

Health Policy

External evaluation of health care in Italy

The Italian Ministry of Health signed a Decree in October 1996,¹ which introduced into the Italian healthcare system a set of 53 indicators as a tool for the external assessment of quality of care. The "indicators for the quality assessment of the health service with reference to personalisation and humanisation of care, the right to information, hotel services, and the patterns of disease prevention" follow the relevant section of the health reform (art 14, Decreto Legislativo 502/1992 and 517/1993) after a year's lag.

The set of indicators applies to all levels of care, from preventive medicine and primary care, to secondary care, hospital care, nursing homes, and rehabilitation facilities.

Of the whole set, the first 17 indicators are about personalisation and humanisation of care, assessing the ease of booking medical services and of carrying out administrative procedures, and the actual respect for patients' rights.

Eight more indicators are on the information given to patients about the services offered, surveys on patients' satisfaction about the care they have received, and patients' rights to information and informed consent.

Nineteen indicators are about the quality of hotel services offered within the healthcare facility; and the last nine deal with the patterns of disease prevention within the Health Service.

There is an ongoing interest and debate in Italy over the quality of health services. The Decree has provoked some controversy² as it requires the measurement of indicators that are actually tools for the external assessment of quality of care. This clashes with the policy of the Italian Society for Quality Assurance in Health Care, which has always supported the internal evaluation of health services as opposed to some forms of external control.

It is argued that guidelines on scientific and technical issues tend to be brought about in the health sector without adequate consultation with the relevant scientific societies and without giving their view careful enough consideration.

Not surprisingly, these indicators seem to require some re-editing as most of them deal with the process of a humane delivery of health care rather than with its outcomes.

In the meantime, the set is likely to constitute just a starting point and perhaps a useful primer for individual healthcare providers who may develop it into a sounder system for the evaluation of humanisation of care in Italy.

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1 Approval of the indicators for the quality assessment of the health service with reference to personalization and humanization of care, the right to information, hotel services, and the patterns of disease prevention. *Gazzetta Ufficiale* 18-01-1997;No14. (Decreto Ministero Sanità 15-10-1996.)

2 Perraro F. Linee guida: dalla finanziaria alla pratica: no, così non va [editorial]. *QA—Organo Ufficiale della Società Italiana per la Qualità dell'Assistenza Sanitaria*. Giugno 1997;7:IV.

Comment

Mariotto and Chitarin describe the Italian approach to publishing comparative quality indicators. This puts their health service in the same position as in many other countries—the release of such data is an international phenomenon. In England we have seen the publication of non-clinical *patient's charter* indicators for several years,¹ and we are about to move into a phase of public availability of clinical indicators for hospitals.² Proponents quote public accountability and consumer choice theory in defence of this approach.

None the less, this is an international phenomenon built on unsteady ground, and as each country adopts such an approach it does so with apparently little reference to important experience elsewhere. The problems are many and include technical issues such as the validity, reliability, and sensitivity to change of the indicators, as well as concerns about the effects of case mix and other confounders on their interpretation.³ Perhaps more important is the effect that this approach may have in stimulating behavioural change. Quality improvement requires change, but use of indicators in an external judgmental fashion may well lead to undesirable changes, which would remain even if the technical problems could be resolved.⁴ These include the creation of perverse incentives, gaming, and on occasions, outright misrepresentation on the part of the services that are being judged, further deflecting them from the desired exploratory effort to improve internal quality.

American experience is particularly apposite—the Health Care Financing Administration that oversees the quality of services for Medicare and Medicaid abandoned publication of risk adjusted hospital mortalities in 1993 after several years of frustrated attempts to make the data useful for quality improvement.⁵ Alternatively, the largest comparative quality indicator database in the United States, the Maryland Quality Indicator Project which involves over 1100 hospitals, uses an approach that collates and feeds back comparative data in an anonymised fashion for internal use. Perhaps more importantly, the project includes supportive and educational components to maximise the value and use of indicator data to support quality improvement.⁶

This is now an international project, with involvement of hospitals in several countries, including Austria, The Netherlands, Belgium, Japan, and the United Kingdom. The United Kingdom was the first country outside of North America to evaluate this work and we have now set up a United Kingdom office supporting the United Kingdom Quality Indicator Project, based in Newcastle upon Tyne. Our experience to date confirms the value of this anonymised internal approach in stimulating quality improvement.⁷

The Italian approach seems particularly ambitious, engaging as it does a wide range of providers. They would do well to undertake a formal evaluation of the release of this data, although this is not easy. However, there is a real opportunity with national approaches such as this, to pursue a radical option, that of randomising participants to either anonymised feedback or public release of indicator data. This would allow comparisons of the approaches in a robust study design. If political imperatives stifle such an approach, a real opportunity may be missed.

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- 1 Department of Health. *The patient's charter: raising the standard*. London: HMSO, 1991.
- 2 Department of Health. *Clinical indicators for the NHS (1994-5): a consultation document*. London: Department of Health, 1997.
- 3 McKee M. Indicators of clinical performance. *BMJ* 1997;**315**:142.
- 4 Walshe K. Indicators won't turn tables. *Health Service Journal* 1997;**24**.
- 5 Blumenthal D. Quality of health care. part 1: Quality of care—what is it? *N Engl J Med* 1996;**335**:891-3.
- 6 Kazandjian VA, Thomson RG, Law WR, et al. Do performance indicators make a difference? *The Joint Commission Journal on Quality Improvement* 1996;**22**:482-91.
- 7 Thomson RG, McElroy H, Kazandjian VA. Maryland Hospital Quality Indicator Project in the United Kingdom: an approach for promoting continuous quality improvement. *Quality in Health Care* 1997;**6**:49-55.