Health outcomes: a challenge to the status quo

Arnold Relman called the new emphasis on patients’ outcomes a revolution in medical care. The main activity to which he referred was the systematic study of the relation between health care and its consequence. The aim in the United States was to provide a rational basis for improving the effectiveness and efficiency of the health care system and to reverse incentives which had for many years encouraged inappropriate overuse, particularly of inpatient procedures and high technology care. The objective was not cost containment but quality improvement, although increased costs might have accrued if the results identified underuse of appropriate services by high risk populations and lead to recommendations and guidelines requiring increased expenditure to improve access and outcomes.

The equivalent revolution – despite a brief pause for the democratic electoral process – is being felt on this side of the Atlantic. The popular cause for greater public accountability of the health service and for measures which enable patients and carers to judge the quality of care according to their improved health is being championed by consumer groups but also has the broad support of an alliance of researchers, social scientists, doctors, other health professionals, and managers. The leaves only the status quo as the redoubtable combatant. Yet in this headlong rush to reorientate the NHS towards health and not just health care it may be worth asking what are the main aims, who should take responsibility for this new development, and how can it work in practice?

The outcomes under consideration are those objectively measured consequences of treatment that have been traditionally used, such as mortality; morbidity; complications and readmissions; clinical assessment, such as physiological functioning; measures of patients’ expectations, values, and preferences; and functional health status (quality of life). There are three main questions:

(1) Whether an intervention should be undertaken at all – would it make any difference to the outcome compared with no intervention?
(2) How are choices made between different options to achieve the desired outcomes?
(3) How are patients’ values included in determining desired outcomes and choice of treatment?

But problems arise when practical solutions are sought. The outcomes of many health care interventions are not well understood, and the scientific basis of the motivation to learn and develop from a very low baseline is perhaps the most striking attribute of nurses in the ex-Communist countries. Also their requirements may not be that different from those of nurses in the United Kingdom. Wherever they are introduced, quality assurance methods which are designed to be an integral mechanism of service development have to be simple, accessible, cheap, effective, and attractive. Perhaps the worlds of nurses are not as far apart as they seem – it is more a matter of degree. We have just as much to learn as we have to teach.

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the need to maximise efficiency (cost per health gain) is implicit in its approach. The priorities identified in the document will also require cross sectoral collaboration, calling on resources from local authority social services departments and the voluntary sector to fulfil the aim of delivering improved health.

There is considerable enthusiasm among researchers to develop improved methods for measuring clinical outcomes in relation to functional health status, perceptions of health, and severity of illness. Studies are under way to identify and analyse the cost effectiveness of alternative options for diagnosis, treatment, and management of a wide range of clinical conditions and to test methods for reducing inappropriate interventions or for tackling variations in practice. But empirical work is also needed to assess how information may be used to bring about the organisational and cultural changes required to ensure routine collection of information on outcomes and methods for analysing and presenting information that will ensure its effective use by clinicians and managers.

In this effort existing mechanisms should be evaluated first. With any new initiative there is a tendency to assume a need for new routes to practice. Yet processes such as medical audit may prove entirely suitable. Early reports suggest that medical audit has precisely the right characteristics: improving communication between peers (for example, physicians discussing with surgeons joint management for gastrointestinal bleeding), improving working relationships between professional groups (for example, anaesthetists agreeing guidelines with nurses for pain control), better organisation (for example, joint managerial, nursing, and medical action to improve the delivery of thrombolytic therapy), and improved collaboration between primary and secondary health care practitioners (for example, shared protocols for referrals or for management and follow up in chronic disease).

Such achievements, if sustained, will lay appropriate foundations for securing the application of health outcomes in improving health service delivery. The success of the initiative will rest on the ability of the health service to provide a forum for patients and doctors to agree the desired outcome, and for collaboration between professionals – primary and secondary care providers – to enable the collection of information which will allow patients to be followed up and their progress assessed in terms of clinical measures and functional health status. In addition, the forum of medical audit may enable analysis of data on outcomes in terms of case mix and severity of disease before the results are discussed with managers or used as a basis for negotiations between purchasers and providers. The establishment in the United Kingdom of a clearing house for information on the assessment of health services outcomes, funded by the Department of Health, is an important development. The clearing house will strengthen the information base available to purchasers and providers: to purchasers for incorporating patients’ assessments into their strategy for improving health and to providers for devising methods to incorporate patients’ values into professional judgements about the appropriateness of interventions.

Despite the few existing methods for evaluating health services according to their outputs the success of the outcomes revolution in health care will depend on widespread acceptance of the approach taken and the methods used. The growing conviction among professionals and the public of the value of this work, the new proximity of researchers to service providers, and the powerful combination of clinical and social science perspectives, if brought to bear on the issue of health services outcomes, may well herald true change in health care and severe blow to the status quo.

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