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Care, Quality of

Magali Robelet

magali.robelet@univ-lyon2.fr

University of Lyon 2, France

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Abstract

Since the 1990s, new definitions, new institutions, and new quality evaluation tools have appeared in most Western nations. Two emblematic tools in this new focus on quality are medical recommendations and initiatives for management within health care organizations. This article aims not to justify and compare the effectiveness of these tools in the actual improvement of quality of care but rather to discuss the appearance of these tools and their effects on the content of medical work and on power relations between doctors, government, and the public. The attention focused on quality of care has caused a resurgence in debates over the autonomy and power of health care professionals, physicians in particular. Quality of care has become an indicator of changes in the regulation of medical professionals, passing from self-regulation to a more hybrid form, leaving more power to government, to health care insurers, and to the public. The evaluation and improvement of quality of care does increase the role of government and payers, but it does not necessarily lead – at least not at the present time – to the reinforcement of constraints and controls on the content of medical work.

Keywords: autonomy; governance; health professions

How can health professionals provide care that is the best possible in terms of quality and safety? Physicians, health authorities, and patients have traditionally relied either on public criteria like medical diplomas, sanctioned by professional organizations and by government, or on more personal standards derived from a particular relationship between doctor and patient. However, over the last thirty years, these criteria no longer appear sufficient to guarantee quality of care. New definitions, new institutions, and new quality evaluation tools have appeared in most Western nations. Two emblematic tools in this new focus on quality are medical recommendations and initiatives for management within health care organisations. According to the principles of evidence-based medicine (EBM), recommendations formulate best practices in clinical applications. The introduction of industrial quality-control management in healthcare organisations involves formalizing care processes through procedures and the traceability of tasks carried out.

This entry aims not to justify and compare the effectiveness of these tools in the actual improvement of quality of care but rather to discuss the appearance of these tools and their effects on the content of medical work and on power relations between doctors, government, and the public. The appearance and diffusion of these tools are explained first of all by political factors and by the socially and economically unacceptable character of unsafe health care. Thus, during the 1990s, the discovery of numerous avoidable deaths in a pediatric surgery service in Bristol, UK, or of the excess mortality from AIDS caused by contaminated blood in France largely contributed, in addition to other events of this type, to legitimizing governmental intervention in the definition and

evaluation of quality of care (Waring et al., 2016). The diffusion of the report from the US Institute of Medicine about high medical error rates also led to the emergence of a worldwide understanding of the causes of failures in healthcare systems and to tools that could prevent and solve these problems (Kohn, Corrigan, and Donaldson 1999).

These adverse events demonstrated the ineffectiveness of controls emanating from professional organisations and placed the struggle for patient safety and improved quality in the public domain (Allsop and Jones 2006). This politicalisation of healthcare quality intended to open up the definition and control of quality to actors outside the medical profession and was sustained by technical issues: the development of clinical research and the analysis of health care organisations provided a better understanding of the causes and effects of poor quality care as well as the development of methods (such as random clinical trials, meta-analyses of the literature, and organisational or clinical audits) permitting the definition, implementation, and verification of quality of care (Setbon 2000). From there, quality of care is understood as a public issue and is defined, organised, and measured as a product of collective action (Kimberly and Minvielle 2000). The attention focused on quality of care has caused a resurgence in debates over the autonomy and power of healthcare professionals, physicians in particular. Quality of care has become an bellwether of changes in the regulation of medical professionals, passing from self-regulation to a more hybrid form, leaving more power to government, to healthcare insurance funds and to the public (Scott and Ruef 2000; Dent 2003). The initial debate bears on the clinical autonomy of physicians. For certain observers, we are facing a process of “deprofessionalization” of medicine because medical decisions would

no longer be made on the basis of individual clinical judgment but would be delegated to objective and quantitative techniques and even driven by governments' efficiency concerns (Hafferty and McKinley 1993).

However, the new tools of evaluation and quality improvement are part of a long process of rationalisation in medicine. Their opponents claim the superiority of clinical judgment over any attempt to render medical decisions predictable and infallible. Thus, random clinical trials are not able to predict the diversity of all possible cases and they present the risk of transferring to the medical treatment of the general population findings obtained under strict experimental conditions. The opposition has weakened over time because it has become clear that quality of care tools have not eroded professional discretion (Timmermans and Berg 2003). In most Western countries, evaluation and quality improvement have been entrusted not only to professional self-regulatory institutions (medical schools or authorities like the English General Medical Council or the French "Order of Physicians") but also to new institutions created by government such as the National Institute for Clinical Excellence in the United Kingdom, the Agency for Healthcare Quality and Research in the United States, or the French National Authority for Health in France. These institutions are independent agencies in which representatives of clinical medicine hold major roles, alongside experts in EBM, quality of care managers, and lay members. These agencies, wishing to obtain clinical consensus in the elaboration of quality of care tools, mobilise work processes that lead to a non-prescriptive formulation of standards and regulations, always leaving a margin for clinical discretion. Locally, at workplace level, reference to best practices can be the opportunity to constitute community-based medical practice that might facilitate everyday cooperation

