

# QUALITY IN HEALTH CARE

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## Editorial

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### Quality improvement: an international commodity?

*The Germans live in Germany, the Romans live in Rome, the Turks live in Turkey, but the English, the English live at home.*  
(Nursery rhyme J H Goring 1909)

One of the editorial aims of this *Journal* is to include papers that reflect the ideas of people working in different countries and in various health care systems<sup>1</sup> and to develop an international readership. So far, most authors are from the United Kingdom and only 10% of published papers are by people working elsewhere. Although the international subscriptions are rising, readers unfamiliar with British health care may be daunted by papers assuming knowledge of British arrangements for clinical audit and details of the British National Health Service (NHS). Considering the international aims of a journal about the quality of health care, therefore, raises some fundamental questions. Is the quality of care – and thus quality improvement – largely culturally specific or specific to a particular health care system? Or does interest in quality of health care cross such boundaries? And can we learn from work done in other countries?

Different cultures base interpretation, diagnosis, and treatment of health problems on different values. Payer, writing on cultural differences in medicine,<sup>2</sup> notes that in Germany a romantic tendency may be the basis of attention to “the heart” (German doctors prescribe six times more heart drugs per capita than French and English doctors). French medicine, however, seems driven by theory and an intuitive approach. Doctors rely more on physical examination, particularly of the abdomen and the digestive system, on rest, good food, and long sickness absence than on tests or operations. Philosophically, British medicine favours facts, preferably acquired through randomised controlled trials. A striking feature of British practice is its economy: consultations are shorter, fewer medicines are prescribed, and fewer operations are performed than in many other countries. American medicine, compared with European medicine, seems aggressive. A guideline on the treatment of acute otitis media – developed for Dutch general practitioners – that discourages use of antibiotics would encounter disbelief in the United States and some other countries. Perhaps this guideline reflects a basic Dutch (Calvinistic?) reserve. Payer concludes: “while medicine benefits from a certain amount of scientific input, culture intervenes at every step of the way.”

Does this type of analysis have any relevance to systems of health care and the organisation of quality improvement programmes? Hofstede investigated cultural values in industrial organisations in almost 50 countries and he came to the view that organisational developments do reflect such values.<sup>3</sup> So, in France, for

instance, where there is a tendency to a centralised approach to organising society it might follow that specialist care should be dominant, general practice less so, and implementation of quality assurance and guidelines for care primarily “top down”. In Germany, where an extensive administrative system supports health care, there are many regulations and guidelines for quality assurance that perhaps reflect an emphasis on precise measures for management of specific situations. In the Netherlands, where consensus is used in many situations, the organisation of quality improvement is largely left to discussion and negotiation between parties (professionals, patient organisations, payers). The United Kingdom system of clinical audit, characterised particularly by collection and feedback of data, fits the national emphasis on facts and results. Perhaps the resistance of some practitioners to clinical audit and centrally developed guidelines reflects a national tendency to individualism.

Whether or not quality improvement mechanisms are moulded by cultural values, important distinctions do exist. Differences in cultural values are also reflected in the way health care is structured in the different countries. For example, in general practice differences in reimbursement systems, list sizes, practice sizes, tasks performed by general practitioners (GPs), and the gate keeper role have been noted throughout Europe.<sup>4</sup> In France and Germany more than 80% of GPs are single handed but in England and Sweden the figure is only 20%. Such differences will influence the system and methods for quality improvement. For instance, in group practices in the United Kingdom multidisciplinary audit and team building can be used as tools for quality improvement. But where many general practitioners work single handed – the Netherlands, Ireland, Germany, Switzerland, and France – and tend to be isolated, small peer audit groups or quality circles are a more appropriate approach.

Despite such differences in values and structures in health care, it is clear that not only the principles but also practical approaches to quality improvement are broadly applicable across boundaries. Developments in quality improvement in general practice have been transferred throughout Europe. For example small group peer review has been adapted within different systems in several countries. In Ireland small group quality improvement is structured within continuing medical education systems that already support isolated doctors working in rural areas. Groups that meet as quality circles in Germany also discuss good care and develop guidelines. In the Netherlands a policy of grouping GPs to reflect future contracting patterns with insurers has provided a convenient structure for professional development and

quality improvement. Small group peer review works well within different health care systems and its use has been helped by exchanging and adapting methodology.<sup>5</sup>

Interviews with a random sample of Dutch GPs about setting up quality improvement in their practices showed a need for education about quality improvement methods; support for data collection; the opportunity to meet with colleagues to discuss quality improvement; financial support; and time.<sup>6</sup> Not surprisingly these also reflect the factors crucial to the GP audit programme in the United Kingdom – mechanisms for introducing GPs to quality improvement techniques; support structures and committees of GPs to steer implementation; facilitators to help practices and financial support. Although GP audit structure in the United Kingdom reflects national policies, clearly there are lessons about methods and structures for setting up practice audits that are applicable to the rest of Europe. In exchange there is much that United Kingdom health professionals can learn about aspects of quality improvement less well developed in the United Kingdom than in other countries. For example the debate on setting guidelines for general practice that is taking place now in the United Kingdom<sup>7 8</sup> took place in the Netherlands in 1986. A model for national guideline development was formed and there are now over 50 scientifically based and broadly accepted clinical guidelines.<sup>9 10</sup>

To increase the exchange of learning about quality improvement we must look beyond parochial boundaries and be prepared to explain our own work so that it is accessible to colleagues from other countries. Two recent papers in this *Journal* provide some useful lessons for others from the British experience of audit in general practice.<sup>11 12</sup> The quality improvement structures set up as the result of central directives have been adapted to suit local needs and preferences. The audit initiative with its apparent restrictions and focus on data collection may have provided British health care professionals with the rudiments of a common language and a mechanism for quality improvement. Audit “United Kingdom style” may go beyond data collection and be much more flexible than has seemed from outside or as described by a Dutch general practice trainee working in the United Kingdom “endlessly going through the records even when the solution to the problem is obvious.”

There is a wealth of experience about quality improvement initiatives throughout Europe. Studies likely to be applicable beyond national boundaries

include the indicators for assessment of quality developed in Catalunya, Spain; the Danish experience on collaboration in quality improvement between hospitals and general practice; and the 100 quality improvement projects set by the Norwegian Medical Association. But to learn from each other we must know something of each other's health care systems and culture of quality assurance. To help readers the *Journal* has now adopted a policy of asking authors to remove acronyms – for example, FSHAs, MAAGs – and to provide essential information about systems and policy, and developments and context of the improvement activities written in a broadly accessible way.<sup>7 11 12 13</sup> To function well as an international journal, *Quality in Health Care* must be an intermediary between readers and authors from different countries. We would like to encourage people from all over Europe to write about their experiences of quality improvement in such an international style. Please be aware of people from other countries who can learn from your experiences; considering readers from other countries may help authors to be aware of whether or not their work on quality improvement can be of general use and to appreciate where it stands in a broader context.

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