The purchaser role in provider quality: lessons from the United States

Purchasers have a responsibility to ensure that the care purchased is of good quality and meets agreed standards, and this is an area in which the experience of the United States may be valuable. Although views on quality may be expressed within specific clauses of purchasing contracts, finding out whether or not the care delivered meets those standards is more difficult. And influencing providers to continue to improve the quality of care is not a straightforward task.

Theoretically, purchasers could use several approaches to influence provider quality. These range from merely requiring that the provider has in place appropriate systems for quality assessment and assurance (such as clinical audit) and being assured of their effectiveness, to purchasers themselves being involved in detailed inspection and monitoring of provider quality through extensive collection and analysis of data. Moreover, the purchaser-provider relationship could be cooperative or to a greater or lesser extent adversarial.

What can purchasers learn from the American experience?

Purchasers need an effective and cost-effective strategy for assuring and influencing the quality of provider care. Can the American experience help work out the balance between extensive purchaser involvement in provider quality and a hands-off approach that some might consider an abrogation of purchaser responsibility? What can purchasers learn from the American model?

Firstly, external monitoring systems are expensive, heavily reliant on extensive data collection, and widely criticised by providers. For example, the mandatory external Peer Review Organisations have consumed considerable resources but have largely developed into bodies whose function seems to be cost containment and the identification of bad care. This approach, not surprisingly, has generated defensiveness and antagonism from clinicians. Secondly, multiple purchasers producing different demands on providers is both inefficient and a costly burden on providers—a feature recognised within the proposed Clinton reforms. Thirdly, external comparative monitoring, such as publication of hospital mortality data, is problematic. The publication of such data in the United States produced an immense media response but also a voluminous response from the hospitals themselves, much of it defensive, questioning the quality of the data or attempting to explain their mortality experience in terms, for instance, of case mix. This has led on to an explosion of approaches to risk adjustment of such data, many of which seem to have been focused on explaining variation rather than on stimulating activity to improve quality. Fourthly, although external accreditation models are widely applied, they are costly, both to organise and to subscribe to. Concerns about systems such as that provided by the Joint Commission on the Accreditation of Health Care Organisations and described in this issue (p 97, 101)\(^1\) include their concentration on structures and processes, seeking to answer, at best, the question “Can this hospital provide good quality care?” and not “Does this hospital provide good quality care?”

External monitoring versus internal continuous quality improvement

One of the most cogent critics of such external approaches is Berwick\(^1\) who has concluded that much effort at quality improvement had been based on the “bad apple” approach, seeking outliers and imposing sanctions, particularly where external systems produce judgements based upon questionable data. He has championed the continuous quality improvement model, recognising that inspection is a limited method for quality improvement and that an organisation’s own internal quality improvement programmes have much greater potential for effective change. Ultimately, this implies that the provider of health care has the prime responsibility for assessing and improving the quality of care. That is not to say that providers should be insulated from appropriate and legitimate external interest in the quality of their care: they should increasingly be able to demonstrate that their systems lead to quality improvement, and they will equally have a responsibility to ensure that their priorities for quality assessment and audit are driven by much more than their own interests and aspirations. Mechanisms are needed to ensure that the views of purchasers, patients, and the public, among others, inform priorities for quality improvement.

Jo Ivey Boufford points out that “purchasers will never have the staff for adequate monitoring,” and we should heed her warning.\(^2\) If purchasers are to develop the means of effectively assuring themselves of the quality of care they are purchasing, they may best focus their efforts on insisting that providers have well developed and demonstrably effective quality systems in place.
rather than trying to develop external assessment or make judgements on provider quality based on inadequate data or understanding.

In conclusion, let us not ignore the American experience, which suggests that we should actively explore cooperative relationships between purchasers and providers in pursuing their joint aspirations for high quality care. The primary emphasis for purchasers should be on the population dimensions of quality and on purchasing the “right things,” while providers should be required to demonstrate effective quality improvement systems, albeit increasingly responsive to the expressed priorities of purchasers and founded in open discussion between purchaser and provider. A key area for exploration here will be the role of guidelines and protocols in purchasing and their monitoring through audit. Perhaps the final word should rest with another American, Avedis Donabedian, who in emphasising the value of the organisation wide approach to quality, wrote: “The challenge is to introduce quality monitoring and its associated controls so that they become an organically functioning part of an organisation, rather than a foreign irritant to be neutralised or repudiated.”

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