical Effectiveness, (*) Research and Development, (*) Openness, and (*) Risk management. This change in quality management has impacted strongly on the roles of professional associations and health professional councils.

Clinical governance aims to encourage a more open environment for discussing and learning from medical errors. Experience from the UK show that the introduction can easily be complicated by the different definitions and methods used in the international literature. Secondly, however, it has been shown that the very realisation of the frequency and nature of medical error in primary care is a first step in developing a policy to reduce harm and improve patient safety (Sandars & Esmail, 2003).

What so ever, the professional councils – such as the General Medical Council (GMC)¹²– now have strict revalidation processes– so medical doctors (amongst other cadres) can demonstrate to patients that they are up to date and deliver safe care. The BMA¹³ has supported this move so far, as long as the criteria used remain “fair and workable”. A new concern is that the Government may attempt to introduce minimal clinical standards as requirements for re-licensing.

Medical doctors clearly have to be registered before they can seek membership of professional associations. The BMA has now adopted a very strict position regarding recognition of a member. Above all, the BMA advocates for doctors’ clinical independence, in a health system with a strong regulatory framework. BMA takes the view that the state-owned NHS is a monopoly employer, with an appointed regulatory body. It is therefore very important for the doctors to preserve their clinical independence when caring for individual patients - and if necessary fight for the right drug, the best treatment, and the patients’ freedom to choose where to be treated.

BMA is also a strong advocate of professional self-regulation, a position which they see as currently under threat. In the wake of several scandals and negative media attention about the quality of care, the Department of Health issued a White Paper in February 2007 “Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century” (Government White Paper, 2007). The paper outlines several policy changes as being necessary to “protect the public” and which essentially amount to a strengthening of centralised control mechanisms on medical doctors and other health professionals.

The BMA opposes Government proposals for the GMC to have appointed rather than elected members and the proposal to change the composition of the GMC Council to include equal numbers of lay and medical members. The current composition has a greater number of medical doctors who are elected by the BMA. The Government would like to separate investigation and prosecution from adjudication of cases. Currently both functions are within the GMC. The BMA questions the evidence being used for this decision and the sources of funding for a second body.

Furthermore, both BMA and GMC oppose that standard labour productivity measures are used

¹² The General Medical Council (GMC) registers doctors to practise medicine in the UK. GMC has four main functions: (1) keeping up-to-date registers of qualified doctors; (2) fostering good medical practice; (3) promoting high standards of medical education; (4) dealing firmly and fairly with doctors whose fitness to practise is in doubt.

¹³ The British Medical Association represents doctors from all branches of medicine all over the UK. It is a voluntary association with about 75 per cent of practising doctors in membership. It has a total membership of over 135,000, rising steadily, including more than 3,000 members overseas and over 15,000 medical student members.

in the NHS. They rather argue to take into account relevant health system outcome measures such as appropriateness, quality and the value attached to the inputs or outputs of the services. This is in addition to the ongoing concerns of the BMA about what it sees to be the “rationalising role” that the National Institute for Health and Clinical Excellence plays vis-à-vis the treatments offered.

The National Institute for Health and Clinical Excellence is a Special Health Authority of the NHS in England and Wales. It was set up as the "National Institute for Clinical Excellence" in 1999, and on 1 April 2005 joined the Health Development Agency to become the new "National Institute for Health and Clinical Excellence" (- it continues to be abbreviated as NICE). NICE publishes clinical appraisals of whether particular treatments should be considered by the NHS. These appraisals are based primarily on cost-effectiveness criteria.

3.1.2 Quality tools

As described above, Clinical Governance is the mechanism used to assure quality of care, and contains the following instruments:

- Education and Training (Continuing education)
- Clinical Audit
- Clinical Effectiveness (Clinical practice guidelines)
- Research and Development (Evidence based decision making)
- Openness - including reporting of “near misses” (equivalent to critical incident reporting)
- Risk management (including reporting of adverse events and medical errors)

Pay for performance: The BMA has taken a strong role in establishing the Quality and Outcomes Framework (QOF) – essentially a performance assessment programme for use in “pay for performance” contracts. Pay for performance is a tool introduced in the NHS in 2004 for family practitioners. The contract increases existing income according to performance with respect to 146 quality indicators, worth between 1-56 points and covering clinical care for 10 chronic diseases, patient experience and the organisation of care delivery (Doran et al, 2006).

The indicators used in the QOF performance assessment programme are – as far as possible – based upon the best available evidence. The number of indicators in each clinical condition has been kept to the minimum number compatible with an accurate assessment of patient care. It is stipulated that data should never be collected purely for audit purposes and that the basis of the consultation should not be distorted by an over-emphasis on data collection. An appropriate balance it believed to have been struck between excess data collection and inadequate sampling. Comparisons across Europe show that the UK was quite unique: approximately 20% of the indicators in the QOF relate to organisational aspects of care whereas in other countries this rate is much lower. However, there is no consensus on the weight to be given to organisational factors in performance assessment. Even in such a well developed system of primary health care services, computer systems in several general practices failed to retrieve data about simple indicators (Baker, 2000).

Initial studies point to the potential of such contracts to create monetary incentives in favour of General Practitioners (GPs) thereby improving the quality of clinical care (Ashworth, 2005). Other investigations, however, raise concerns about the systems as it is up to practitioners to self-report their performance. The system is open to abuse whereby practitioners can classify patients as ineligible for quality indicators for reasons other than sound clinical ones. The principle of exclusion is in place to avoid inappropriate treatment of certain patient groups (e.g. the

terminally ill). Given that higher performance leads to higher income – each point earning £76 up to a maximum of £79,800 per practice and £25,000 per GP- it is possible that doctors may exclude cases with poor outcomes (Doran et al, 2006). Differences according to socio-economic context as well as practice and population characteristics are all thought to be variables which could affect pay for performance contracts and are being researched in a series of ongoing studies.

Another issue that always emerges in the context of modernising outpatient services in the NHS is clinical efficiency. In the context of the current ongoing decade of reform a partial booking systems is being introduced. This is a new approach to tackling the “waiting time” problem that has long been a bone of contention in the NHS. In the Patient’s Charter (established in 1991 under the conservative government and subsequently withdrawn in 2000, with the launch of the latest 10 year Reform), the standard was laid down that all patients who attend out-patients should be seen within 30 minutes of their appointment time. Attempts made to monitor these criteria often took a purely quantitative approach. Several studies argued that statistical monitoring alone isn’t enough to deliver quality improvements, but that qualitative analysis of patients’ perceptions and experiences are also needed (Hart, 1995; Hart, 1997). The intention behind the new partial booking system is that improvement strategies will allow for more patients to be seen and for waiting times and numbers to reduce. Eventually, it is hoped that it will lead to greater predictability regarding the number of patients, allowing for better planning of resources and more time for each individual case.

3.1.3 The role of medical associations

There has been an ongoing emasculation of the role central government allocates to medical associations in the area of quality management. Traditionally, professional associations were seen as being responsible in this area and practiced self-regulation. As of 1999 Trust boards assumed a legal responsibility for quality of care within the framework of “clinical governance”. Strict licensing and revalidation processes are managed by professional councils – with professional associations able to approve continuing medical education. Self regulation is currently seen by the BMA to be under threat. Professional associations protest that the ongoing rationalisation and efficiency drive in the NHS seeks to reduce complex health processes to standard labour productivity measures and that quality of care is suffering as a consequence.

3.2 Netherlands

The quality of care in the Netherlands is typically regarded as good, when compared internationally. Between 2000-2004, the costs of providing this highly accessible health care rose in the same range as other EU countries. In 2003, 9.1% of GDP was attributable to the health care system, a proportion that puts the Netherlands well below the spending levels of other countries such as Germany, France, Canada and especially Switzerland and the United States. The system is well funded with three main sources – employer contributions, government grant and a private sector contribution. These are supplemented by taxes and out of pocket payments. This system has also a strong history of consensus-seeking and debate in the community.

The primary health care system relies on family physicians that function as “gatekeepers”. The successful impact of gate keeping in the Dutch system is reflected by a very low referral rates from primary care providers– usually around 6% of all cases. The other remarkable feature is

the low prescription rate of drugs – delivered to only two thirds of cases – compared to 75-95% in other European countries. In this health care system, family physicians are encouraged to spend a great deal of time talking with patients – to discuss both the nature of the medical problem and also various psychosocial aspects, rather than prescribing drugs.

However, there is still room for improvement, especially with regards to the effectiveness of prevention and care, patient safety and coordination of “transmural care” – care given “across the walls” to bridge the gap between general outpatients and specialised inpatients care (Exter et al, WHO, 2004).

3.2.1 Quality Improvement

In 1989, the first national broad-based conference on quality in healthcare was held. Participants agreed that health care professionals, doctors, nurses and other personnel together with institutions such as hospitals and nursing homes should all develop their own quality systems. As a result professionals and their associations went down the line of focusing very much upon “treatment” through the introduction of formalised, accredited training programmes, mandatory re-licensing procedures for health professionals, as well as the introduction of national practice guidelines, peer reviews and audit programmes for different health professional groups. Family doctors, for example, are re-assessed every 5 years, based on their practice experience and the post-graduate courses they have taken during this time.

Healthcare institutions have developed quality management programs based on the European Foundation for Quality Management (EFQM) model, the International Organization for Standardization (ISO) model and the North American Accreditation model. These systems include an important component of processes related dimensions of delivery of care.

Legislation followed in the wake of this with the 1995 Quality in Institutions Act and the endorsement of the principle of self-regulation in law. However in 2000, some experts pointed out to the danger of a division emerging between professionals and institutions rather than the development of integrated care.

Public insurance schemes are regulated through the Sick Fund Law (ZWF), covering most of the treatment sector (e.g. hospitals, ambulatory services) and prescription drugs, and the Catastrophic Illness Act (AWBZ), covering most of the care in institutions (e.g. nursing homes, homes for the elderly, home care) (Klazinga, 2001).

Since 2006 a radical market reform merged social and voluntary private health insurances into one mandatory system executed by private insurers (Douven et al, 2006). It then became the role of the Government to supervise and regulate practitioners to ensure accessibility and quality in health care, whilst private health providers took up the responsible for service delivery. The population over 18 years and not socially disadvantaged has to purchase private health insurance covering a basic package of health care services. Although the Ministry of Health (Ministerie van Volksgezondheid, Welzijn en Sport) determines a standard premium, the insurance companies are free to offer other additional packages at prices they define. It is with these additional fees that the insurance companies compete with each other. Proposals are being developed to merge the Catastrophic Illness Act (AWBZ) and Sick Fund Law (ZWF) under one basic insurance package for treatment and care. However, bringing all stakeholders together within a coherent quality framework for the country has been a difficult task.

3.2.2 Quality tools

The quality management system in the Netherlands relies on different instruments. Besides the instruments presented in the subsequent paragraphs, there are also practice visits where the Dutch College of Family Physicians (NHG) undertakes supervisory visits which are seen to be more supportive than for controlling and benchmarking. Despite this, the subject of benchmarking has pushed the question of performance indicators for health systems up the Dutch political agenda. The indicators the first studies used, like Disability-Adjusted Life Expectancy or fairness in financial contribution, were not perceived by the public to really address the “real” problems such as waiting times and labour shortages. The resulting academic and public debate led to the Dutch pioneering the concept of performance assessment (see below).

Clinical Practice Guideline Development: The first major movement to improve quality in the Netherlands focused upon the development of national clinical practice guidelines. This effort was spearheaded by the Dutch Institute for Health Care Improvement and the NHG. Multidisciplinary collaboration for quality improvement is a salient feature of the Dutch system. Professional associations for all cadres have been involved in the development of their own guidelines since the mid 1990s. More than 80 clinical guidelines are in place for primary care alone (Grol, 2006).

A positive example cited in the literature is the experience of the NHG, which has elaborated clinical practice guidelines supported and promoted by the development of a range of materials, such as cards that summarize the content of the guidelines, packages for individual and group education, knowledge tests, written patient information materials, electronic prescribing system, and practice visits by trained practice consultants.

Continuous Medical Education (CME): Tools and courses have been constantly developed in order to convey the content of the above guidelines as they have been produced. The monitoring of guideline use is also well established with data showing that adherence to guidelines is better than in the UK or the USA (Seddon et al, 2001).

Licensing of doctors: Prior to the mid 1990s, the evaluation in primary care was limited to licensing doctors on the basis of CME. Currently, indicators and assessment tools to measure clinical performance, prevention, management of services and patient experiences with the care provided are in place.

Quality Circles: In the mid 1980s, local collaborations were developed in the Netherlands and continue to be one of the most widely used methods of continuous quality improvement in primary care. They are multidisciplinary teams who discuss clinical guidelines, performance issues, exchange best practices and plan for change. Their effectiveness has been enlightened in some research studies (Geboers et al, 1999).

