Keeping Quality On The Policy Agenda

How many more people have to die before we accept that quality is everyone’s problem?

by Elizabeth A. McGlynn and Robert H. Brook

ABSTRACT: Quality of care in the United States and elsewhere consistently fails to meet established standards. These failures subject patients to premature death and needless suffering. Yet, unlike the experience with other threats to life (tire failures or airplane rudders), public and private policymakers have been unable to maintain sufficient interest in identifying and solving problems with quality to change the way in which care is delivered. We discuss why it is hard to keep quality on the policy agenda and suggest short-term steps that are necessary if quality is to improve here and in the rest of the world.

The United States ranks thirty-seventh in the world in overall health system performance and seventy-second on population health, according to a recent World Health Organization (WHO) report. These rankings are at odds with many Americans’ belief that the United States has the best quality of care in the world. Objective information on U.S. health system failures is generally met with a day or two of media flurry and no sustained policy response. By contrast, Congress took immediate steps to identify and correct problems that had led to defective Firestone tires, and the Federal Aviation Administration (FAA) ordered a redesign of faulty rudders on Boeing 737s following a series of reported failures in the 1990s. Policymakers are capable of taking action to protect human life in many other areas, but efforts directed at the health care system remain uncommon. Without sustained public attention to solving the quality deficit problem in health care, little progress will be made.

The Quality Of Health Care Is Substandard

How good is quality of care in the United States? We don’t really know, but a review of the best scientific literature reveals the fol-
ollowing sobering facts. Only half of the population receives needed preventive care; 70 percent receive recommended care for acute problems, such as colds or stomach pain; and just 60 percent of those with a chronic illness such as diabetes or hypertension get the care they need. On the other hand, about one-third of the care delivered for acute problems is not needed (for example, antibiotics prescribed for the common cold) and may actually be harmful. About one-fifth of the care given to persons with chronic conditions is also unnecessary and possibly harmful. Given the public outcry over a few deaths from bad tires, the lack of public outrage over thousands of preventable deaths in medicine is astounding.

Serious deficits are also manifest in how skillfully care is delivered. Coronary angiography is an invasive test used to diagnose cardiac disease and determine what treatment is appropriate for a patient. Analysis of a random sample of angiographies performed in one state showed that only half of the tests were done competently enough to be accurately interpreted. When the tests were reread by a group of expert cardiologists, one-quarter of patients determined by the original reading to have the most severe disease did not have it. Six percent of persons who were told that their test results were not severely abnormal actually had severely abnormal results. One-third of persons whose bypass surgery was considered necessary or appropriate based on the original interpretation of the angiography results underwent surgery that was of uncertain benefit or inappropriate based on the gold-standard review. Nearly 1.3 million coronary angiographies were performed in 1998 nationally. If the results of this study held nationally, nearly 650,000 tests would be difficult to interpret accurately; at $12,450 per test, that is more than $8 billion in wasted expense.

Countless other examples show that medicine as practiced in the United States today is dangerous. The Institute of Medicine recently estimated that as many as 98,000 people may die in any given year from medical errors. Although stories on errors in medicine continue to appear in the media, serious action to improve the situation has yet to emerge.

Deficits in quality of care are not unique to the United States. A summary of the international literature showed that only about half of what is recommended in medicine gets done. Studies of the appropriateness of various diagnostic and therapeutic surgical procedures in the United Kingdom, Canada, Israel, and Sweden show similar results to those in the United States.

Such statistics point to health care systems that pose real and potential threats to human life far greater than those from defective tires or airplane rudders. Deficits in quality have been noted consis-
tently throughout the past three or four decades, despite changes in how services are paid for (for example, prospective payment under Medicare) or delivered (managed care). Quality deficits are also found in countries with very different organizational and financial structures. Fixing quality requires a fundamentally different policy approach than either increasing or reducing expenditures.

**Why Is It So Difficult To Sustain Public Interest?**

The message that there is a problem with the quality of health care around the world is not a new one. Given that poor quality affects whether and how well people live, why is it so difficult to sustain public interest in this problem? We provide several reasons that underscore how the health care system differs from other economic sectors. Strategies to address these barriers should be useful for improving quality in the United States and internationally.

- **Diffuse responsibility.** When a problem with the processes or outcomes of care is identified, no single or large manufacturer is to blame—no Firestone or Boeing. Research has shown that persons undergoing coronary artery bypass graft surgery have a variable likelihood of survival after the procedure. However, to motivate improved surgical care, problems must be identified and solutions developed in each of thousands of hospitals. There is rarely a credible threat that poor-quality providers will be driven out of business or even suffer a significant loss of revenue.

