Drivers of quality
Patients should receive the care they need, which is known to be effective, and in a way that does not harm them. Patients should not receive care that is not necessary, leading to waste and increased risks of side effects. These 3 aspects (effectiveness, appropriateness, and safety of care) represent a basis to define and measure quality of care from the perspective of the healthcare system. In addition, from the perspective of the patient, or client, another aspect is fundamental: satisfaction with the care received and the way the healthcare system is organized, including choice of services, financing mechanism and cost.

Both in Western Europe and in the countries in transition, including those formerly belonging to the Soviet Union, there is a trend to improve the quality of care at primary care level. This is because the need for more cost effective health systems in general has resulted in a greater emphasis on primary care level.

Strong primary care means: easy access to first contact services, a comprehensive supply of effective and safe curative and preventive services, continuity of care and coordination with other levels of care and interdisciplinary cooperation. The question is whether primary care systems currently meet these high expectations.

Answering this question requires that these expectations are ‘translated’ into explicit and measurable criteria that can be used to thoroughly review primary care services. Such reviews are able to identify spots of poor quality which should, subsequently, be remedied by improvement actions.

In most countries, the assessment of the quality of primary care is much less advanced than the quality assessment of hospital services. Available studies point to large variations in quality in primary care and insufficient keeping to standards of good care (Seddon et al., 2001; Kirk et al., 2003). Compared to hospitals, so far there have been less requirements on primary care to demonstrate quality. Primary care is often provided in a fragmented way, and in much smaller units of provision than the enterprises of hospitals. Apart from that, hospitals usually have special quality assurance staff and much better information systems which are essential to generate performance data needed for quality reviews and initiate improvement actions.
Quality as a function in health care systems

Assessing and improving the quality of care is a major function in any health care system. Stewardship, one of the health system functions as formulated in the WHO health systems framework (see Murray and Frenk, 2000), includes performance assessment and consumer protection. However, the way in which this function is implemented and whose responsibility it is may differ according to the type of health care system. First of all, the position of primary care may strongly differ. For instance, in some countries general practice has a dominant position in the provision of primary care services, while in other countries also several medical specialties provide such services. The way primary care is organised determines both the quality indicators to be used and the strategy for gathering the information.

The different roles of actors in health care is another relevant health system feature in this context. National Health Systems are usually characterised by a strong role for central and/or regional authorities in the financing and provision of services. In contrast, in Social Health Insurance systems power in health care is usually shared among authorities, health insurers and organisations of providers (especially physicians). In all cases there may be a varying role for organisations of patients and consumers.

In a shared power situation assessment and improvement of quality of care may be more divided among stakeholder organisations; each stressing their own perspective of quality. Besides, there are differences between countries in the way the health care system is organised and managed. In strongly centralised systems with a command and control style of management in health care, quality assessment and improvement will be primarily top-down, and in such situations providers may be more difficult to motivate for improvement of their performance than in decentralised systems. Lessons can be learned from foreign experiences in quality improvement, but not without adaptations to take national circumstances in health care into account (Marshall et al., 2003).

Dimensions of quality and focus of evaluations

Two types of dimensions of quality can be distinguished: generic dimensions and dimensions which are specific for primary care. Generic dimensions (Campbell et al. 2000), which are applicable to all health care services, are:
- accessibility of services
- clinical effectiveness (related to the professional state of the art)
- interpersonal effectiveness (related to communication and meeting patients' needs)

Specific dimensions are the typical attributes of a primary care system:
- comprehensiveness (broad range of curative and preventive services)
- continuity of care (longitudinal care; interpersonal continuity)
- coordination (with other professionals and levels of care)
Quality improvement activities in primary care may cover both generic and specific dimensions. The focus of quality improvement in primary care can be either on care for individuals (for instance adherence to clinical guidelines) or for populations (for instance, on social or geographical inequalities in utilisation).

Quality can be focussed either on structure of care, the process of care or the outcomes of it; this is the well-known framework developed by Donabedian. ‘Structure’ refers to physical characteristics (such as premises, equipment, human resources, the organisation and management of resources, teamwork). ‘Process’ refers to the actual delivery of primary care (in particular the clinical and interpersonal aspects). ‘Outcomes’ are the results or consequences of the process of care (health status or evaluations by patients).

Concrete quality assessment and improvement mechanisms and activities can be classified on the basis of this framework.

**Examples of quality assessment mechanisms.**
Related to ‘structure’ are: safety regulations; activities of a state inspectorate; a system of disciplinary rules for professionals; (re)certification and accreditation schemes; regulations for the establishment of independent practitioners; human resource training policies in health care organisations; the use of a quality handbook (specifying procedures, safety, privacy etc. in health care organisations); promotion of electronic medical record systems; use of official job descriptions of health professionals; promotion of teamwork among health professionals

Process-related activities are: supporting evidence based medicine; structured peer review among health professionals; professional guidelines; benchmarking; practice audits; projects aiming at more rational referring and prescribing; promotion of patient information materials; practice visitation; patient complaint procedures; facility-based quality improvement projects.