Performance Assessment: The Dutch Ministry of Health, Welfare and Sports commissioned the National Institute of Public Health to compile a “Dutch Healthcare Performance Report” every two years beginning in 2006. The development of the methodology was a major effort to monitor health care system performance whilst safeguarding coherence in the system and assuring that it becomes less service-based and more community oriented. Furthermore, it sought to develop national performance indicators that are integrated in the whole system and meaningfully link public health data and the performance data of individual services. The Healthcare Performance Framework covers several dimensions of quality, access and costs:

- 68 Quality indicators have been selected to measure effectiveness, patient safety, pa-

tient centeredness and innovativeness. Examples include: GP's adherence to guidelines and percentage of wound infections in hospital.

- 37 Access indicators to measure patient choice, timeliness (delivery of time-sensitive care) accessibility (e.g. spatial access) and availability of staff. Examples include: waiting lists and waiting time to consultation.
- 26 Cost of Health Care indicators which measure macro expenditure, market elements, productivity and the financial position of health care providers and insurers.
- 125 Health Policy indicators to measure health impact, susceptibility to being influenced by the health care system, policy importance and the Organisation for Economic Co-operation and Development (OECD) indicator framework. They look at time trends, how the Netherlands compares internationally, whether there is provider variability within the country and adherence to norms, among other issues.

The reform process in the Dutch health system – monitored through the above framework – has shown important quality improvements, as well as the significant potential for more effective prevention. This is being used to lobby for increased research into preventive interventions and on how to reach more high risk groups.

Patient information: The NHG support GPs how to provide information to patients and the public. Whilst patient's interest groups exist in all countries mentioned in this review, the Dutch Federation of Patients and Consumers is particularly capable in its approach and intent to convey information about the quality of health services to consumers.

Patients' complaints procedures are available across the entire health care system. The complaints committee has an independent chair. Experience has shown, however, that the level of participation in ambulatory care is much lower when compared to long institutional stays.

Break-through Collaborative: Breakthrough Series Collaborative (BSC) is to have learning sessions with professionals from the different professional corps of hospitals, clinics or group practices (physicians, nurses, administration staff, etc) and, focusing on specific topics that require improvement. Experience on the subject of strokes in the Netherlands has shown that this method has been able to promote multidisciplinary teams to take a new look at their practice and how they could improve their services (Minkman et al, 2005:7). The teams considered different aspects, and fixed multiple aims, spread over time. "Within the timeframe of the project, 36% of the first and 33% of the second project group achieved significant improvements on all aims which testify to the potential this innovative approach would seem to have" (Minkman et al, 2005:7).

3.2.3 The role of medical professional associations

Regarding the role of the medical professional association in quality of care management, there is a clear differentiation between the union and scientific functions of the professional medical associations in the Netherlands.

The NHG is the scientific organisation and centre of knowledge for GPs which contributes significantly to the professionalisation of general practice and support of GPs in their daily practice (NHG, 2007). On the other hand, the Dutch Association of General Practitioners (LHV) is the union of GPs.

NHG has spearheaded the move to develop Clinical Practice Guidelines and formulated innovative interdisciplinary agreements with other primary care disciplines – midwives, occupational

therapists, district nurses and paramedics. They also collaborate closely in the development of pharmaceutical recommendations and practice guidelines.

The annual NHG congress and NHG Science Days have important functions as scientific meeting points for GPs and provide a platform for discussion. A great deal of attention is paid to feedback – NHG keeping its members very well informed. They also advise and support districts in the development and evaluation regarding the implantation of quality measures.

NHG has overseen the introduction of information and communication technologies (ICT) so that they have become an integral part of general practice. Since the 1980s NHG has formulated reference models which describe the minimum requirements for a GP system.

NHG encourages scientific research on subjects which are directly relevant for general practice. Gaps in the scientific basis for practice guidelines are published on their website in the forms of research questions.

The Royal Dutch Medical Association (KNMG) is the federation of medical practitioners' professional associations. It has two main mandates – continuing medical education and licensing and revalidation of practitioners. Additionally KNMG provides support to the member professional associations in terms of facilities and services, such as advice on legal and ethical issues (e.g. euthanasia).

3.3 France

In France, the State – as the responsible entity of the public interest, the improvement of the health status of the population – controls the relations between the financing institutions, the professional and patient associations. The Parliament is advised by the National Health Conference (composed of professional representatives, institutions and health care settings, regional health conferences) who guides the State in priorities and orientations for the health policies. The National Health Conference is advised by the *High Committee for Public Health* (Haut Comité de Santé Publique), the *High Authority for Health* (Haute Autorité de Santé, HAS), and at the regional level, by the *Regional Health Conference*.

Outpatient care is mainly provided by self-employed doctors, both generalists and specialists, who are settled in their own practices and work alone. Indeed, only 38% of doctors are involved in group practices, which aim at providing specialized care that require extensive technical capacity. (European Observatory on Health Care Systems, 2004)

In France, there are two sorts of medical associations: (1) the professional associations for each medical organisation, whose concern is medical ethics and the supervision of professional practice, and (2) the trade unions which look after the interests of the different professional groups. The representation of the unions is rather weak, due to the fact that it's fragmented as a result of the differences between professional statuses (e.g. salaried versus self-employed professionals).

3.3.1 Quality Improvement

Starting in the 1990s, several reforms have been undertaken by the State, including the introduction of Quality Management tools. The quality of care and the evaluation of medical practice

were promoted through two main tools: the establishment and dissemination of a system of practice guidelines and the promotion of continuing medical education. However, some of the constraining measures resulted in complaints and resistance amongst the health staff, and some measures had to be withdrawn (e.g. sanctions to doctors if they didn't follow the guidelines on fees and prescriptions). In consequence, the relationship between the medical profession on one hand and the government and health insurance funds on the other hand, have been tense and with a strong opposition on the part of the medical profession. Furthermore, the reforms have accentuated the breach in the unity of the medical profession between the general practitioners and the specialists, due to the fact that the health insurance funds could set separate agreements with each one of those two categories of practitioners.

The HAS, previously named as the National Agency for Accreditation and Evaluation of Health Care (ANAES), was created in 1997. Composed of doctors, other health care professionals, economists, and other professionals, HAS is working in collaboration with health insurance funds and medical unions to advise the Ministry of Health. The Parliament has delegated to the HAS the following functions related to the regulation and improvement of the health system: "assessing the quality of organizations and practices; assessing the expected or actual benefit of goods and services; defining the clinical and financial management of long-term conditions; providing information to professionals and to the general public; helping to assess how well public health is managed by the health system". (HAS, 2005: 1)

In summary, HAS has the following mandate (HAS, 2005: 4): (1) provision to the public authorities with the information they need in order to decide which medical products and services should be reimbursed by the National Health Insurance (NHI) (assessment of the clinical benefit of medicines, medical devices and procedures reimbursed by the NHI; definition of the range of care that may be reimbursed to patients with long-term conditions); (2) promotion of good professional practice (clinical practice guidelines; guides to managing chronic conditions); (3) improvement of the quality of healthcare structures, resources, and practice (accreditation, assessment of health centres and reference centres for treating rare diseases; certification of doctors and medical teams; continuing professional development for doctors); and (4) provision of information for healthcare professionals and the general public.

The QM initiatives promoted by HAS are: a compulsory accreditation process for public and private hospitals and other voluntary QM tools (mainly audits, but also benchmarking, practice visits, peer review) for the self-employed professionals. HAS also prepares practice guidelines that are issued and distributed to the entire medical profession and elaborates recommendations. There is no systematic evaluation at the level of the individual health care professional, and in cases of malpractices and complaints, the issues are dealt by the professional associations and the courts. The system of penalties that was introduced in 1996 and that was responsible for drastic complaints was seldom used before it was abolished by a judicial decision, and the guidelines are being applied on a self-regulatory basis.

The other actors who are promoting the recommendations of the HAS are the medical 'lobbies', such as the Confédération des Syndicats Médicaux Français (CSMF), the General Practitioner Union (MG-France) and the professional associations of each medical specialty.

Accreditation is a voluntary procedure for all public and private health care organizations and its validation lasts for 4 years. Accreditation is listed in the tools available for the evaluation of professional practice (EPP) and it is mandatory for the certification of the organizations. The enforcement of accreditation procedures also led to the financial participation of the national insurance fund of salaried physicians (CNAMTS).

Continuing medical education (CME): CME is regulated jointly by HAS, the National Councils for Continuing Medical Education (CNFMC), the Regional Associations of Independent Doctors (URML), the National Medical Council of the Ordre des Médecins (CNOM), and the Medical Committees (CME) of public and private hospitals. To improve the participation into continuing medical education, provisions were made to ensure that finances for educational programmes are provided by the health insurance funds, and that allowances are paid to the health professionals who participate in CME. Furthermore, CME became compulsory and its implementation is under the supervision of the CNOM.

Evaluation of Professional Practice (EPP): Since 2005, EPP is mandatory for all physicians in all settings. HAS was given the assignment to regulate this requirement in coordination with medical associations and trade unions. The EPP requires each physician to participate into a CME training and to apply one QM tool (audit, benchmarking, peer review, practice visit) every 5 years. The EPP aims at improving quality by comparing the effective practices and the outcomes according to the professional recommendations.

HAS leaves to the professional associations the role of organising their EPP in order to respect the specificities of their profession. Therefore, professional associations set the criteria for the evaluations. HAS intervenes as a supervisor, as it validates the methods chosen for the evaluation.

Certification doctors and medical teams in health care organizations can apply for certification and thus receive a contribution toward the payment of their professional liability insurance. Certification is made on a voluntary basis and among the QM tools used, a structured negative incident reporting system is a requirement.

Since HAS is the authority responsible for the quality improvement of health care and it is a national entity, the financing of QM is assured by the State. At the regional level, funds were created – Fonds d'aide à la Qualité des Soins de Ville (FAQSV) – in 1999 and are available for a period of 8 years. Those funds are addressed to the health professionals to help them modernize their health system towards an improvement in the quality of care and a better coordination of care available in the city (health care networks).

3.3.2 Quality tools

The Practice Assessment Department of HAS offers physicians tools and methods for assessing and improving their practice. Since July 2005, Continuous Quality Improvement (CQI) methods have been made available to public and private health care organizations and to ambulatory care settings (HAS, 2005: 27).

CQI methods used for Health Care Organisations: review of appropriateness of care, morbidity and mortality review, clinical pathway, statistical control of healthcare processes, clinical audit and targeted clinical audit.

CQI methods used for ambulatory care:

Peer review groups: a group of physicians meets 6 to 8 times per year to analyze problems appearing in their files and comparing them to evidence-based references.

Shared care networks: shared care networks offer to health professionals and patients a clinical multi-disciplinary expertise, meetings and information-sharing tools. The participation to an active network is a form of EPP (Professional Practice Evaluation). The networks include health organization staff, health professionals, social workers, patients groups.

Interdisciplinary cooperation meetings in selected areas: setting up of coordination centers in the healthcare organizations within a regional network and around a selected topic. Its aim is to give a therapeutic multidisciplinary opinion to patients.

Staff evidence-based medicine meetings: regular meetings (every 2-3 months) of professionals whom, after a file review associated to a literature review (or vice-versa), identify ways to improve care using the best references, the best clinical expertise and the best patient's choice.

Performance indicator monitoring: the aim is to define simple and operational elements of best practice. The measure is used to assess the quality of care of a patient and then improve practices using a model for reference-practice. The criteria must be appropriate, evidence-based and easy to implement. Practically, a person identifies a theme and a group of professionals chosen by that person work on the subject to define the simple and operational elements of best practice.

3.3.3 Role of medical associations

As stated above, the professional organisations are separated into two groups: the professional associations, which are concerned with medical ethics and the supervision of professional practice, and the trade unions, which look after the interests of different professional groups. Despite a large number of existing unions for general practitioners, only about 30% of them are union members.

In France, QM initiatives are carried by the HAS and taken in collaboration with the professional organizations, to assure their adequacy to the specificities of their profession. Those are mainly the "Regional union of liberal physicians" – URML and the Medical Commission for health care settings – CME. Those organisations advise the HAS to set the criteria for the evaluation.

3.4 Germany

The German health service is highly decentralized. Each of the 16 states share responsibility with the central government for the building and upkeep of hospitals, while the state-regulated health insurance providers exert some control over running costs. Of Germany's 2,030 hospitals, 790 are publicly owned, 820 are private non-profit, and 420 are private for-profit. The Catholic and Protestant churches run many of the hospitals with federal or state subsidies. The overall quality of care, especially in hospitals, is high (WHO comparison) with generous staffing levels and an advanced level of technological means.

The system is largely funded through the contributions of employees. Until they reach the retirement age of 65, people must, by law, contribute into health insurance plans (and, since 1994, into an additional long-term care plan). The health insurance plans are either state-regulated or private. After retirement, contribution payments for the state-regulated plans stop (although private patients continue to pay), but coverage is continued until death. For privately

insured people the premium is not related to income, their premium is generally higher during retirement.

