

Is money spent on quality improvement better spent on clinical care? — No

Professor Bill Runciman believes much clinical care is inappropriate, and QI can be effective

NO The evidence that more care does not mean better care is overwhelming, and the scope for savings . . . is huge.¹

There are many established health care practices and an ever-increasing number of advances that unequivocally represent value for money. However, we hear daily about unacceptable delays for public patients in access to both established and new high-value interventions. As quality improvement (QI) activities consume resources and do not provide direct clinical care, it has been suggested that resources be diverted from QI to fund more clinical care. There would be a powerful argument for this if clinical care was appropriate and properly delivered, and if all QI activities were futile and did not improve care or outcomes. However, neither is the case.

Much clinical care is neither appropriate nor properly delivered. For common conditions for which evidence is available, patients receive appropriate care only about half the time, with enormous regional variations.^{2,3} In the United States, the quintile of the population that consumes 50% more health care resources per person than the lowest quintile does not have better outcomes or better perceptions of their care.⁴ On top of this, at least 10% of admissions to acute care hospitals are associated with health-care-associated harm, as are over a million general practice consultations each year in Australia.⁵ This is not a “good look” for a health care system that costs over \$100 billion per year (nearly 10% of gross domestic product), and which is on a trajectory to becoming unaffordable. Diverting funds to “more of the same” will produce more of the same. With an ageing population and ever-increasing possibilities and expectations, there is an urgent need to provide rational care and redirect funding from ineffective or non-cost-effective practices.⁵ Continuing to fund inappropriate care and substandard practices automatically while denying high-value appropriate care to many of those in need represents institutionalised unethical practice.

Well designed QI activities do not fail to deliver on improved care or outcomes; indeed, many represent remarkable value for money. Proper implementation of a “central venous line” care bundle can sustainably virtually eliminate deaths from catheter-related bloodstream infections.⁶ The effective use of surgical checklists can reduce perioperative morbidity by a third and mortality by nearly half — potentially saving thousands of lives each year in Australia.⁷ What is really remarkable is that uptake of these fairly straightforward interventions has been slow and patchy in Australia, opposed with the usual mantras about recipe-book medicine, erosion of clinical autonomy, and patients, contexts and practices somehow being different.

There is no doubt that much QI activity has failed to use rigorous methods and has resulted in a plethora of poorly designed, under-powered local projects which lack credibility and have little impact on clinical practice. However, this should not lead to the reflex dismissal of all QI activities. The real problem is that current practices in both clinical care and QI are often deeply flawed. There are inherent difficulties in QI and health services research that underlie the general lack of progress. These have been summarised recently, and a carefully argued case made for the use of process as well as outcome measures, ideally incorporated into randomised cluster or stepped-wedge research designs.⁸ Another well argued approach is to develop national clinical registries to “target condi-

tions or procedures . . . associated with large variations in processes or outcomes of care . . . that impact significantly on healthcare costs and patient morbidity”.⁹

Whether the approach taken is population-based, condition-based or both, national level research involving both public and private patients across all health care settings is needed. We need to be able to determine, on an ongoing basis, who is getting what care from whom and why, to decide what constitutes appropriate care and to develop clinical standards and tools to apply them. Like the examples cited above for central lines and surgery, the tools need to reflect clinical standards (either implicitly or explicitly), to constitute the mechanism by which compliance is documented, and allow easy audit (preferably electronic) that should form the basis for credentialling of individual clinicians and accreditation of health care services.¹⁰

Much needs to be done in retiring inappropriate care and ineffective QI; we simply cannot afford more of the same.^{3,5} The need for national clinical standards — for the meshing of QI and clinical care in our nationally funded system — is urgent. Inappropriate care and ineffective QI should not be funded. The money currently wasted would be better spent on creating a new amalgam of evidence-based care with built-in QI. The need for health care to be based on sound doctor–patient relationships will remain, but should be built on a foundation of both getting the basics right and being seen to do so.

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References

- 1 Godlee F. Tackling practice variation [Editor's choice]. *BMJ* 2011; 342: d1080.
- 2 McGlynn EA, Asch SM, Adams J, et al. The quality of health delivered to adults in the United States. *N Engl J Med* 2003; 348: 2635-2645.
- 3 Runciman WB, Merry A, Walton M. Safety and ethics in healthcare; a guide to getting it right. Aldershot, UK: Ashgate, 2007.
- 4 Sutherland JM, Fisher ES, Skinner JS. Getting past denial — the high cost of health care in the United States. *N Engl J Med* 2009; 361: 1227-1230.
- 5 Elshaug AG, Moss JR, Littlejohns P, et al. Identifying existing health care services that do not provide value for money. *Med J Aust* 2009; 190: 269-273.
- 6 Pronovost PJ, Goeschel CA, Colantuoni E, et al. Sustaining reductions in catheter-related bloodstream infections in Michigan intensive care units; observational study. *BMJ* 2010; 340: c309.
- 7 de Vries EN, Prins HA, Crolla R, et al. Effect of a comprehensive surgical safety system on patient outcomes. *N Engl J Med* 2010; 363: 1928-1937.
- 8 Brown C, Lilford R. Evaluating service delivery interventions to enhance patient safety. *BMJ* 2008; 337: a2764.
- 9 Evans SM, Scott IA, Johnson NP, et al. Development of clinical-quality registries in Australia: the way forward. *Med J Aust* 2011; 194: 360-363.
- 10 Runciman WB, Lumby J. Regulating clinical practice. In: Healy J, Dugdale P, editors. Patient safety first: responsive regulation in health care. Sydney: Allen and Unwin, 2009: 192-220.

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