

“Quality” in Medical Care: A conceptual Framework

Pages with reference to book, From 53 To 54

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Quality assurance and audits are the important components of an industry or a business. “Quality” in medical profession is similarly essential for achieving highest possible care at lowest possible cost¹. Concerns about quality of medical care must be as old as medicine itself. Among the pioneers of methodical assessment was Florence Nightingale². Quality of care is not the same as clinical efficiency. Medical process incorporates a set of both client and provider behaviours with complex interaction between them which follows use of services and health and welfare of the client. Thus assessment of “quality” can be defined as a judgement concerning the process of care, based on the extent to which that care contributes to a valued outcome. Donabedian¹ had provided the components of quality of care as: a) structure (physical features of health care); b) process (interaction and activities between doctors and patients) and c) outcome (changes in a patient's current and future health status). Since then, this concept has been refined by Williamson³ and Doll⁴. There are however, problems in this type of framework. Even if structure and outcome can be measured, the relation between them is variable and badly defined; structure is an indirect measure⁵. An alternative approach using ‘structure’ (for assessing quality of care) is to measure the capability of health unit to perform the specific activities and compare it with the standard⁶. Similarly the causal relationship to changes in health status due to the ‘process’ of care is not easy to establish⁷. Process variables are relatively easy to identify and have been studied more frequently⁸. ‘Outcome’ of care is hard to define and may be controversial. The most commonly available variable for outcome “mortality” is too rare to detect the small differences in care and frequently appear too long after the care⁹.

Lately scope of “Quality” has been broadened to “Quality assurance”¹⁰ and “medical”^{11,12} implying not only assessment of quality but also identification of reason for low quality and interventions so as to improve it. Quality has also been assessed from another angle by identifying its dimensions in terms of effectiveness, equity, efficiency and humanity^{2,10}. “Medical audit” has been labelled as “third clinical science”¹³ after biomedical and health care researches because of its pursuance in scientific principles and methodological rigour. Thus a number of synonyms are interchangeably used for “quality” with few modifications⁵ in their meanings. A conceptual framework for assessing quality of medical care should incorporate “goodness” of technical care¹⁴ as well as consumer's satisfaction^{15,16}. The technical care of the providers is in turn influenced by his/her knowledge and skill and attitudes to an organization of services. In contrast lay images of health, specific goals of consumers and levels of experience of health care, besides the technical care of providers affect the consumer's satisfaction and hence quality of care of the providers. Assessment of quality of care followed by identification of areas of improvement can help in increasing efficiency of medical care, especially in the private sector. Necessity of assessing quality of care of private practitioners in developed countries was realized in 70's^{7,18} and has resulted in marked improvement of their health services. In Pakistan, like in other developing countries where more than half of the population is seeking private medical care¹⁹, ensuring good “quality” will help in improving the efficiency of health services. However, it is very necessary that health professionals should volunteer themselves for “audit”. so as to identify “weaknesses” in management of their practice. This process of assessing the quality of care, can then, become a necessary requirement for licensing the practice and its annual/biennial renewal by the bodies like Pakistan Medical and Dental Council (PMDC).

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