Only certain groups are allowed to take out private health insurance and once you have “opted out” of the state regulated system it is very difficult to “opt back in”. The vast majority of people are obliged to use state-regulated plans and, depending on their individual circumstances, choose from one of about 400 options. The government regulates the fees of state-regulated plans, has a system of balancing out the risks between the different insurances – managed competition model - and covers the health insurance contributions for the unemployed and those with low income (Gress et al, 2001).

The statutory health insurance system is laid down in the Social Welfare Code. It stipulates the regulation, registration, accreditation and control of health service providers – this includes strict limits on hospital expenditures and the number and type of medication practitioners are allowed to prescribe. The entire issue of quality management is closely linked with health sector reforms in Germany, which are known to be driven by the urgent need to control (and to lower) the costs of health care.

3.4.1 Quality Improvement

The reform process has had several effects on the quality aspects of service delivery (Breckenkamp et al, 2007):

- the obligatory introduction and further elaboration of internal quality management systems in hospitals;
- inter-sectoral contracts between providers and insurance funds;
- introduction of family doctor model with financial incentives for patients to join;
- introduction of restrictive list of effective drugs (replacing concept of list of ineffective drugs on the market).

In 2004 the Diagnoses Related Groups (DRG) concept was introduced in hospital care based largely on cost-benefit analysis of medical technologies and the development of treatment guidelines. The DRG concept now forms the basis of payment schemes and has brought with it an increased need for quality management.

A new regulatory body the Federal Joint Committee (G-BA, Gemeinsamer Bundesausschuss) was formed in 2004 and replaced several former bodies. It has been jointly formed by the federal associations of contracted physicians, the hospital federation and the federation associations of health insurance funds. G-BA has a range of responsibilities including the implementation and development of directives and criteria of quality management in ambulatory medical care as well as the overseeing of sanctions for hospitals not complying with quality directives. The decision making process in hospitals requires consultation with the Federal Medical Chamber (Bundesärztekammer), the Federation of Private Health Insurance Funds and the Nursing Association. These organizations participate in the negotiations but have no vote (Breckenkamp et al, 2007).

With regards to ambulatory (outpatients) care, the law obliges providers to introduce internal quality management systems and arrange for external quality control measures as well. As mentioned above, G-BA was the body mandated to develop the guidance for this to be achieved. Strong concerns have been voiced by medical doctors that cost reduction interests are hidden behind quality assurance measures.

Additionally the Institute for Quality and Economy in Health Care was founded as an independent institution to analyse medical treatments and drugs, evaluation of treatment guidelines and development of recommendations for disease management, as well as for informing the public.

A working group for Promoting Quality Assurance in Medicine undertakes system wide analysis of quality management in Germany with a view to improving coherence between efforts of different sectors and professional groups. Coordination and transparency of efforts remains a difficult task in the German context as does the collection of data to monitor progress. The health reform process has not been without political controversy and has fuelled fears about a loss in quality, saving money in the wrong places and the development of a “two class health system”. On several occasions the need for improving quality in the provision of screening facilities for the early detection of breast cancer, in palliative care, in the co-ordination between inpatient and ambulatory care and in the inter-linkage between social services departments, have been subjects of academic and media discussions.

3.4.2 Quality tools

Germany has implemented several high profile initiatives with relation to quality in hospitals. They are not the focus of this review, but a few should be mentioned: Cooperation for Transparency and Quality in Hospitals, KTQ ©, Pilot Project Quality Management in Hospitals and Hospital Quality Model, among others. KTQ consists of a self assessment module with a subsequent audit and certification exercise. The tool has been developed for hospitals, retirement homes, rehabilitation and recently (2004) for ambulatory care. The development was funded originally through a grant from the German Ministry for Research and Technology (BMFT). A NGO was created later on for the application and certification process (www.ktq.de).

Quality and Development for Practice (QEP ®, Qualität und Entwicklung in Praxen www.kbv.de/themen/qualitaetsmanagement.html) is a newly developed QM scheme (since 2006) for ambulatory care developed by the National Association for Ambulatory Care Physicians (Kassenärztliche Bundesvereinigung, KBV). It addresses quality in outpatient care and uses indicators to monitor patient safety and care, information and documentation, collaborators, office organisation and continuing education, and offers a possibility for certification. It is set to become a routine quality management system in ambulatory practice.

The **European Practice Assessment (EPA)** aims to improve the organisation of general practices in a systematic way. Picking up some initial experience in different countries, including the UK, the Bertelsmann Foundation in Germany funded the development of a European-wide set of indicators to measure the “structures and processes meant to enable the delivery of good quality patient care” (Engels et al, 2005). The instrument combines multidimensional elements such as self-assessment by GPs, patient feedback, evaluation by other team members such as nurses and assistants, as well as a practice visit. The “visitor” to the practice serves not only as an assessor, but also as a facilitator for feedback and improvement. (Engels et al 2006). The results showed that a total of 57 indicators were valid, feasible, reliable and discriminative in all participating countries. The instrument was able to detect differences in practice management within and between countries. Overall, it provided important feedback about facilitates quality improvement (Engels et al, 2005).

Medical error and critical incident reporting: in Germany there is still a rather hesitant attitude towards speaking about medical error or critical incidents (i.e. events which had the poten-

tial to lead to an undesirable outcome if they had been left to progress). Increasingly those involved in QM in health in Germany are seeing that much can still be learned in this regard from other countries and also from industry. There is still a need for greater confidence that the culture for admitting errors is not one of sanctioning but that the focus is on avoiding that they occur again.

“Critical Incident Reporting System” (CIRS ®) on the Internet is an initiative which offers a platform for confidential and anonymous anecdotal reporting and discussions of critical incidents and experiences in anaesthesia in primary care. It is operated by the Department of Anaesthesia, University of Basel, Switzerland, and it is based on the experiences from the Australian-Incident-Monitoring-Study (Runciman et al, 1993). Initially it comprises individual postings; when sufficient material is in place a compilation of key points is undertaken. The level of response has been modest so far. This is in line with the experiences in Switzerland of Brun 2005, who introduced a similar internet-based reporting system but experienced difficulties in engaging the attentiveness of physicians for apparently harmless daily critical incidents. The search for incentives to motivate busy practitioners to report potential incidents in an anonymous reporting system remains to be fully explored (Brun, 2005).

Quality Circles: In 1993, the German Professional Board of Ambulatory Care Doctors issued guidelines for the establishment of quality assurance programs which emphasized the promotion of quality circles in primary care (Tausch and Härter, 2001: 239). A study in the district of Südbaden among GPs working in ambulatory care settings evaluated the efficacy and effectiveness of quality circles. Quality circles were a step used in this German experience in the phase of assimilation and dissemination of guidelines. However, the study reports some reluctance from the physicians in relation to a few QM procedures: “although the majority of quality circles used the guidelines for discussions in their group work, they did not follow the Plan-Do-Check-Act (PDCA) cycle in order to bring about changes in their daily practice care”. However, the overall result of the study showed the GPs participating in the quality circles reported that they improved the doctor-doctor relationships, the agreement on diagnostic and therapeutic procedures and the exchange of practice experiences with colleagues. Hence, the engagement of GPs in peer review increases their job satisfaction (ibid, 2001:244).

3.4.3 Role of medical associations

Professional associations enjoy a strong role in quality management processes in Germany. Since 2004 the decision making process in hospitals comprises consultation between the Federal Medical Chamber, the Federation of Private Health Insurance Funds and the Nursing Association.

The Federal Joint Committee – G-BA, Gemeinsamer Bundesausschuss, is the main regulatory body and a legal entity under public law. It was formed in 2004 by the federal associations of contracted physicians, the hospital federation and the federation of associations of health insurance funds, all of which played an important fore-runner role in quality developments in Germany. G-BA reports to the Ministry of Health and holds responsibility regarding assessment and licensing of new treatments –particularly in ambulatory care-, the development and issuing of directives in medical care and the regulation of medicament remuneration (Breckenkamp et al, 2007).

Professional associations for different medical specialties are plentiful and are legally mandated to provide continuing medical education which is a key component of revalidation of practitio-

ners.

3.5 Denmark

The defining feature of the Danish health care system has historically been the decentralized responsibility for primary and secondary health care to the counties and municipalities, where most decisions on the form and content of health care activity are taken. Traditionally Danish politicians appear to have considered local self governance (and its potential to achieve innovation) to be more important than geographical equity. This has led to some differences between counties in waiting times, availability of medical technology and rates of specific diagnostic and curative activities, such as global screening for breast cancer or the use of expensive drugs for ovarian cancer. However, there are important channels for negotiation and coordination between the state, counties and municipalities, and the political focus on controlling health care costs has encouraged a trend towards more formal cooperation and a greater role for the state.

The responsibility for legislating and providing overall guidelines for the health sector lies within the Ministry of Health. Each year the Ministry of Health, the Ministry of Finance and the county and municipal councils, represented by the Association of County Councils and the National Association of Local Authorities, take part in a national budget negotiation to set targets for health care expenditure.

Increased costs of health care and scarcity of health care professionals have led to calls for greater cost-effectiveness. The Government has brought about measures to strengthen the link between finances and services provided. A new initiative makes data on the cost-effectiveness of various health care units publicly available. A rationalisation is also ongoing with the existing 15 regional health authorities being in the process of being reduced to five.

The system of financing has been reformed. The new regions will not – as is the case of the existing counties – have the power to impose taxes. Instead their funding will be based on objective demographic conditions and the amount of services they provide. A major objective of the reform is to provide the basis for making comparisons between the regions by creating a level playing field. The aim is that differences in the economy of taxpayers and the health status of the population in the regions can be minimized as explanations for the differences in performance between regions. This will pave the way for increased focus on real differences of performance and allow for identifying best performance as the unequivocal standard of excellence.

In line with these reforms, which are largely driven by cost-containment needs, politicians have begun to question the effect of health care on mortality, and greater attention was given to primary health care, disease prevention and health promotion. Primary health care in Denmark is provided by private practitioners and municipal health services. General practitioners play a key role in the Danish health care system as the first point of contact and as gatekeepers for hospitals, specialists and physiotherapists. General practitioners derive their income from the National Health Security System (NHSS), according to a scale of fees agreed by the Organization of General Practitioners and the NHSS Committee. Trade Unions also play a role in these negotiations.

In order to practice, a physician must be licensed at central level. Additionally, in order to receive fees from the NHSS, general practitioners must be licensed by the county where they operate. Counties limit the number of practising GPs as a means of controlling costs, and the

number of practising GPs per county is negotiated by the counties and the Organization of General Practitioners. Thanks to the NHSS and to the fact that Denmark trains many doctors, there is a relatively even distribution of doctors across the country.

The National Board of Health, a central body connected to the Ministry of Health, is responsible for supervising health personnel and institutions and for advising different ministries, counties and municipalities on health issues. Although they have some capacity to influence the counties' behavior through recommendations and suggestions, the counties are not obliged to follow their advice. The National Board of Health is actually entitled to decide where specialties should be located, but in practice it rarely exercises this right.

Since all training of authorized health professionals is public, the state does exert control over the supply of health professionals, provided there are applicants for all places, which is not always the case for nurses. The state can also influence health professionals' qualifications by determining the content of their training. The National Board of Health is particularly influential with regard to postgraduate training. Licensing still has more to do with regulating numbers than looking into the details of each individual practitioner's credentials. There are quotas for physiotherapists and, in order to buy a general practice, one must have authorization as a general practitioner from the National Board of Health and a license from the NHSS.

3.5.1 Quality Improvement

In line with the greater coordinating role of the state, in 2001 the Danish Quality Model was introduced as an initiative to integrate and systematize existing quality interventions as well as pushing forward a more ambitious national agenda. A central goal is the certification of all hospitals according to general standards for optimal patient treatments and flow. Currently, the application of the model is just starting to be applied to private practitioners and municipal health services as well.

Data generated through the Danish Quality Model is to be made available for health professionals and the general public. The Danish model is meant to meet citizens' expectations of a transparent health care service and enable them to make informed choices about where to go for treatment. The National Indicator Project, which is integrated into the Danish Model, has already made available data on treatment of selected disorders, e.g. apoplexy, lung cancer and schizophrenia.

The results are available at the recently created integrated website for health matters in Denmark, which serves both professionals and the general public. At the website, citizens can view their own medical record (treatment at hospitals) and the prescription medication they have purchased by using a digital signature, among other services.

3.5.2 Quality tools

Patient involvement and satisfaction: The Danish Ministry of Health, together with the Association of County Councils in Denmark, carried out the first national survey of patients' views of Danish hospitals in 2000. Results from this survey show that 89% of patients are satisfied with their stay in hospital, 92% are satisfied with doctors and 94% are satisfied with nurses

The Danish Ministry of Finance publishes current analyses of citizens' views of the public sector, including satisfaction with health care services. According to the latest analysis (2000), Dan-

ish citizens are in general mostly satisfied with general practitioners (4.2 on a scale from 1 (very dissatisfied) to 5 (very satisfied)). Citizens express slightly less satisfaction with emergency medical services (3.5). This goes hand in hand with the advanced status of patient's rights groups in Denmark – their position being formalized with a legalized charter.

