EDITORIAL

QUALITY ASSESSMENT STUDIES IN THE U.S.A.

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"Quality" has become a "buzz word" in Washington and elsewhere in the past few years, replacing "access" and "cost" as a topic of major concern, but obviously not as problems for the medical profession. Quality can have both subjective and objective characteristics. In the operating room or procedural unit, quality control relates to the procedures followed by the personnel, the equipment used, and other measures. Quality assurance has come to connote structure, process and outcome, and has become an important consideration by the Joint Commission on the Accreditation of Hospitals in the USA.

Quality assessment, on the other hand, is a relatively new concept, which has been enhanced because of the development of the prospective payment system in the USA, since 1984. Central to this system was the development of the diagnosis related group (DRG) concept which divided medical and surgical disease and procedures into approximately 470 categories. This has enabled the ability to collect large numbers of patient related events. The first illustration of this is a recently published government survey reporting data on 24 million Americans admitted to acute care hospitals during 1985. Thus the grouping of illnesses etc. become the hallmarks of quality assessment activities, with the emphasis being placed on data collection rather than on processes.

That many of these quality assessment attempts have been viewed with confusion by physicians (who already considered themselves devoted to quality) is understandable; however, it is important that physicians participate in quality assessment in a manner which is comprehensible to those outside the field of medicine (the "consumers", formerly called patients!) as well as third party payers.

The American College of Physicians, representing over 65,000 specialists in the specialty and sub-specialties of internal Medicine in the U.S. has several major quality assessment functions at the national level, through its Health and Public Policy Committee. These include:

1. The clinical efficacy assessment project, dating from 1976, which uses the technique of literature based technology assessment. This project had produced over 50 position papers including the recent "medical necessity guidelines" of common diagnostic tests used by internists and others.
2. The clinical privileges project, which assesses the clinical competence standards for internists performing certain procedures (e.g. sigmoidoscopy, upper gastrointestinal endoscopy, renal biopsy). This activity provides national guide lines which can be utilized by hospital credentialing committees.
3. The health care financing subcommittee, which addresses issues of short term and long term financing of health care and is currently addressing the financing of care of patients with AIDS.
4. The health care professions, subcommittee which deals with health manpower needs, credentialing of physicians for services, and number of physicians needed to perform essential services. A current project is an evaluation of the number of medical students currently enrolled in medical schools in the US and correlating these with future health care needs of the population.
5. The clinical practice subcommittee related to quality issues directly affecting the practice of medicine by the physician, and has also addressed such subjects as health fraud and the appropriate use of drugs.
6. The health promotion subcommittee deals with ethical and professional responsibilities of the physician, as well as aspects relating to preventive medicine.
7. The subcommittee on aging addressing issues facing the health care needs of older persons and the problems encountered by physicians who treat such patients.
8. The human rights subcommittee in conjunction with other organizations, addresses concerns raised by physicians acting as physicians, whose human rights may have been infringed in the process.

The American College of Physicians also sponsors many other activities which relate indirectly to quality assessment and provides a model for national professional organizational activities in this area.

The Institute of Medicine Council on Health Care Technology was formed two years ago to address technology assessment and cost effectiveness throughout the entire field of medicine, and has broad representation on the council related panels. For example, the information panel is working closely with the National Library of Medicine to provide up to date technology assessment data which can be readily available for physicians throughout the country in various specialities.

The evaluation panel addresses techniques for technology evaluation which are broadly applicable, and the methods panel addresses specific elements of technology assessment from a methodologic viewpoint.

The General Accounting Office was commissioned by the Ways and Means Committee of the U.S. House of Representatives to address the quality of care in the Medicare program and an ongoing study is addressing long term and short term problems related to Medicare and the ability to obtain accurate quality assessment data.

While Medicine as a profession has proved itself on devotion to quality and has internally set standards in hospitals and in specialties because of the cost of medical profession, which is often perplexing to the physician. Understanding of the areas of interest and concern of one specialty to another as well as physician participation is meaningful quality assessment and data collection can greatly benefit our patients as well as having a positive effect on the profession itself.

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