Learning from quality systems in different countries: quality improvement across borders?

Is quality improvement a parochial activity, focused on local problems, determined by local context, and generally lacking lessons for people or organisations not involved? Or is it an activity with various key features that apply wherever and whenever improvement in quality is attempted? We would argue that quality improvement is indeed an activity or discipline that has a common core. Its principles cross the boundaries of country, healthcare system, and even type of profession or industry. Indeed, this is the belief on which the journal is founded.

Much of the work of quality improvement has application in any healthcare system. Team development, organisational change, strategies for implementing evidenced-based health care, methods for improving patient safety, and enabling patients to make choices are all areas of practical concern to clinicians and managers worldwide. But the direction and emphasis, and even the language of quality improvement, are influenced by national context. In the UK, government directives can mandate quite considerable change in the NHS, the main provider of health care. For example, the introduction of medical and clinical audit in 1990 was the result of government policy. More recently the current UK government set out an ambitious set of reforms—to be implemented in the next year or so—that include the introduction of new structures intended to improve the quality of care.1,2 These include a Commission for Health Improvement (CHI); a framework for bringing together professional concerns with managerial and organisational concerns about quality improvement—called “clinical governance”—; and a National Institute for Clinical Excellence (NICE) whose work will include appraising the effectiveness of therapeutic interventions and dissemination of guidelines. Expectation is high for these reforms; there are already at least two journals of clinical governance. Two papers in this issue review aspects of the recent UK reforms.1,4 One discusses clinical governance and maps this new concept to more familiar approaches to quality improvement and the other explores the potential pitfalls—that the new external inspectorate—the Commission for Health Improvement—must avoid if it is to contribute to improving the quality of patient care. Others’ experience of external inspection as a lever for quality improvement should inform the development of the Commission for Health Improvement in England and Wales.

The purpose of this journal is to contribute actively to the debate about the quality of care; work that describes the implementation and development of these UK initiatives and evidence of their impact on the quality of patient care will be reported. Several aspects of the reforms in the UK will be of general interest. Firstly, is the broad system of clinical governance an approach worth emulating in other countries? By bringing together all manner of activities that might improve quality, will more be achieved? Secondly, what should the culture of such a quality improvement system be? Thirdly, will the arrangements for accountability (to the public, fellow professionals, and health service management) be adequate, in the context of a state funded health care system, to maintain the motivation for quality, or would a system with some element of competition be more effective?

A significant proportion of readers of Quality in Health Care work in other countries, however, and for them the reforms in the UK are likely to be at best of peripheral interest, and some of the new terms and acronyms now part of the health service vernacular will seem odd. And in many other countries reforms have been, or are being, introduced that have as their objective improvements in the quality of care, and therefore improvements in health. There is an urgent need to learn from all these “natural experiments”. In five or 10 years time we should have learnt many new lessons—and probably been reminded of just as many old lessons. If we are to make best use of the experiences that are to come in healthcare quality improvement, systematic exchange of information is an essential prerequisite.

International meetings, forums, and books all can contribute to achieving this objective. Journals also have a major role. The challenge to the editorial team of Quality in Health Care is to publish papers on healthcare reforms that not only take forward the national thinking but also contribute to the wider international debate on quality improvement. The challenge to authors is to look beyond parochial concerns and consider the wider implications of their experience, and look at their work in the context of the building blocks of quality improvement, for example organisational development, change management, measurement, and process reengineering. To encourage a wider perspective on national changes we encourage comments from experts from other countries, as we have for papers in the occasional series Health Policy. And, of course, if you are working in a country that has recently, or is now, introducing reforms driven by concern about the quality of care, or have been evaluating the success of your quality improvement system, we need to hear from you. Perhaps an additional, and final, step should be added to the quality cycle—you should inform others of the successes and failures and the strengths and weaknesses of your system, so that all can learn as quickly as possible how to make health care as acceptable, effective, and efficient as it should be.

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