In recent years political and media interest in the issue of waiting lists has led to a number of state-initiated investigations and reports. More specific initiatives have involved the allocation of funds to counties and general statements about the maximum allowable waiting times for specific treatments. In 2002 a scheme was introduced which allows patients to choose private hospital treatment paid for by the country when waiting time for treatment at a public facility exceeds two months – thus allowing for competition among public hospitals. Legislative guarantees extend to patients with life-threatening diseases, which are defined on a list.

Quality management and accreditation systems for hospitals: The Copenhagen Hospital Corporation is planning to introduce a general accreditation scheme for all hospitals in the area. The accreditation will be based on the scheme developed by the American Joint Commission of Accreditation of Health Care Organizations and aims at allowing comparisons between different hospitals and to encourage self-evaluation procedures. However, discussions about this particular scheme have highlighted that it pays too much attention to structure and processes rather than to outcomes. The budget negotiation for year 2000 also included the setting up of a National Council for Quality Assurance, which oversees and coordinates all hospital efforts to establish indicators.

Clinical databases and electronic booking: A data system covering general practitioners, specialists, pharmacies and hospitals is currently under development. It is already in use for administrative purposes such as electronic transfer of patient records, prescriptions, orders and payments. The long-term aim is to build clinical databases, which will extend the existing possibilities to undertake health care evaluations and research across different provider levels and institutions.

3.5.3 Role of medical associations

The Danish Medical Association (DMA) is the main professional association and has an Executive Council at national level as well as branches at county level. Members are registered with the Executive Council but also obliged to enroll with their local county branch. DMA has subdivided over the course of history into three subdivisions or “crafts” – the Association of Junior Hospital Doctors, the Association of Medical Specialists and the Association of General Practitioners. About 94% of doctors authorised to practice are members of the DMA as well as one of the three organisational subdivisions (DMA, 2007).

The role of DMA is modest; its main mandate is to look after its member's professional and financial interests. Given the strong regulating arm of the state through its centralized and decentralized levels, this function seems to overlap with trade union functions. The three subdivisions of DMA are involved in contract negotiations vis-à-vis public authorities. Every second year terms and conditions are renegotiated. Regarding the professional interests, the association outlines ethical regulations concerning patients' rights to information and doctor's commitments to confidentiality. The DMA can reprimand doctors who do not respect these regulations. DMA has carved out a strong role for itself in the pursuit of scientific endeavor. It is active in the Nordic Medical Council and World Medical Association and produces a medical bulletin. DMA is closely involved in quality management developments in Denmark – although the main impetus

has always been and continues to be Government driven.

3.6 Canada, Alberta Province

Canada is a federal state with divided authorities and responsibilities in concordance with the constitution. The federal government is responsible for protecting the health and security of Canadians, and therefore has the role of setting up the standards for the national Medicare system and taking up its responsibilities in public health, drug and food safety regulations and health research.

At the regional level, each province and territory has legislation governing the administration of hospital and medical services and the remuneration of physicians. However, those fees are negotiated with provincial medical associations. Starting in late 1980s, provinces began to go through reforms to re-organise their health delivery systems, where most jurisdictions were based at the level of regional health authorities.

The Canadian health care system is highly influenced by a large number of health-service agencies, associations, charities, health professional associations, unions, colleges and private research institutes. Some of those associations are working at the provincial level with a national umbrella, and their influence in facilitating and coordinating the country-wide initiatives set at the national level is remarkable.

At the national level, the following organizations have an especially important influence:

- The *Canadian Council on Health Services Accreditation* (CCHSA).
- The Canadian Medical Association (CMA), which gathers at national level the organization for physicians, including specialists and general practitioners.
- the *Provincial colleges of physicians and surgeons*, which are responsible for the licensing of physicians, the development and enforcement of standards of practice and the investigation and discipline of physicians concerning standards of practice or breaches of ethical and professional conduct.
- The *Canadian Nurses Association* (CNA).
- The *Canadian Healthcare Association* (a citizen-based health care group).

In Alberta province, the Health Professions Act (HPA) establishes common rules for the governance, regulation and discipline of all regulated health professions.

3.6.1 Quality Improvement

Some provinces have established health research agencies or health quality councils with a mandate to help the provinces improve health outcomes. Alberta was the first province in Canada to negotiate a fundamental change in how physicians, health regions and government work together. This tri-lateral agreement set an emphasis on the improvement of access to basic health care services and in developing local primary care services, which include basic care through a family physician, psychological counseling, screening for chronic disease, family planning, child care and geriatric care.

Alberta was the first province to create an Electronic Health Record system in Canada that links physicians, pharmacists, hospitals, home care and other providers across the province. This electronic system allows health care providers to access the patient's prescription history, aller-

gies and laboratory test results by computer, to improve the diagnosis and treatment activities.

In 2004, the Health Services Utilisation and Outcomes Commission was replaced by the **Health Quality Council of Alberta**, which is under the supervision of the Ministry of Health. This council has the task to inform on the quality and performance of the health care system by identifying best practices, reviewing and monitoring health care quality, including access, effectiveness, efficiency and patient safety. The council runs population based surveys throughout the province to evaluate where improvements are still needed from the point of view of the patients. The council also works closely with the province's health regions and professionals, liaises with the National Health Council and the Canadian Patient Safety Institute and collaborates with other provincial bodies that address quality of care.

Under the authority of the Medical Profession Act, the **College of Physicians and Surgeons of Alberta** (CPSA) is responsible for the licensing of physicians, the setting and monitoring of standards of medical practice, investigating complaints about physicians and for advising on ethical, medical-legal and general quality of care matters. A number of policies and guidelines are available to inform and assist physicians. The College of Physicians and Surgeons of Alberta has also developed a QM initiative in collaboration with the Universities of Calgary and Alberta: the Peer-Assessment Review.

The funding of the CPSA operations comes from various sources, including fees paid by physicians, their professional corporations or health facilities. The Quality improvement programs are funded by the regional health authorities and are operated on a cost-recovery basis. The Quality of Care Department of the CPSA focuses on quality improvements to ensure that Alberta physicians meet the highest standards in providing effective medical services, according to the regulation established by the Medical Profession Act.

3.6.2 Quality Tools

Accreditation Programs

An accreditation process, that includes either an on-site inspection or a distance review for both independent and public facilities, is in place to ensure optimum safety and effectiveness. Advisory committees develop and administer standards for personnel, equipment and service performance in various types of facilities.

Practice reviews

Practice reviews are used in specific programs, such as the CPSA Methadone Program, where physicians have to follow specific standards and guidelines and undergo practice reviews to insure that safe, consistent, accessible and effective clinical care for opioid dependent patients is given.

Peer Review Program

The Peer Review Program of CPSA provides physicians and the College with feedback about a physician's practice. Peer reviews involve: pre-visit questionnaires, review of physicians' latest practitioner profile from Alberta Health & Wellness, site visits to physicians' offices by medical colleagues in a similar type of practice who has received training to conduct a peer review, inspections of the physicians' offices, audits of samples of clinical records and discussions of case management from the clinical records. The College collates the data gathered from all of these sources into a peer review report and meets with physicians to discuss the reports findings and recommendations.

Physician Achievement Review (PAR) programme

The Physician Achievement Review programme consists of questionnaires given out by doctors to their patients, colleagues and co-workers. Topics range from medical competency and management abilities to communication skills and patient management. The College retains a professional evaluation firm that receives and thoroughly assesses this information and reports back to each physician.

PAR is designed to provide doctors with information about their medical practice through the eyes of those they work with and serve. The unbiased feedback is enormously helpful to the doctors, who will be able to build on their strengths and correct any possible problems. Physicians are expected to participate in this process once every five years.

The program ensures confidentiality of patient records and protection of the patient-doctor information. Since PAR is educational in nature, results from any review cannot be used in any legal action or disciplinary process.

The Triplicate Prescription Program (TPP)

In 1986, the Council of the College of Physicians and Surgeons of Alberta (CPSA) established the Triplicate Prescription Program (TPP) in partnership with pharmacists and dentists to monitor the use of certain drugs prone to misuse and abuse for non-medical purposes. A triplicate prescription is a three-part prescription form that is applied to medications listed as TPP: the prescriber retains one copy, and the two other copies are given to the patient to be used by the pharmacist to dispense the medication. The pharmacist retains one copy and the other copy is forwarded to the CPSA on a weekly basis. Information from the triplicate prescription is entered into a database to monitor utilisation.

3.6.3 Role of medical associations

As mentioned above, the CMA is the overall organisation for physicians, including specialists and general practitioners. Their main activities are the lobbying for its members' interests, the conduct of research on policies and the publishing of the biweekly *Canadian Medical Association Journal*. Under the CMA, 12 provincial and territorial medical associations are self-governing their activities.

The role of the CMA and its provincial divisions must be separated from the regulatory role of the provincial colleges of physicians and surgeons (CPS). CPSs are responsible for overseeing the postgraduate training of physicians, the certification of specialists and the development and review of standards of practice. Its stated mission is to guide the medical profession and to protect the public. The CPS of Alberta claims to provide leadership and direction on issues relevant to the health care system, such as access to services, quality improvement, patient safety and privacy (College of physicians and surgeons of Alberta, 2007).

The College of Physicians and Surgeons of Alberta has its own quality of care department which focuses on quality improvement in the nine health regions of the province. Authority and responsibility to regulate non-hospital facilities in Alberta is detailed in the *Medical Profession Act*. An accreditation process is in place to ensure safety and effectiveness. This process includes either on-site visits or distance reviews for private and public facilities.

In the province of Alberta, it is the CPS who has developed the Physician Achievement Review

programme which seeks to assess the performance of physicians in order to improve the quality of medical practice.

3.7 Switzerland

History, as well as social, economic and geographical diversities have contributed to dividing Switzerland into independent cantons, each with its own political status and linguistic, religious and cultural characteristics. Thus, the country decision-making, planning and administrative functions within the health sector are strongly devoluted: resources, functions and authority are transferred from the centre to the periphery. Cantons have the responsibility for planning, monitoring and partly providing health care within a defined geographical area. The Cantonal responsibilities encompass among others the regulation of ambulatory care.

With regard to the provision of health services, private and public providers coexist. Services provided in the ambulatory sector, outpatient departments and short stay inpatient care in hospitals are usually reimbursed by health insurances to patients under a fee-for-service payment system. Point values are agreed annually and appear in a national fee schedule which has to be approved by the Federal Council. The price attached to the point value is negotiated at Cantonal level between the association of medical doctors and insurances for compulsory health insurance, but negotiation takes place at the federal level for other types of insurance. With the exception of a moratorium on the opening of new practices (currently in place up to July 2008), Federal and Cantonal authorities have no direct planning controls over ambulatory services but have significant controls over hospitals and residential nursing homes.

The Swiss health care delivery system is a mix of private and public providers, with a large area of responsibility for the private sector, mainly for ambulatory care and to a lesser extent for hospital care. Other important functions are also delegated to the private sector such as health financing. Indeed, about 35% of the financing of the health system is assumed by insurance companies, another 40% is being financed directly out of pocket by patients and their families and the remaining 25% is being paid by the municipal, cantonal and federal administrations through taxes. Since 1994, when the law on health insurance was approved by vote at federal level, adherence to a health insurance company is mandatory.

Ambulatory care providers are principally financed by payments from health insurance companies or by direct payments by patients. The services covered by the compulsory health insurance are defined in the federal law. Insurance companies are free to set the premiums, which are allowed to vary among Cantons, but not within a Canton. The biggest part of health public expenditure is borne by Cantons and to a lesser extent by municipalities.

3.7.1 Quality Improvement

The 1994 health insurance regulation (“Krankenversicherungsgesetz“) introduced some changes within the Swiss health care system. Two paragraphs (Art. 58 and 59) relate to quality of care and provide some indications on quality assurance for health care providers. However, the law does not define quality measurements, approaches or instruments to be used and only outlines general formulations on the necessity for quality assurance. No indications are given in relation to how and by whom this should be done. Recently the “Geschäftsprüfungskommission” of the Council of States (“Ständerat“) has pointed out that the Federal Council does not sufficiently well make use of his guiding role with regard to quality management systems and patient

safety (GPK, 2007). Among else the commission recommended that the Federal Council should become more pro-active and set minimal standards with regard to quality assurance.

However, over the last years various initiatives have emerged in this area (Schilling et al. 2001). Accreditation and certification have been established in the domain of laboratory testing, but otherwise there has not been a nationwide breakthrough. This may have been due to the strong decentralisation of decision-making within the Swiss health care system. Nevertheless, in some areas such as for Health Maintenance Organization or networks of ambulatory care, certification of providers has gained importance over the last years.

There is no single institution or agency with the mandate to oversee quality management in health care. However, various institutions have been created over the last years to promote quality management systems. Many of them, such as the “Verein Outcome”, are focused on the hospital sector. Others, such as the Institute for Quality and Research in Health Care (“Swis-sep”), conduct operational research among ambulatory care providers, for example in the area of patient satisfaction or certification, in order to establish quality management systems at ambulatory level.