Examples of outcome-related initiatives are patients evaluation surveys, structured client consultations and complaint procedures.

**Should outcome measures be preferred?**
Although measures of outcome seem to be more attractive to assess the quality of care, information on structure and process have their value as well. Where the process of care is difficult to measure outcomes may help, if other determinants are controlled for. However, usually a health care intervention is only one of the determinants of the outcome and, apart from that, outcomes are not useful to assess the quality at practice level. The use of structure and process indicators has the advantage that they are more amenable to change in the short run and more sensitive to differences between units or providers (Mant, 2001).
Classifying QI mechanisms

Producing an instrument to assess the state of quality control and quality improvement in primary care is complex for a number of reasons. Both central and de-centralised policies are involved; a potentially wide range of mechanisms and activities, as shown by the above-mentioned examples, at different levels and of different scale need to be taken into account. Furthermore, the type of the indicators to assess quality of care may differ considerably (for instance to the extent they are based on evidence) and different actors/stakeholder with different views on quality improvement may be involved. The instrument should allow to draw a conclusion on the stage of quality assessment and improvement in primary care in a country (compare: Wagner et al., 1999).

A major activity is to construct a typology to order the information to be collected in member states. This structuring will safeguard the uniformity of repeated assessments, which is a condition to determine progress. The following elements or criteria are relevant for such a typology of mechanisms and activities:

1. **Quality dimension**: the following can be addressed by quality related activities: accessibility; clinical effectiveness; interpersonal effectiveness; efficiency; patient-centeredness; continuity and coordination; equity; safety.
2. **Focus**: is the quality assessment or improvement related to structure, process or outcome of primary care
3. **Subject**: what type of primary care activity or service is the assessment or improvement action about (for instance, diabetes care by GPs; patient information in pharmacies)
4. **Scale**: national/population level; regional level; level of a primary care facility/organisation or practice level
5. **Actor / stakeholder**: which actors or stakeholders are involved and what is their role (central or regional decision makers; managers; provider organisations; providers; patient organisations)
6. **Perspective**: involvement of either providers or patients in the assessment and improvement of quality
7. **Evidence base**: if indicators for quality are used, what is their validity and to which extent they are based on scientific evidence (see: McColl et al., 1998; Hutchinson et al., 2003)
8. **Type of data used**: routine (administrative) data or collected for the purpose; reliability of data.

From assessment to improvement

If quality assessment has identified lack of quality, then improvement activities are the logic next step. A quality improvement effort aims to make changes in the healthcare system that
address the causes of poor quality. With strategies for improvement of health services 3 phases can be identified:

1. The identification of issues and the solutions which are most promising for its solution; this identification can best be made through small-scale pilot improvement projects;

2. The replication of changes and interventions which have proven to be effective on a larger scale in the health care system;

3. The institutionalisation of the improvement throughout the healthcare system.

Effective institutionalised quality improvement mechanisms require activation of various functions, such as (USAID, 2006):

Stewardship or leadership for quality at every level and within each stakeholder needs to be present. Leadership will be more effective when it comes with charisma and technical credibility.

Facilitation and advisory: a “structure” should be in charge of facilitating and advising a Ministry of Health or other health authorities on progress regarding the implementation of a quality improvement strategy.

Advocacy function: various parties involved need to be sensitized and convinced of the importance, features and impact of the quality improvement strategy. This is a shared responsibility between the Ministry and the coordinating or advisory structure. The advocacy function also consists in identifying incentives and disincentives for quality activities and the promotion of motivation.

Implementation Function: this implies that roles and responsibilities of all stakeholders must be clearly identified to carry out the following activities:

- Promotion of Evidence Based Medicine, including the development and revision guidelines and protocols and their dissemination/implementation;
- Quality monitoring systems at facility and regional levels, and measurement of national indicators of quality/performance;
- Specific facility-based quality improvement projects;
- Development of patients’ charter (rights and obligations and complaint mechanisms)
- Health technology assessment;
- Licensing and certification of health professionals;
- Accreditation of health facilities;
- Safety programs and projects.

Teaching function: this relates to training mechanisms, whether undergraduates, postgraduate or through continuous medical education; opportunities to build the knowledge and skills needed to carry out the various quality activities listed above.
Monitoring & Evaluation: should be planned with a focus on the implementation processes and results of the quality improvement strategy. The plan should describe successes and failures, analyze their causes, promote reflection among stakeholders and make recommendations.

Research: research departments and universities have an important role to play to assess the effectiveness of the quality improvement policy.

Communication: for an effective communication both the content and the channels of communication must be identified between all stakeholders of the strategy.

When all of these functions are carried out in an integrated way and on a continuous basis, one can consider that quality improvement is institutionalized into the health system.