  The Health Care Financing Administration (HCFA) tried in the mid-1980s to create an environment of accountability by developing standardized reports on whether the death rate in each hospital was what one might expect given how sick the patients were at admission. These mortality reports were discontinued in 1993 primarily for political reasons, but they inspired the development of some local organizations (for example, the Northern New England Cardiovascular Disease Study Group) dedicated to improving care. Although some of these efforts have been successful, few such examples exist nationally. Even the Peer Review Organization (PRO) program, which has been overseeing quality in the Medicare program since 1986, has not solved the problem of substandard care.9

- **Cognitive dissonance.** Most people assume that their own doctor is excellent and that any problems identified by researchers, accreditors, the media, or malpractice lawyers affect someone else. Most doctors believe that they deliver care consistent with guidelines and standards. But if the public and the medical profession do not acknowledge that suboptimal care is delivered throughout the medical care system and that significant reengineering is essential, then thousands more lives will be needlessly lost.
Reports on medical errors have come closest in recent times to breaking through this cognitive dissonance. We need to find ways to use the dialogue that has begun around errors to promote a shared understanding of the quality problem without fundamentally undermining trust in the medical care system.

■ **Outmoded system design.** The U.S. health care system is a technological anomaly. We have made amazing advances in the availability of diagnostic machines, chemicals to treat or cure illnesses, and microsurgical techniques to repair the ravages of disease or injury. Yet most physicians and hospitals rely on barely legible, handwritten notes to track what is done to a patient and how the patient responds.

Doctors also are expected to maintain in their individual memories the appropriate approaches to diagnosing and treating a wide variety of diseases as they are manifest in human beings of radically different designs (age, race, height, weight, other health problems). By contrast, airline pilots are only allowed to fly one type of airplane and rely on extensive checklists and computer monitoring to ensure its safe operation. Nonetheless, we are surprised when physicians, using systems from the nineteenth century, and subject to the limitations of being human, fall well short of perfection.

The medical establishment has actively dismissed attempts to introduce systems principles into medical care. Physicians dismiss “cookbook” medical practice as if consistent delivery of known practices is necessarily a bad thing. In many other areas of consumable goods and services, consumers expect to get the same thing (such as a Big Mac or local currency from an automated teller machine anywhere in the world), at the same level of quality, no matter where they are. In medicine, the focus on individually tailored services means that if one has a heart attack, survival is dependent on whether the hospital used—usually the closest one—consistently uses appropriate and timely diagnostic and therapeutic procedures.

Much of the research on quality looks retrospectively at whether care already delivered is consistent with standards. Although these methods are useful for documenting the nature of the problem, they do not offer a solution. We cannot recall defective medical care the way we can recall a defective car. Systems must be in place to guide doctors’ actions while the patient is being seen or to bring patients in for routine monitoring.

■ **Information void.** We lack basic, objective information on how well the health system is functioning and what would make it function better. There is no national tracking system for identifying defects and correcting them before someone dies. There are few early warning systems to identify problems before they become
“We need a ‘war on poor quality’ that has the same level of public commitment as the war on cancer.”

widespread. There are no systems in place for ensuring that best practices are consistently implemented. There is almost no systematic information on what reengineering strategies are likely to work on a large scale. Many small projects (including many of the PRO projects) done in one state, one health system, or one hospital have demonstrated that improvement is possible. These individual projects (many of which are never published) have not led to any generalized knowledge of what changes are necessary to improve quality. Randomized trials in this area are rare but can add much to our understanding of generalizable quality improvement techniques.10

■ The tendency to shoot the messenger. Finally, a common response to objective quality-performance results is to insist that the data are inaccurate and do not reflect what is really happening in any particular hospital or doctor’s office. This attitude is part of what led to the demise of the HCFA mortality reports. Doctors and system administrators are not only reluctant to use information, they are often reluctant to participate in efforts to obtain good information about performance. This shoot-the-messenger attitude means that more energy is devoted to undermining the findings than to formulating and implementing solutions.

Is Change Hopeless, Or Can We Make Progress?

The authors of this essay, perhaps eternal optimists, remain hopeful that change is possible. Because the problem is complex and the solutions require innovative strategies, we must generate sustained public interest to improve quality. Patience and perseverance will be essential, as will cooperation between the private and public sectors. We would like to give an outline of the exact interventions that would work best, but this knowledge does not exist. Leadership is the necessary first step.

■ Create quality champions. Fundamentally, we need a “war on poor quality” that has the same level of public commitment as the war on cancer or the campaign to put a man on the moon. We believe that the subsequent funding of needed research in response to this declaration of war will lead to the development of specific strategies that should be followed. Both the private and public sectors will have to demand a complete overhaul of medical practice, and implementing such change will necessitate leadership from clinicians and a vigilant constituency.
Advocacy organizations have been successful in raising funds for research related to curing specific diseases such as human immunodeficiency virus (HIV) or breast cancer. If such groups added to their mission pressure on health systems and public and private purchasers to pay only for high-quality care that is consistent with best practices, great progress could be made. These advocacy organizations could be champions who would put quality first and insist on design changes that ensure that the health care system gets the fundamentals right.