3.7.2 Quality Tools

The only mandatory quality of care used in the ambulatory sector is Continuing Medical Education and Learning (CME&L). Indeed, the Swiss Federal law relating to university trained medical personnel outlines principles for specialisation (post-graduate training) and CME&L and devolves responsibilities for accreditation and standards to the Swiss Medical Association (FMH) (Schweizerische Eidgenossenschaft, 2006). CME&L for doctors is regulated by a special decree of the FMH, the “Fortbildungsordnung”, which provides the rules and procedures for CME&L (FMH, 2002). The decree lists the type of activities being recognised for CME&L, defines quality standards and annual requirements. It is required that each doctor has to collect 50 credits per year corresponding to 50 hours, and has to allocate an additional 30 hours for self-study. These time inputs do correspond to 10 working days. The type of activities being recognized for CME&L are the participation in: a) national or international congresses, b) lectures, courses, and workshops organized by hospitals, c) workshops of professional associations, for example the association of general medicine, d) quality circles (peer review groups), and e) private initiatives.

Besides CME&L, various tools are used by ambulatory providers on a non mandatory basis. Clinical practice guidelines have been development by various specialty societies of the FMH and peer review groups have been set-up and are running in various places. They typically consist of physicians, such as family doctors, meeting every other month to review and analyse situations within their professional practice comparing them against evidence-based references. No inventory or study is available on how many ambulatory providers do adhere to a peer review group.

Benchmarking of clinic performance has been and is being promoted by the “Verein Outcome” in collaboration with hospitals, but has also been used in limited instances in relation to ambulatory care, such as in the follow-up of deliveries (Schwappach et al. 2003, Schwappach et al., 2004). Benchmarking has not emerged as a standard instrument among Swiss ambulatory care providers.

There are various ambulatory providers who adhere to the European Practice Assessment which is overseen in Switzerland by swisspep –the Institute for Quality and Research in the Health System (“Institut für Qualität und Forschung im Gesundheitswesen”). This quality management system consists of various elements including a self-assessment by ambulatory providers, elaboration of targets, and benchmarking through a comparison with other ambulatory providers (swisspep, 2007). This then may be followed by a certification through the agency EQUAM.

Critical incidence reporting systems have been developed in the hospital sector, such as in the area of anaesthesia reporting at the level of the University hospital in Basel (Staender et al, 1997; for further information see: <http://www.medana.unibas.ch/cirs/>). But this is not widely used in the ambulatory care sector yet. As pointed out in the German case study, there are difficulties relating to the engagement of physicians to report apparently harmless daily critical incidents. It has been concluded that there is a need to identify incentives for motivating practitioners to report potential incidents in the context of anonymous reporting systems (Brun, 2005).

Other quality management initiatives have focused on communication aspects between providers and patients (Garnerin et al, 2001), especially in multi-cultural hospital settings, which are also of relevance in the ambulatory sector.

At the level of Health Maintenance Organization, there is a marked movement towards the certification of ambulatory care providers, where yet twelve HMOs and networks of ambulatory care providers have already been certified. The certification agency EQUAM, has elaborated a broad range of standards which include clinical processes and also patient satisfaction measurements.

3.7.3 Role of medical associations

The Swiss Medical Association (FMH) is the main professional association of doctors and has a central committee and secretariat at national level as well as branches at cantonal level. Members are registered with the cantonal branch but are also enrolled at national level. Further, doctors can obtain their specialty license with one of the 44 societies of the FMH. As indicated above, the specialty societies of the FMH oversee the adherence to CME&L standards and guidelines of their members.

The FMH, respectively the 44 specialty societies affiliated to FMH are also in charge to oversee post-graduate studies and the accreditation of their members. This mandate has recently been questioned by the Swiss Science and Technology Council, suggesting the creation of a specific institute for post-graduate studies affiliated to universities (SWTR, 2007)

The “Arbeitsgruppe für Qualität” of the FMH has initiated conceptual thinking on how to set up quality management systems in ambulatory care and outlined directions for a holistic view of quality (Peltenburg et al. 2005). Some further initial ideas on how the FMH may position itself with regard to the promotion of quality management systems in ambulatory care are outlined in chapter 5.1.

3.8 United States

As there is a multitude of actors and systems in place in the United States, the subsequent sec-

tion specifically focuses the role of the American Medical Association (AMA) in relation to quality management systems. Experiences and the role of other actors or institutions, such as those of governmental and state run programs (Medicare, Medicaid), are not specifically addressed.

The United States is the only major industrialised nation in the world lacking universal health care access. The system is funded through a mix of public and private financing. In 2004, private insurance paid for 35% of personal health expenditures, private out-of-pocket payments were 15%, while federal, state and local governments paid 44%. Spending on health, estimated to be 15% of the GDP, is the highest in the world. Health care is provided by a diverse array of individuals and legal entities. Ambulatory care has a particular relevance in the US; most health care provided in the US occurs in the outpatient setting (Chheda, 2007). The last decade has seen the emergence of executive health programs (“concierge medicine”), where enhanced care and services are provided by primary care physicians for additional fees (Ma and Stafford, 2005), such as nicer and less crowded reception areas, priority appointments, 24-hour access to the physician, house calls and out of office care, possibly including accompanying patients to appointments with specialists. This trend has raised concerns of having a two-tiered health system in the US which would favour the wealthy.

3.8.1 Quality Improvement

The debate about US health care focuses upon questions of access, efficiency and quality of the services provided vis-à-vis the high sums of money which are spent. A plethora of actors are involved from the US Department of Health and Human Services (HHS) as part of the Office for Civil Rights, to the Agency for Healthcare Research and Quality (AHRQ) – a department of HSS and the lead Federal agency in charge of improving quality and safety of health care; or the Quality Interagency Coordination Task Force (QuIC), accreditation bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the American Medical Accreditation Programme (AMAP), the Accreditation Association for Ambulatory Health Care (AAAHC), the Performance Measurement Coordinating Council (PMCC), the Centre for Disease Control, which hosts the National Centre for Health Statistics, and professional associations.

The American Medical Association (AMA) will be described in the following paragraphs in greater detail. The AMA operates on behalf of doctors, medical students and patients and it essentially runs as a commercial enterprise. Investments make up an important proportion of the income generated and membership fees accounted for nearly \$47 million in revenues in 2006 alone.

The AMA has always been concerned with issues of safety and quality care for patients in the health care system. In 2005 the association led the passage of the Patient Safety and Quality Improvement Act. The act establishes a confidential reporting structure in which physicians, hospitals and other health care professionals and entities can voluntarily report information on errors to Patient Safety Organizations (PSOs). PSOs, in turn, analyse the data to develop patient safety improvement strategies. It seeks to regulate the balance between maintaining confidentiality and legal protections for reporting information on medical errors and maintaining accountability and patients’ legal rights. (PSOs may be public or private and must meet certain criteria to be certified by HHS). The act further stipulates that the US Department of Health and Human Services (HHS) - through the Agency for Healthcare Research and Quality (AHRQ) - then takes the process over and suggest to professionals the methods that may reduce errors and increase patient safety. The American accrediting bodies – e.g. Joint Commission on Ac-

creditation of Healthcare Organisations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA) and the American Medical Accreditation Programme (AMAP), cannot take an accrediting action against a provider based on data reported in this context.

Other activities which AMA is involved in, with regard to Quality Improvement, include advocacy, professional support for members, litigation support and generation of an electronic newsletter which summarises updated health care highlights.

3.8.2 Quality Tools

Quality in the ambulatory sector has traditionally included the establishment of quality standards, measuring performance, providing consultation and education, and helping ambulatory care organizations to what they should comply with. The Accreditation Association for Ambulatory Care (AAAHC) oversaw these developments. However, the reach of a non-profit organisation proved to be quite limited. The demand for a national accreditation programme has been fuelled by the ongoing shift from fee-for-service to managed care, which goes often along with a higher need for physician to accountability and assurance of quality of patient care.

The **American Medical Accreditation Programme (AMAP)** now seeks to standardise information on physicians' quality of care and has entered into agreements with all other accreditation agencies. The agreements allow AMAP to continue to accept accreditation by these organisations. AMAP aspires to streamline many areas of quality management. Previously, each health plan collected and verified information on physicians' credentials. A typical physician may have to do with more than 11 health plans each which caused a massive duplication of effort and expenses. AMAP is establishing a "gold standard" for physicians' quality of care that will be universally accepted by consumers, hospitals, ambulatory providers and insurers. The voluntary process will eventually evaluate individual physicians against national standards, criteria and peer performance in 5 areas: **credentials** (formal training and work history), **personal qualifications** (ethical behaviour and documented participation in continuing medical education, peer reviews and self-assessment of performance), **environment of care** (clinical, operational and management systems), **clinical performance** (measures of patient care processes) and **patient care results**. AMAP is a unique collaboration between the Government and the AMA.

Other major quality initiatives are entirely dominated by Government and managed by the Quality Interagency Coordination Task Force (QuIC, 2007). The US Federal Government not only provides billions of dollars in support of health care research per year, but is also the largest purchaser and provider of health care services – via programmes like Medicare and Medicaid, the Federal Employee's Health Benefits Plan and facilities for armed forces and veterans. All federal agency activities related to health and quality are coordinated by QuIC. Key areas which apply to all levels of health care (hospital and ambulatory) include: Patient and Consumer Information, Improving Quality Measurement (in collaboration with AHRQ), Improving Clinical Quality (currently focused upon diabetes and depression), Improving Information Systems, Reducing Hazards in Patient Safety and Improving Safety and Quality through Value Based Purchasing. The concept here is that buyers hold providers accountable for the costs and quality of care and thus balance regulatory approaches with purchasing mechanisms. It focuses on managing the use of the health care system to reduce inappropriate care.

An article published in the International Journal for Quality in Health Care discusses the results of a study on a **Breakthrough Series Collaborative** in ambulatory care settings, in the US. The results presented show that the collaborative tool was not very stimulating for the professionals,

and this for two main reasons: physicians having too little time available to allocate it to QM projects, and CSB being competitive with other quality improvement projects and priorities already underway. (Gandhi et al, 2000: 121) Furthermore, the study points at the major role of leadership in implementing and maintaining quality improvement projects.

3.8.3 Role of medical associations

AMA plays a key role in quality control of physicians working in both inpatient and outpatient care settings. Many see AMA as being well suited to the task – although it is clear that the scope is large as the US has more than half a million physicians. However others are concerned that AMA is acting in its self-interest and putting physicians' needs before patients'.

This is particularly the case when it comes to accreditation. A key aspect of AMAs involvement in quality improvement efforts is related to the American Medical Accreditation Programme (AMAP). AMAP's chair is concurrently vice chair of the AMA's Board of Trustees. AMA has been the guiding agency in the establishment of AMAP, the emergence of which marks a major step towards a single, nationally standardised source of information related to quality of physician care. AMA is closely involved in the development of clinical performance measurements for patient care. AMA charges member physicians a fixed fee for the review and accreditation process (and non-members a much higher fixed fee) which have to be renewed every two years. Health care organisations (e.g. insurers) then pay a fee to access a physician accreditation profile. The information is not made public. In this set up, AHRQ is the third party which undertakes regular outcome studies comparing AMAP accredited physicians with non-accredited physicians.

However, since 2004 the leading role in quality improvement in ambulatory care has been played by AHRQ which heads a collaborative effort known as the Ambulatory Care Quality Alliance (AQA). The main goals are: to agree on measures of ambulatory care that stakeholders can apply in their own settings, to develop a model (including framework and governing structure) for aggregating, sharing and stewarding data, and to outline steps for relaying relevant information to providers, consumers and purchasers. The process is steered through forum meetings co-sponsored by AHRQ together with philanthropic organizations like the American Academy of Family Physicians, and brings together government agencies, health insurance plans, business coalitions, consumers and several professional associations including AMA.

4 Characteristics of quality managements systems across selected countries

Chapter 3 has provided an overview on main characteristics of different quality management systems in selected countries. In the following sections we summarize this information and briefly compare the systems across the countries through a series of synthetic tables. Table 1 presents key characteristics of the health systems under review. Not surprisingly these countries differ greatly with regard to their organizational setting, financing mechanisms of health services and with the roles attributed to the ambulatory care sector.