(Cambrosio et al., 2009). The principal engine of the use of quality of care tools seems not found in the constraints or sanctions exercised by outside actors, but in the locally-based motivation of health professionals to work in interaction together (Castel and Robelet 2009).

This last consideration leads to a second debate which concerns the political autonomy of physicians considering the growing intervention of actors outside the health professions in the regulation of medical practices and health organisations. Indeed, quality of care is subject to pervasive measurement to support quality management processes, patient choice and Payment for Performance, under the pressure of patient demands for transparency and of costcontainment policies.

For at least twenty years, new healthcare policy tools are spreading across western countries, fueled by sets of quality indicators. Such quality indicator-sets differ in the mix of structure, process (favoured in France) or outcome-based (favoured in the UK) approaches to measuring quality and in the dimensions of quality targeted (medical efficiency, patient centeredness, treatment delays and access, efficiency, medical reporting) and finally in the part of the hospital to which each indicators pertains. Each quality indicator-set is shaped by country specific demands and constraints of national healthcare systems of governance traditions as well as the interest and veto power of key actors (medical associations, government, insurance funds), public preferences and the structure of the wider political system (Beaussier et al. 2020).

Among those public policy tools, Pay-for-performance (P4P) has enjoyed international success despite unproven effectiveness (Jha 2013 ; Markovitz 2017). Theoretically, P4P

nudges providers towards value-based care because it ties reimbursement to metric-driven outcomes, proven best practices and patient satisfaction, thus aligning payment with value and quality. P4P relies on a number of assumptions relating to the behavior of health professionals faced with an economic incentive.

First, professionals are assumed to be interested in financial gains, for themselves or for their establishment. Second, they would be sensitive to reputation effects, so that by comparing themselves to the best, they would engage in changes in practice to get closer to excellence. P4P is then supposed to be a good incentive to improve the quality of care, through an “arm’s length” control on health professionals, between professional self-regulation, direct governmental regulation and sanctions, and market regulation. Health professionals must be accountable before public authorities and patients, but it is more a question of means (respect of recommendations, submission to organizational or clinical audits) rather than ends (measures of mortality or morbidity) (Kuhlmann and Saks 2008).

In addition to an effectiveness that is difficult to prove, payment by performance is the subject of several criticisms. First, it can produce carryover effects : health professionals focus on the dimensions of quality included in the incentive at the expense of others, which are equally important for the overall quality of care (Ryan et al. 2016). In addition, the main effect of P4P lies in the modification of information systems, such as patient records, so as to facilitate quality assessment, a process typical of the auditing society, put forward by Michael Power (Power 1999). Moreover, like other attempts to introduce incentives regarding outcomes (for example, the diffusion of public reporting of hospital quality in the UK), P4P have ended up in “game playing” or deceptive behavior (Hood and Bevan 2006).

Last but not least, the quality of hospital care is less the result of the application of procedures and the measurement of indicators than the product of the collective work of healthcare professionals to work well together with patients (Baker et al. 2006). This work involves informal adjustments and time for discussion of recommendations for good practice and work organisation. The role of work teams in producing quality care seems to be neglected in the instruments developed at government or managerial level. The impossibility of precisely prescribing this local production of quality and these arrangements between professionals may explain the disappointing results of P4P.

The multiple pressures that healthcare professionals face in many western countries, in hospitals and primary care - pressure from patients, managers and the imperative of efficiency - are not conducive to the health of working teams, which is essential to the quality of care.

SEE ALSO: Political Economy of; Health Professions, Physicians and professionalism;
Health Professions and the State; Medical Knowledge

SUGGESTED READINGS

Beaussier, A.L, Demeritt, D., Griffiths, A., Rothstein, H. 2020. "Steering by their own lights : why regulators across Europe use different indicators to measure Health Quality." *Health Policy*, 124: 501-510.

Waring, J., Allen, D., Braithwaite, J., Sandall, J. 2016. "Healthcare quality and safety: a review of policy, practice and research." *Sociology of Health & Illness*, 38(2): 198-215.

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