# MEASURING QUALITY IN HEALTH CARE – EQUIP POSITION PAPER 2010 (draft 14.9.10)

EQuiP position paper on measuring quality in health care is a statement for all partners in health care on how patient data should be gathered and used for quality purposes. With this position paper EQuiP wants to emphasise the ethical dimensions of patient data handling in quality measurement. This should in all situations guarantee patients' privacy and confidentiality in doctor patient relationship.

This document, when referring

- to quality in health care, means the degree to which health care systems, services and supplies for individuals and populations increase the likelihood for positive health outcomes and are consistent with current professional knowledge (IOM definition)
- to quality measurement of health care, includes collecting, storing and comparing any data of health care performance and patient health

Measuring quality in primary care is a complex matter, because general practice care has a very large undertaking and many of the goals, values and problems managed by a general practitioner are hardly measurable. It is seldom possible to measure ethics and humanism in consultations or on setting the right priorities in everyday practice. The special dimensions of quality in general practice for both the patient and the society would be

- holistic and patient-centred consultation that enables patients to manage illness, living and health
- general practitioner has time enough to perceive patient's concerns and expectations
- inappropriate investigations and treatments are not made, still not neglecting those necessary

However, quality measurements are of paramount importance for improvement, but keeping in mind that the measurements of medical quality in general practice hitherto have essentially been measuring adherence to guidelines. One must be aware of that what is measured is also given importance, which may set unwanted priorities.

Quality measurements on health care performance have a political, administrative and professional perspective. It is important to realise that these different perspectives exist and also, that the aims of using data may differ between the stakeholders. Electronic patient records enable increased use of clinical data to measure the quality of care and also electronic data handling can give possibilities to combine the information attained from different sources.

Data collected in health care can be used for different purposes such as patient care, quality improvement, research, epidemiology, statistics and administration. Personal health data in patient records that is collected during medical consultations are also used for these different purposes. It is important, however, to notice that the main reason why the data are collected also determines its appropriateness for other use. Because data in medical records are primarily collected to be used in patient care, they may have limitations in research and quality measurement. However, the opposite also applies, i.e. if the physician mainly pays attention to data gathering and not to patient care, good record keeping for patient care may be jeopardised.

EQuiP emphasises that the following principles should be followed in all measurements of quality in health care:

1. GPs are urged to monitor systematically the quality of their own work and their team’s work as well as their working

environment. The measurements should cover the different generic aspects of quality as defined by EQuiP; patient centeredness, equity in care, work satisfaction of physicians and other personnel as well as processes and clinical outcomes.

2. Quality measurements in health care, both internal and external, should in all situations guarantee patients' privacy and confidentiality in doctor patient relationship.

3. Data collection should not be an aim in itself. Gathering patient information on defined aspects of care is only justified when it can improve patient care and it is cost-effective, not demanding time, staff or financial investment beyond the benefits of tentative quality improvement or increased patient safety.

4. External quality measurements should be limited to a reasonable number of indicators and concentrate on the aspects of care that contribute most to better and safer patient care.

5. Reporting systems in electronic patient records should be developed so that it is easy to extract data for local quality work and further send the data to authorities for external quality evaluation. This external reporting can be done in a way that de-identifies individuals.

6. All indicators that are used for bench marking or external evaluation should be scientifically tested and validated i.e. evidence based and the medical profession have to approve them before general use.

7. GPs should evaluate the best way to collect the data in order to attain the most accurate results with the appropriate amount of work. Examples can be sampling of data during a specified period, obtaining reports from the electronic patient records or from health care or administrative registers.

8. Personal health data should be gathered only when the parties agree on the paramount intention of improving quality. The whole process of gathering data, analysis and the subsequent use of the results for the improvement of processes should be determined from the outset.

9. A GP can collect data on his/her own patients for comparison and benchmarking within his/her own unit or between health care units by using data that do not identify individuals.

10. Quality measurements for administrative use should rely on measurements of resource quality, such as the use of services by different patient groups. If data includes patient identification, quality measurements for administrative purposes should follow the rules of scientific health data collection (the declaration of Helsinki) and a written consent by the patient must be obtained. Otherwise clinical data can be collected without the patient's consent and only in an aggregated form from each individual doctor's practice.

11. Payment for quality i.e. so called payment for performance is beneficial when it is based on the various aspects of quality. Both the profession and the providers have to realise that there are dangers when payments are made for some aspects of the health care while others are ignored. Financial incentives are proved to be a good way to change practice for the benefit of patients, not only cost cuts.