Table 1. Selected characteristics of the health systems under review

Selected characteristics of the health system
<p>United Kingdom</p> <ul style="list-style-type: none"> ▪ The National Health System is controlled by the UK government through the Department of Health. ▪ Tax funded system with an internal market whereby NHS Primary Care Trusts commission health care from General Practitioners and Hospitals and pay them at government agreed rates. ▪ 10 year reform launched 2000 to improve efficiency, further strengthen trusts within regulated framework
<p>Netherlands</p> <ul style="list-style-type: none"> ▪ Social health insurance system supplemented by taxes and out-of-pocket payments ▪ Since 2006 a radical market reform fused social and private health insurance into one mandatory system. Population now purchases private health insurance covering a fixed basic package ▪ System with a strong history of consensus-seeking, debate and multidisciplinary collaboration between different health professionals ▪ Initially rather diffuse quality developments - professional associations focusing more on improvements in "treatment" , with institutions taking up more the improvement of "care"
<p>France</p> <ul style="list-style-type: none"> ▪ System with 3 levels of administration (municipality, local authorities and regions) ▪ Health care financing integrated into the social security system, with strong role attributed to the state. ▪ Outpatient care is mainly provided by self-employed doctors, both generalists and specialists, who are settled in their own practices and work alone
<p>Germany</p> <ul style="list-style-type: none"> ▪ Decentralized health system with general policy framework through central government ▪ Social health insurance system based on employees and employers contributions and co-payments ▪ Financing of ambulatory care through health insurances and co-payments of patients ▪ On-going debate around gate-keeper role of family doctors
<p>Denmark</p> <ul style="list-style-type: none"> ▪ Traditionally a highly decentralised system with most responsibilities for health within counties. ▪ Health sector reform is part of an overarching reform of public sector to achieve greater transparency, efficiency and quality. State now seeking greater role for itself at central level. ▪ General practitioners play a very important role in the system. They are licensed at the decentralised level as a way of controlling the country wide distribution of practitioners.
<p>Canada, Province of Alberta</p> <ul style="list-style-type: none"> ▪ Decentralized system with 13 provinces and territories having constitutional responsibility to administer and deliver health care ▪ Predominantly tax-funded health system with delivery effected through private (for-profit and not-for-profit) and public providers ▪ Ambulatory care mostly through private practice reimbursed on a fee-for-service basis
<p>Switzerland</p> <ul style="list-style-type: none"> ▪ Decentralized system with a high a degree of autonomy at cantonal level ▪ Social health insurance system supplemented by taxes and out-of-pocket payments ▪ Ambulatory care through private practice reimbursed on a fee-for-service basis (exception HMO)
<p>United States</p> <ul style="list-style-type: none"> ▪ Government is major provider, purchaser and therefore financier of health services. Additionally private insurance covers a large proportion of health care costs together with out-of-pocket payments ▪ Universal health care access remains elusive ▪ Ambulatory care has particular relevance.

4.1 Legal and policy framework

Table 2. Legal and policy framework of quality management systems in ambulatory care in study countries

Legal and policy framework	
United Kingdom	<ul style="list-style-type: none"> ▪ The policy framework for the introduction of “Clinical governance” as NHS key quality concept came in a Government White Paper, “Quality in the new NHS”, Department of Health, London, 1999. ▪ Health Reform in England: Update & Next Steps (2005) & White Paper "Trust, Assurance, Safety" (2007) outline reform direction specifically: <ul style="list-style-type: none"> - Strict centralised system of revalidation regulated by General Medical Council and move against self-regulation. - CME forms compulsory part of revalidation and is managed by General Medical Council. Professional organisations can formally recognise a doctor's CME activities.
Netherlands	<ul style="list-style-type: none"> ▪ Historical absence of a coherent quality framework with a high degree of self-regulating, professional led systems. CME continues to be provided by professional associations. ▪ Healthcare Performance Framework established in 2006 by National Institute of Public Health on a Government initiative. The framework addresses Quality, Access and Costs in different health care settings ▪ The Royal Dutch Medical Association (KNMG) stipulates the requirements and manages revalidation ▪ Patient information and complaints procedure financed by Dutch College Family Physicians, patient associations
France	<ul style="list-style-type: none"> ▪ In 1996, continuing education was made compulsory, which was to be supervised by HAS ▪ Since 2005, it is mandatory for physicians to go through an evaluation of professional practices (EPP) consisting of 1 QM tool among a list and participate into a CME every 5 years, which is supervised by the HAS in accordance with medical associations. ▪ Accreditation is a voluntary procedure for all public and private health care organizations, including ambulatory providers, but necessary for certification and is one QM tool of the EPP.
Germany	<ul style="list-style-type: none"> ▪ The statutory health insurance system is laid down in the Social Welfare Code and stipulates the regulation, registration, accreditation and control of health service providers ▪ The Federal Joint Committee - G-BA, Gemeinsamer Bundesausschuss has responsibility for development of directives and criteria of quality management. So far the process of following such directives isn't mandatory in ambulatory care. ▪ Over the last years wide reaching reforms underway to manage costs, improve interlinks between hospitals and ambulatory care. Collaboration of policy makers, professional associations and funding agencies for the development quality management
Denmark	<ul style="list-style-type: none"> ▪ Responsibility for preparing formal guidelines for the health sector lies with the Ministry of Health at central level. However, since providing health care is largely a county responsibility, most legislation does not specify how services should be organised or which services are to be provided. ▪ Since 1994 the counties and municipalities are required to develop a health plan every four years. The plans are submitted to the National Board of Health for approval. The number of counties is currently being reduced as part of a large scale reform to streamline the public sector. ▪ Local level health policy draws on a mix of formal and informal mechanisms such as circulars, incentives and information. The number of general practitioners in each county is agreed annually at this level.
Canada, Province of Alberta	<ul style="list-style-type: none"> ▪ Section 103 of the Medical Professions Act defines the requirements for the registered practitioners in Alberta
Switzerland	<ul style="list-style-type: none"> ▪ Law on professional health staff (“Medizinalberufegesetz”) from 1.9.2007 ▪ Swiss Federal law on university trained medical personnel from 2006 stipulates the regulation, registration, accreditation and control of health service providers
United States*	<ul style="list-style-type: none"> ▪ 2005 Patient Safety and Quality Act is of high relevance. The American Medical Association was instrumental in seeing the passage of this legislation. ▪ American Medical Accreditation Programme provides national standards. Voluntary process for each individual physician to be evaluated against these standards, criteria and peer performance.

* The section on the US is not extensive as the review's focus is limited to the specific role of the American Medical Association

As in the case of the organisational arrangements, legal and policy measures taken to carry forward quality management systems in the countries under study differ widely. In the UK, for example, a policy framework for the introduction of “Clinical governance” was established, which outlines approaches and tools. Other countries, such as Switzerland, have yet been less active in the legal and policy arena, possibly also because such agreements are much more difficult to achieve in highly decentralized countries.

4.2 Financing of quality management systems

Table 3. Financing of quality management systems in ambulatory care in study countries

Financing of quality management systems	
United Kingdom	<ul style="list-style-type: none"> ▪ “Clinical governance” financed principally through NHS: clinical practice guidelines, clinical audit, critical incident, complaints procedures and pay for performance by NHS ▪ CME co-funded by ambulatory care providers ▪ Licensing financed by ambulatory health professionals
Netherlands	<ul style="list-style-type: none"> ▪ Dutch College of Family Physicians is a scientific organisation and centre of knowledge which seeks and receives research monies (co-funding for clinical guidelines) ▪ Licensing and revalidation is regulated by the Royal Dutch Medical Association (KNMG) ▪ Quality circles and practice visits financed by ambulatory care providers ▪ Government finances National Institute of Public Health to implement performance assessments and benchmarking ▪ Patient information and complaints procedure financed by Dutch College Family Physicians, patient associations
France	<ul style="list-style-type: none"> ▪ CME is financed by the health insurance funds, and doctors participating in courses receive allowances ▪ Management of quality improvement programs and tools are funded by the “Haute Autorité de Santé” under the Ministry Health
Germany	<ul style="list-style-type: none"> ▪ Quality management systems generally financed by ambulatory care providers ▪ Patient information financed through various sources including via health insurance providers ▪ Professional Associations financed through a mix of public and private funds. Mandated by Ministry of Health to provide continuing medical education.
Denmark	<ul style="list-style-type: none"> ▪ All general practitioners derive their income from the National Health Security System according to fixed salary scales ▪ Licensing requirements at central and country level are all state funded ▪ To introduce competition and stimulate quality improvement, Government have increased the choice of citizens to choose between services paid for by taxes ▪ Promotion and implementation of the Danish Quality Model is publicly funded. ▪ Continuing medical education is provided by universities and the National Board of Health – all publicly funded
Canada, Province of Alberta	<ul style="list-style-type: none"> ▪ Since 2007, each health regional authority is responsible for funding the quality improvement programmes promoted by the College of Physicians, operating on a cost-recovery basis ▪ Review and monitoring of health care quality run by the Health quality council of Alberta is financed by the Ministry of Health.
Switzerland	<ul style="list-style-type: none"> ▪ CME funded by ambulatory care providers ▪ Other QM tools/instruments such as certification programs financed by ambulatory care providers
United States	<ul style="list-style-type: none"> ▪ Government dominates financing of quality management initiatives. Since 2004 leading role in ambulatory care has been played by Agency for Healthcare Research and Quality – a department of US Federal Department of Health and Human Services. ▪ Initial accreditation efforts have generally been via non-profit organisations, but are now being overshadowed by the Medical Accreditation Programme in which the American Medical Association (AMA)

plays a leading role and members/non-members pay varying fees for review

- AMA is run as a commercial enterprise with income coming from membership fees, investments and government research grants.

The funding of QM measures in ambulatory care varies across countries (table 3). Typically an important role is being played by the practice owner. Only in few cases there are subsidies from the health care financing organizations, particularly in national health care systems such as the UK where the NHS finances the elaboration of clinical guidelines or audits.

Even though in those countries where QM systems are principally financed by ambulatory care providers, there is a variety of indirect benefits for health care professionals: in France, for example, certification of a private practice owner may lead to a reduction in professional liability insurance fees. To some extent certified practices may negotiate better prices for services in Germany. In those countries where professional liability is a strong issue, there is a greater benefit in terms of protection from legal cases if a quality system is used.

In some countries such as Germany, research grants play an important role for the development of QM tools or instruments as well as QM programs.

4.3 Key actors involved in QM

In various countries under review, such as Switzerland, medical associations are a key actor with regard to quality management. More generally, they have maintained their role of licensing health care professionals and dealing with continuous training initiatives and have assumed the responsibility of generating and validating CPGs for the various medical disciplines.

In some countries, medical associations have formed coalitions with other stakeholders, such as medical insurances or accreditation and economic evaluation agencies, to assure their leading role in guaranteeing quality of care. This is the case in France, where the “Haut Autorité de Santé” has been established as scientific and public but independent entity integrating also the former accreditation agency, “Agence nationale d'accréditation et d'évaluation en santé (ANAES)”.

In other countries such as the UK, medical associations have lost their leading role in favour of regulatory bodies which were previously dealing with financial control only (e.g. the UK NHS trust boards).

Table 4 on the following page lists key actors involved in quality management systems.

Table 4. Key actors involved quality management systems in ambulatory care in study countries

Key actors involved in QM	
United Kingdom	<ul style="list-style-type: none"> ▪ Department of Health ▪ General Medical and other professional councils ▪ Royal College of Medicine ▪ British Medical Association ▪ National Institute for Clinical Effectiveness
Netherlands	<ul style="list-style-type: none"> ▪ Ministry of Health, Welfare and Sport ▪ Dutch Institute for Health Care Improvement ▪ Dutch College of Family Physicians (NHG) ▪ Royal Dutch Medical Association (KNMG) ▪ National Institute of Public Health
France	<ul style="list-style-type: none"> ▪ Haute Autorité de Santé (HAS) under the responsibility of Ministry of Health ▪ Trade Unions (« Confédération des Syndicats Médicaux Français ») ▪ Association of general practitioners (« Médecins Généralistes de France »)
Germany	<ul style="list-style-type: none"> ▪ The Federal Joint Committee („Gemeinsamer Bundesausschuss“) ▪ Federal Medical Chamber (“Bundesärzteskammer”) ▪ Chamber of ambulatory care physicians and health insurances (=“Kassenärztliche Vereinigung”) ▪ Professional medical associations ▪ Various other actors such as KTQ (“Komperation und Transparenz
Denmark	<ul style="list-style-type: none"> ▪ Ministry of Health ▪ National Board of Health- central body connected to the Ministry of Health and responsible for supervising health personnel and institutions and for advising different ministries, counties and municipalities on health issues. ▪ Association of Counties ▪ Trade Unions ▪ Danish Medical Association
Canada, Province of Alberta	<ul style="list-style-type: none"> ▪ Provincial health authority ▪ Alberta health and wellness (Ministry of Health of the Alberta province) ▪ Health Quality Council of Alberta dealing also with research related aspects ▪ College of Physicians and Surgeons of Alberta
Switzerland	<ul style="list-style-type: none"> ▪ Swiss medical association (FMH) ▪ Specific agencies (Swisspep overseeing European Practice Assessment, EQUAM) ▪ State Secretariat for Education and Research (“Staatssekretariat für Bildung & Forschung”)
United States	<ul style="list-style-type: none"> ▪ United States Department of Health and Human Services – specifically a department thereof – the Agency for Healthcare Research and Quality ▪ Quality Interagency Coordination Task Force (to align federal activities) ▪ Accreditation bodies – Joint Commission on Accreditation of Healthcare Organisations, National Committee for Quality Assurance ▪ Centre for Disease Control – hosts National Centre for Health Statistics ▪ Professional Associations – American Medical Association etc