Medicare could similarly become a quality champion by setting higher standards for public reporting on quality. HCFA does require that managed care plans report data on measures in the Health Plan Employer Data and Information Set (HEDIS). The National Committee for Quality Assurance (NCQA) has demonstrated that managed care plans publicly reporting HEDIS data for three consecutive years have higher quality than plans that do not make data available. But we can no longer tolerate the lack of information on performance in the non–managed care sector.

**Develop a functional information system.** Second, health care professionals and organizations need to embrace computer technologies that can be used to receive and transmit information. The private sector should lead the way by making investment in such systems an allowable expense in calculating health insurance premiums. The government should undertake an evaluation of tax incentives that might further spur the adoption of computer technologies in office-based medical practice. No serious advances in quality of care can be made without a functioning, computer-based information system. Computerized order-entry systems used in hospitals have been shown to reduce adverse events associated with errors in the prescribing and administering of medications.

Right now, nobody is penalized financially for failing to adopt computerized clinical management systems. Regulators and purchasers should use every available tool to provide such a disincentive. Adequate clinical management hardware and software could become a condition of licensure, contracting, malpractice insurance policies, and reimbursement. Although these demands could not be made overnight, compliance within five years would be more than reasonable in the current environment.

**Routinely monitor and report on performance.** Third, an independent group should routinely compile information into a national report on whether average levels of and variation in quality are increasing or decreasing. There have been scattered attempts to do this, including an effort mandated by Congress, but the amount of funding allocated to these efforts has been grossly inadequate.
The New York State Cardiac Reporting System offers an example of the benefits to be had from public reporting. Risk-adjusted mortality rates following bypass surgery have declined significantly in the state since the reporting system was introduced.13

To motivate change, public reports on communities, hospitals, health systems, and providers must also be available. Communities could compete to provide the best care to their citizens: If you have a heart attack in Paris, London, or Los Angeles, in which city are you most likely to survive? Families regularly make relocation decisions based on the quality of schools in an area; they might choose to factor quality of medical care into the equation as well.

- **Ensure adequate funding for quality measurement.** To make all of this work, sustained investments must be made in the tools that are used to set standards, promulgate current and scientifically valid measures for monitoring, provide consistent information to physicians on best practices, make information easily accessible to decisionmakers, and so on. This is not a trivial enterprise.

  Developing guidelines for care is difficult and expensive, and it requires the highest level of scientific integrity. If guidelines are promulgated by individuals without much support, they will be done carelessly and will be (properly) ignored. If guidelines are issued by those who stand to benefit financially, they will be suspect and fail to attract necessary consensus. The Agency for Healthcare Research and Quality (AHRQ) should have as its primary mission improving quality of care through facilitating use of information systems, developing guidelines and other standards of practice, updating and improving quality measurement tools, producing data for national reports on quality, and developing a strategic plan for quality improvement. This ambitious and essential undertaking will require a few billion dollars of new money each year. This amount pales in comparison with total spending on health care (more than $1 trillion), the size of the proposed tax cut ($1.6 trillion), and the budget of the National Institutes of Health ($19 billion in 2001).14 AHRQ will have to be insulated from political forces that have previously limited its ability to provide strong leadership.

“If guidelines are issued by those who stand to benefit financially, they will be suspect.”
WHERE MIGHT THESE STEPS TAKE US by the year 2010? They could mean that people, especially when they required urgent care, would not have to worry about where they go for care. Patients and their families might not need to be warned, as they are today, that they should carefully monitor what medical services they do and do not receive because their inattention might result in serious problems. The science that the nation spent so much public and private money developing could produce its promised benefits. Waste could be eliminated so that all Americans, not just those who have health insurance, could get the care they need.

These achievements are within our grasp. We spend more money on health care than any country in the world; one of every seven dollars spent in this country goes to medical care. We have sophisticated physicians and social scientists. But we lack the will to reengineer our own health system.

Leadership for this reengineering will have to come from both government and the private sector. The government role is particularly critical, something that has been recognized in all other Western nations except the United States. Reengineering the health care system will be complicated by the fact that we cannot shut down the system and import our health care while we slowly redesign processes and plants. We must develop an incentive structure that promotes reengineering while enabling us to operate a system that is providing care to patients.

We must find a way to keep quality of care at the top of the health policy agenda. After providing insurance to all Americans, there is no issue of equal importance.

An earlier version of this paper was presented at the Ditchley Park Conference on Improving the Quality of Health Care in the United States and the United Kingdom, cosponsored by the Commonwealth Fund and the Nuffield Trust, Oxfordshire, England, 10 June 2000. The authors thank Paul Shekelle for discussions that shaped the arguments presented here and Mary Vaiana for editorial assistance.

NOTES
4. L.L. Leape et al., “Effect of Variability in the Interpretation of Coronary Angiograms on the Appropriateness of Use of Coronary Revascularization
13. Hannan et al., “Improving the Outcomes of Coronary Artery Bypass Surgery.”