4.4 QM Tools/instruments

Table 4. Tools and instruments used in ambulatory care in study countries

QM tools and instruments
<p>United Kingdom</p> <ul style="list-style-type: none"> ▪ General Medical Council (licensing agency) follows up random samples of doctors using funds from fees of those seeking registration ▪ Clinical governance concept including: <ul style="list-style-type: none"> - Continuing medical education - Licensing and revalidation requirements for ambulatory providers - Clinical practice guidelines - Clinical audit - Critical incident/medical error reporting ▪ Pay for performance schemes with indicator based assessment ▪ Mechanisms for patient: patient information, appointment systems, complaints procedures
<p>Netherlands</p> <ul style="list-style-type: none"> ▪ Clinical Practice Guideline Development ▪ Licensing of doctors (criteria cover CME & peer review of performance etc) ▪ Quality Circles ▪ Practice Visits ▪ Performance Assessment Framework set standards; possible benchmarking ▪ Patient information and complaints procedure
<p>France</p> <ul style="list-style-type: none"> ▪ Peer review groups ▪ Shared care networks ▪ Interdisciplinary cooperation meetings in selected areas (e.g. oncology) ▪ Staff evidence-based medicine meetings ▪ Performance indicator monitoring
<p>Germany</p> <p>Various but no mandatory tools for ambulatory care including:</p> <ul style="list-style-type: none"> - European Practice Assessment - Continuing medical education - Certification with quality schemes - Quality Circles - Clinical Practice guidelines in specialized areas of ambulatory care - Medical error/critical incident reporting on pilot basis - Patient information
<p>Denmark</p> <ul style="list-style-type: none"> ▪ Danish Quality Model including: <ul style="list-style-type: none"> - ICT supported tools such as electronic booking for shortening waiting times - Strong patient involvement and monitoring of their satisfaction - Monitoring of health indicators ▪ Accreditation initiatives so far largely focused upon inpatient care
<p>Canada, Province of Alberta</p> <ul style="list-style-type: none"> ▪ Accreditation programs ▪ Practice reviews for selected ambulatory care (e.g. methadone programs) ▪ Peer review program ▪ Physician Achievement Review (PAR) programme ▪ Triplicate Prescription Program (TPP)
<p>Switzerland</p> <ul style="list-style-type: none"> ▪ Continuing medical education ▪ Guidelines ▪ Quality Circles ▪ European Practice Assessment ▪ Certification
<p>United States</p> <ul style="list-style-type: none"> ▪ American Medical Accreditation Programme – strives to cover all physicians and sets standards on credentials, qualifications (including continuing medical education, peer reviews, self assessment), environment of care, clinical performance (patient care processes) and Patient Care Results. ▪ Patient and Consumer Information ▪ Improving clinical quality, information systems ▪ Value based purchasing – where purchasers hold providers accountable on quality & cost of services

5 Conclusion

Professional self-regulation has for a long time been the main quality assurance instrument used in most health care systems in Western Europe. Consequently, the professional associations were the key bodies to ascertain technical skills of health professionals. Key instruments were licensing and continuing medical education. With the increasing costs of national health systems, the pressure towards more cost-effective delivery of health care services and cost containment arose, mainly from health care financing bodies, tax payers, political and industrial (reduction of secondary labour costs) bodies. Due to the increasing complexity of regulating medical care, new stakeholders have appeared in the discussion or previous stakeholders have added their voice, which has forced some medical associations to become active in the promotion of the quality of care. Frequently, regulatory bodies have done groundwork in mandating professional bodies to increase quality and effectiveness of health care provision. The introduction of quality management systems being first introduced in the hospital sector, has shown promising results and these systems have also been subsequently promoted for use in the ambulatory sector.

The role of medical associations in the promotion of quality improvement strategies in ambulatory care has varied depending on the organization of the health care systems. Within the scope of quality improvement, new functions have been developed, with new responsibilities. Classic functions of professional self-regulation, which are shared across most of health care systems are:

- Representation of health professionals,
- Licensing of physicians and other health professionals,
- Continuing medical education, review of training curricula

but also

- Negotiation of service prices with health care financing institutions, definition of reimbursement schemes and financial control

New functions, which have evolved since the 1990s are:

- Quality assessment and the promotion of improvement mechanisms like quality management
- Development of clinical practice guidelines (CPG) along Evidence Based Medicine (EBM) principles
- Quality control and auditing of services
- Productivity, performance and outcome measures
- Definition of services and drugs to be covered by financial mechanisms, (e.g. Health Technology Assessment, positive or negative lists for drugs, others).
- Certification, accreditation, Total Quality Management (TQM)
- Quality target setting, quality improvement targets.
- Representation of stakeholder interests (e.g. patient interest groups)

Depending on the health system, central or local administrations have created the legal basis and mandated to introduce QM systems in ambulatory care. Medical associations have generally maintained their role of licensing health care professionals and dealing with continuous training initiatives. Generally, they have added the responsibility to generate and validate CPGs for the various medical disciplines.

However, many have formed coalitions with other stakeholders, like medical insurances or accreditation and economic evaluation agencies, in order to ensure their leading role in guaranteeing quality of care. In France for example, the “Haut Autorité de Santé” has been established as scientific and public but independent entity integrating also the former accreditation agency, “Agence nationale d'accréditation et d'évaluation en santé” (ANAES). In some countries, particularly the ones with national health care financing mechanisms, they have lost their leading role in favour of regulatory bodies which were previously dealing with financial control only (e.g. the UK NHS trust boards). Other medical associations added a scientific reference function for their constituencies (e.g. Denmark).

The definition of quality, its assessment and continuous improvement, play an increasingly important role in ambulatory care. On one hand, this leads to clinical appraisals and raises issues of what medical procedures are worthwhile to be funded by which financial mechanisms (e.g. UK, National Institute for Health and Clinical Excellence: HTA work). On the other hand research and assessment tools have been developed for performance measurements and quality control, which in turn may lead to performance based payment schemes for health professionals (e.g. UK). It is noteworthy that following the idea of QM, many of these performance measurements do not only include clinical parameters, but increasingly incorporate organisational variables, access issues (e.g. waiting time for patients, opening hours), interdisciplinary collaborations (doctors, nurses, midwives), collaboration across levels (hospital, ambulatory care, rehabilitation), among others. Instruments for quality control are varied: scientific approaches with questionnaires, self assessment instruments and auditing, peer reviews, or TQM schemes using PDCA approaches. In Germany, considerable research funds have been involved to generate quality assessment tools (the KTQ scheme, which started in hospitals, and QEP developed for ambulatory care). To some extent, a collaboration of existing bodies involved in quality improvement is used to perform external quality assessments. However, in some cases, independent organisations are created for this type of assessment feeding the information back to the providers and establishing benchmarking systems to elaborate quality standards and to provide learning opportunities for participants (e.g. KTQ, Germany; Outcome Verein Zürich, Switzerland and others).

The funding of QM measures in ambulatory care is mainly ascertained through the practice owner. Only in a few cases there are subsidies from the health care financing organizations, particularly in national health care systems. However, there is a variety of indirect benefits for health care professionals: In France for example, certification of a private practice owner may lead to a reduction in professional liability insurance fees. To some extent certified practices may negotiate better prices for services in Germany. In many countries where professional liability is a strong issue, there is a greater benefit in terms of protection from legal cases if a quality systems are in place.

5.1 Possible next steps

Depending on its priorities, the Swiss Medical Association has several options for further developing its role with regard to quality management systems in ambulatory care. Based on the various experiences from other countries and the observed trends in the quality debate from a professional as well as regulatory point of view, there seem to be three likely scenarios:

- Focus on quality of medical care
- Moderator of change
- Active player in shaping future working environments for ambulatory care.

Mixed forms of engagement are also possible.

Focussing on **quality of medical care** through CME, curricula development, promoting evidence based procedures and practices and others would be a concentration on the present FMH “core business”. The organisation could develop a scientific and research edge and, in collaboration with professional communities, facilitate the transfer of emerging medical knowledge to ambulatory providers, thus continuously updating and improving the quality of medical care provided. The association would strengthen its CME component, be involved in medical education and to some extent in applied research (or operational research) to identify best practices and promote these to its members. Thereby a leading role would likely to be within the medical societies of the FMH (“medizinische Fachgesellschaften”) involved in the provision of ambulatory care, such as the society for general medicine, gynaecology & obstetrics or paediatrics. Considering the current activities of the FMH, this approach has the advantage that it is a continuum in a field where the FMH is already strong, but with an effort to sharpen its profile towards a guarantor of high quality medical care. The risk is, however, that with an increasing pressure towards the introduction of QM instruments, which focus more on the institutional and systems quality, other players (e.g. associations like EQUAM, OUTCOME Verein, etc.) might fill this gap and the FMH may lose some of its current influence, particularly in terms of self-regulation.

Table 6. Possible positions of the Swiss medical association (FMH) towards quality management systems in ambulatory care

Scenario	Potential Opportunities	Potential risks
Focus on quality of medical care (current “core business”): CME, curricula development, promoting scientifically evident procedures and practices	Strengthen areas where the institution is already good at, guarantor of high quality medical care	Other players will fill the gap in the areas of institutional and systems quality. Professional associations may lose some of its influence
Moderation of Change: introduction of continuous quality improvement measures such as quality circles, peer audits, self assessment to certification	Neutral institutional standpoint on QM, providing reliable information for individual decision making for its members	Limited influence on shaping the regulatory and practical working environment
Pro-active player for QM systems improvement: partnerships with other actors or joint creation of institutions for quality assessment or the development of QM improvement strategies	High influence on policy change and the introduction of QM measures, active representation of members in the policy debate, competitor with providers of QM schemes	Limited capacity as well as loss of visibility through engaging in partnerships, many additional tasks, loss of neutral position for its members

In many highly decentralised health care systems the discussion on the introduction of QM in ambulatory care has produced a variety of practical approaches from quality circles, peer audits, self assessment to certification. Additionally to the role above, the FMH could **moderate the change** towards the introduction of continuous quality improvement initiatives for its members. Key tasks would be, amongst others, to provide a discussion forum for these issues, to review currently used approaches, assess their efficiency, generate lessons learnt and provide information to its members. Additionally, it could generate a network of partners or collaborators, which are more involved in QM, thus facilitating access for its members to QM services. This approach would require the professional associations to build up their capacity to review and evaluate institutional and systems aspects of quality additionally to professional aspects. Networking with other professional associations on regional and international scale could be an advantage. These additional requirements could also be accomplished through partnerships or

outsourcing. A clear advantage of this approach is that the institution maintains a relatively neutral standpoint in the QM debate and enriches it with facts and lessons learnt. The members can individually subscribe to the ideas or not. However, with other stakeholders playing an active role in the debate and the professional associations being the observers and mediators, the influence on shaping of the regulatory environment to the advantage of its members might be limited.

Taking an **active position in the QM debate** would increase the role of the FMH in the policy debate and the regulatory process, having its members actively participate in the shaping of their working environment. Thereby the FMH clearly would be able to prove that the traditional self-regulatory mechanisms maintain their functionality even under changing frame conditions, which in turn strengthens the association's leadership role in the policy debate. Besides its traditional role, the FMH would have to widen the scope towards a systems view within a multi-stakeholder environment not limited to interdisciplinary (various medical disciplines) and multi-level (e.g. interfaces between ambulatory care, hospital care, rehabilitation, etc.) views, but also incorporating related stakeholders (e.g. NGOs in QM, patients' organisations, health insurers, cantonal administration). It requires setting up coalitions and partnerships with other stakeholders in the QM debate to create common understanding and a joint approach for quality. The FMH may search partnerships with other actors or jointly create institutions for quality assessment or the development of improvement strategies (following the model of e.g. Outcome Verein Zürich, ÄZQ Berlin). Potential entry points would be the discussion on a joint view of what quality consists of in today's ambulatory care environment and how that can be measured. Self assessment and QM tools may be used to improve institutional performance in incremental steps. A benchmarking system may generate lessons learnt for quality improvement. However, this approach would mean many additional tasks for the FMH, where it may have limited capacity at present. The engagement in partnerships and coalitions might entail a loss of visibility to their members and the public. Taking an active position also limits the neutrality of the institution and might not be well accepted by some members. Although the engagement in partnerships increases the capacity of the institution, there is limited opportunity to completely outsource the additional tasks.

The current debate on the introduction of QM in ambulatory care may change the role that self regulatory mechanisms play in professional quality assurance. As the traditional guarantor of quality of medical care in Switzerland, the FMH will have to choose what role to play in the future. More generally: with the creation of new quality requirements and the appearance of new stakeholders in the movement towards quality improvement in ambulatory care, it is evident that Medical Associations cannot continue to rely entirely on their classical instruments if they want to play a central role in the quality discussion in the near future. An increasing transparency in the evaluation of quality, stronger interdisciplinary collaboration and integration of client expectations, is needed. Professional self regulation may be limited in the future and a stronger collaboration with other stakeholders will be needed to participate actively and shape the quality discussion. Lobbying on the policy level on the one side, and promoting the idea of QM to its members on the other side, will be an essential function of medical associations. Shaping this debate may have considerable impact on future health care financing schemes and payment of individual ambulatory care practices. Being the traditional actor in medical quality assurance, medical associations should become more active in the field of the new quality definitions and the development of assessment and performance measures, which are in line with the multi-stakeholder environment of health care delivery systems.

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Annex 1. Glossary on Quality Management tools/instruments and measuring systems

Benchmarking

Benchmarking is the process of comparing one's performance with the best performers and thereby sets a classification in performance. The basis for comparison can be the local setting or a wider setting (national for example). The benchmarking tool is aiming at the improvement of quality of care and organisational learning rather than individual error tracking or blame, based on the evidence that most negative incidence is due to organisational dysfunctions than individual errors.

A benchmarking experience has been done in Switzerland in 2000, focusing on emergency care departments. The experience involved the participation of 12 community hospitals and two indicators were chosen: the speed and accuracy of patient assessment, and patients' experiences with care provided by the emergency department. The data was collected in two measurement cycles of one year interval. The second cycle reported improvements in the reduction of under- and over-prioritization, the increase in appropriate classifications of 'urgent' patients, the decrease of the time from admission to established diagnosis.

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Breakthrough Series Collaborative

The idea of Breakthrough Series Collaborative (BSC) is to have learning sessions with professionals from the different professional corps of hospitals, clinics or group practices (physicians, nurses, administration staff, etc) and, focusing on specific topics that require improvement, participate in 6 to 15 months learning sessions followed by action sessions. The tool combines elements of several quality tools namely, assessment, training and quality circles at an interdisciplinary level in order to define strategies and small improvement projects based on lessons learnt and best practices. BSC aims at filling the gap in the cooperation and collaborative behaviours in health care settings that are often lacking: information is not properly shared, help is not easily requested, communication skills are poor, stressful behaviours is not uncommon.

The Breakthrough Series Collaborative is a tool that was introduced in the mid 1990s in the American health care system to respond to low quality in care reflected by high costs, injuries to patients, unscientific care and poor service. It is mainly elaborated to be applied to large settings such as hospitals and large group practices as can be found in the United States. The leading actor implementing and promoting this tool is the Institute for Healthcare Improvement in Boston.

This tool is reported to enhance numerous improvements in quality, for instance in waiting time, in savings, in chronic care (increase of self-monitoring patients), in adverse drug events, caesarean section rates (by reducing admission for false or early labour), in adult cardiac surgery (by reducing the time of median post surgical ventilator times, by reducing the time from admission to feeding).

Further information:

Breakthrough Series Collaborative Information Packet, National Center for Child Traumatic Stress, Revised 2-28-05

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Clinical Audit

Often used in a narrow definition of a collection of data about performance, an audit can be apprehended in a broader definition that qualifies it as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change" (NICE, 2002, cited in Baker et al., 2006: 210). This definition emphasizes the outcome aspect of an audit and its aim to implement change. The audit is usually done by another health care person, usually a peer, in order to be able to give strong feedback and to enhance mutual learning. However, the improvement in quality of care depends on the way the audit – and its feedback – is provided and perceived by the health care providers. Indeed, an audit feedback must be aiming at improving the quality of care, and therefore must be addressed in a helpful rather than threatening way.

Reported positive experience with audits as a tool to improve the quality of care and the participation come from Denmark, Sweden, Iceland and Norway. Also, in the United Kingdom, audit has played a major role in quality improvement activities since the early 1990s: "the combination of new health service policy, a limited amount of funding and local structures to provide leadership and encouragement, led to the participation of most health professionals, in primary care in audit projects. General practices have reported taking part in a media of three projects each per year, with changes in care being implemented in two-thirds of the audits." (Baker et al., 2006:210-11)

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Clinical Practice Guidelines

As defined by Field & Lohr in 1990, guidelines are “systematically developed statements to assist practitioner decisions about appropriate health care for specific clinical circumstances” (cited in Woodward, 2000:17). Guidelines need to be developed for each specific clinical procedure, elaborated by renowned and referable practitioners, regularly updated and available to all through public publishing. In most European countries, national guidelines exist and aim at improving the quality, the coherence and the consistency of the performances of primary care professionals. The implementation of guidelines is linked to the evidence-based medicine movement. In the elaboration of guidelines, “a structured development procedure is used, which combines systematic assessment of the research evidence and the judgment of experienced GPs” (Baker et al., 2006:210).

According to a study on “translating guidelines into practice”, any guideline should include strategies to assure its adoption: “consideration of the nature of the guideline, the nature and beliefs of the physicians to whom it is directed, and environmental factors that could facilitate or impede its adoption, is a necessary ingredient in the translation of practice guidelines into improved performance or health care outcomes” (Davis and Taylor-Vaisey, 1997: 414). Indeed, the elaboration of guidelines without a strong emphasis on their adoption and implementation strategies is a time and money consuming procedure that has little impact. Results from this study show that the variables that influence the adoption of the guidelines are: the quality of the guidelines (must be relatively uncomplicated and be observed or tried by the clinician); the characteristics of professionals using them (age and provenance); the characteristics of the practice setting or environment; the incentives (legal or financial issues), the regulation mechanisms (accreditation); and then the patient factors (patient type, individual demands, etc.). (ibid, 1997:411-12)

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Computer-based clinical decision support

In some literature, computerised support system is considered as a quality improvement tool rather than a more general technology improvement that has applications in the health sector. For others, the computer-based clinical decision support is mainly seen as an evolving technology that will develop and improve, and is therefore, a compulsory step for the improvement of the health sector. The use of computers to assist professionals in decision making, such as generated reminders to enhance the quality of preventive care, to determine the dose for toxic drugs, information about the cost and testing adequacy for each patient (given information about previous test findings for the patient), can enhance improvements in the quality of care. Studies report that this tool helps reducing the cases of adverse events and mortality when used as a support of medical decision regarding medication, also reducing the drug costs per patient, and the repeat prescribing issues.

However, this tool shows little efficiency in diagnosis. It has considerable development and maintenance costs, in order to insure access and context-specific application, as well as time and cost consuming needs in training.

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SWINGLEHURST D.A., PIERCE M. AND FULLER JCA (2001), "A clinical informaticist to support primary care decision making", in *Quality and Safety in Health Care*, 10, pp. 245-249.

THOMSON Richard, ROBINSON Angela, GREENAWAY Jane and LOWE Philip (2002), "Development and description of a decision analysis based decision support tool for stroke prevention in atrial fibrillation", in *Quality and Safety in Health Care*, 11, pp. 25-31.

Continuing medical education and learning

Continuous medical education is mostly available in the form of written educational material, courses, seminars or conferences. This tool has the function to keep professionals informed on the changes occurring in health practice, such as new evidences, drugs, practices and so on, which may be useful for the professionals to incorporate in their own practice. For the information transmitted to have an influence on the improvement of quality of care, it has to be relevant and of interest to the health professionals given their domain and setting.

Continuous education is a common tool that is used not only in the medical field (Continuous medical education, CME) but also in many other branches where professionals needs to keep informed and improve according to scientific advances. CME is part of the European quality assurance system in health.

Although knowledge of an area of practice can be improved with continuous medical education, research shows that written educational material is not sufficient to change the behaviour and practice. "Educational materials, including professional journals and electronically transmitted information, are better seen as part of a package of learning activities and materials that can assist health care personnel in improving the quality of care they provide." (Woodward, 2000:16)

Further information:

WOODWARD Christel A. (2000), "Strategies for assisting health workers to modify and improve skills: Developing quality health care – a process of change", in *Issues in health services delivery*, Discussion paper N°1, Geneva.

Negative Incident Reporting

Analysis of adverse events involving hospitalised patients showed that 69% of all accidental injuries were caused by errors or failure to follow accepted practices (Wilf-Miron et al. 2003: 35). The negative incident reporting tool – also known as adverse event reporting – is applied to report, document and analyse medical errors. Ideally, the tool aims at improving safe medical processes and procedures, applying a systems and non-punitive approach. The aim is the institutionalisation of a permanent programme for risk identification, analysis and dissemination of lessons learnt throughout the professional community.

Further information:

KINGSTON Marilyn J, EVANS Sue M., SMITH Brian J. and BERRY Jesia G. (2004) "Attitudes of doctors and nurses towards incident reporting: a qualitative analysis", in *The Medical Journal of Australia*, 181(1), pp. 36-39.

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Patient's complaints procedure

The patient being an important parameter in the definition of quality of care, procedures can be applied to measure the patient's evaluation of the quality of care received. The patient's complaints procedures are usually found in the form of questionnaires that patients fill-in after a consultation. The questionnaires are seeking to measure the patient's opinion in the main sectors of access, clinical performance and patient's personal experience. The access indicates the ease with which the health care setting can be reached including financial, organisational, cultural and emotional dimensions. The clinical performance is evaluated through the appropriateness of the delivery of clinical services according to one's condition, the safety, the competence, the time frame and the information received. Last, the patient's personal experience measurement reflects the overall satisfaction that includes the information, the respect and caring, and the continuity and coordination. (Lawthers et al, 1999: 503-4)

For Swiss examples of patient's complaints settings and use of data collected through questionnaires and focus groups, see the study from Institut universitaire de médecine sociale et préventive in Lausanne "Qualité des soins ambulatoires, opinion des patients infectés par le VIH", 2001, and also an article on patient's survey in Swiss hospitals on women's experiences with low-risk singleton in-hospital delivery (Schwappach et al, 2004).

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Pay-for-performance

Pay for performance is an emerging movement in health insurance (initially in Britain and United States). Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services. This is a fundamental change from fee for service payment

Also known as "P4P" or "value-based purchasing," this payment model involves the establishing of a contract between family practitioners/their practices whereby according to performance with respect to certain quality and efficiency indicators, points are awarded. Each point has a monetary value which goes either to the individual or the practice – usually there is an upper limit. The indicators generally cover clinical care, patient experience and increasingly – through experience sharing between European countries – with regards to the organisation of care delivery (Doran et al, 2006). Pilot studies underway in several large healthcare systems have shown modest improvements in specific outcomes and increased efficiency, but little cost savings. Statements by professional medical societies reinforce the general need for incentivising performance, but also express concern with the validity of quality indicators, patient and physician autonomy and privacy, and increased administrative burdens.

Further information:

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DORAN T, FULLWOOD C, GRAVELLE H, REEVES D, KONTOPANTELI E, HIROEH U, ROLAND M (2006) " Pay-for-performance programs in family practices in the United Kingdom", *New England Journal of Medicine*, July, 27;355(4):375-84.

Quality circles / peer review groups

In primary care in Europe, the terms quality circles and peer review groups are used as synonyms. They refer to groups of 5-10 professional peers who meet at regular intervals. The main activities of the group are the setting of criteria, the collection of data, the evaluation of each other's work and the elaboration of specific arrangements aiming at improving the quality of care through change in performance. The regular group meetings enable practitioners to meet their peers and exchange on ideas and practices. However, limited evidence has proven that quality circles as a single strategy is improving quality of care given. Peer review groups may be particularly suited to individual GP settings, as they allow regular meetings and discussions on common issues and practices.

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- LEE Li-Chuan, YANG Ke-Ping and CHEN, Tai-Ying (2000), "A quasi-experimental study on a quality circle program in a Taiwanese hospital", in *International Journal for Quality in Health Care*, vol 12, n° 5, pp. 413-418.
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Measuring system 1. European Practice Assessment (EPA)

Across Europe comparisons have been drawn between different countries and the indicators they have used to assess performance of primary care practices. The resulting indicators based method aims at improving organisation of general practices in a systematic way. The tools used include structured interviews and practice visits. The objective of the practice visit is that one or more observers – a peer or a non-physician observer – collects data in preparation for the visit according to the specific needs of the individual health care personnel (specific type of patient or clinical problem), and then, visits the practice, assess and discuss the quality of care or services. In a second time frame, the person gives a feedback on the practice's performance.

This tool is an alternative to peer review groups in countries where group practices are common. Ideally, practice visits are a challenge for practitioners and teams to review and improve their performance and methods.

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Measuring System2. Performance Assessment Programmes

Performance Assessment Programmes were developed with dual aim of protecting patients and enhancing clinical performance of doctors. Three levels can be identified: Level 1 screens either an entire population or a random sampling of doctors. Level 2 targets groups whose personal attributes or practice profile place them at risk of poor performance (eg. working in professional isolation). Level 3 assesses doctors about whom there are specific concerns (eg. through corner's investigations, audits etc) (Finucane et al, 2003). Performance assessment programmes usually supported by legislation regulating the practice of medical professionals, most often

under a licensing authority – as ultimately suspension or removal of license may be required. In many cases there is an appeals process in place, often involving professional associations and using review panels comprising peer colleagues and public appointees to the association in question. Level 1 assessments are generally done amongst random samples of professionals on a register and are usually funded from annual member dues. They tend to rely more on questionnaires and practice profiles than in-depth visits and structured interviews.

Further information:

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