

Guest editorial

Uniting health care quality and equity: the challenge of measurement

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Health care in the 21st century is affected by a host of factors intrinsic and external to the individuals, groups and communities that make up societies. Many of the conditions which impact on health reflect a tension between private decision making and the impact this has on the health profiles of a nation at a public level. This in turn affects the measurable quality indicators such as health outputs, achievement of targets and service user expectations. As such, national statistics reflecting health statuses, life chances and patterns of service use are as much a reflection of personal decisions relating to health prevention measures, willingness or ability to seek early interventions or treatment adherence as of appropriateness of policy or quality measures.

It is in this arena, where the personal and public factors impacting on health are played out, that clinicians, policy makers and service providers engage in a constant battle to ensure high quality health care. It is well recognised that the contexts in which health and health care are experienced vary within and between countries and societies.^{1–6} However, the need to provide for the health needs of people of every nation is the responsibility of and familiar to all countries worldwide. This has become more apparent in the last decade with the shrinking of geographical boundaries and an increase in awareness of global health challenges. The exponential growth in information, technology and communication enables clinicians, patients and service providers from any one country to have unprecedented insight into individual health – that of groups of citizens as well as communities across the globe. This produces a very different scenario for health care in the 21st century within which quality must be maintained and advanced.

The healthcare quality agenda in the future needs to be conceptualised differently in an age of informed patients, global health challenges and awareness of the impact of the environment on public health. The key message from this is that the challenge of continuously providing high-quality health care cannot be achieved solely through the endeavours of clinicians working in isolation with colleagues from their own disciplines.^{7–9} It

is increasingly apparent that provision of health services to meet these wide-ranging and continuously changing needs must be diversified.^{9,10} It is therefore not surprising that many of the new healthcare policies and directives have clearly articulated the importance of service user and carer involvement, interprofessional practice and entrepreneurial activity as central tools in future healthcare practice.^{7,10} One of the strongest messages in recent policy directives is the importance of realigning quality outputs with the experiences of patients at an individual level, and actively striving for health equity across societies.^{10,11} This message appears to be reiterated across a range of healthcare service delivery models, including the centrally funded systems of the British NHS and the private/public funding models of the USA and elsewhere.^{12–14}

The recently published White Paper on health in England, *Equity and Excellence: liberating the NHS*¹⁰ openly acknowledges that the NHS, while lauded for its basic philosophy on providing high-quality care, free at the point of delivery, also scores relatively poorly on being responsive to the needs of patients. The paper highlights that:

It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. Too often, patients are expected to fit around services, rather than services around patients.¹⁰ (p. 8)

The paper goes on to highlight that achieving consistency in excellence, across different social groups and different health conditions, is a central requirement of health care in the future. This call for consistency (or equity) in healthcare provision is neither new nor restricted to the English or British political context. *The World Health Report 2010 – Health Systems Financing: the path to universal coverage*¹⁵ recognises that good health and high-quality care are essential prerequisites to human welfare and to sustained economic and social development across the globe. This latest report (due in November 2010) takes on board the impact that the global financial crisis may have on healthcare provision, access to services and availability of treatments in many countries. The

report will outline how the World Health Organization (WHO) member states have agreed targets to develop their health financing systems so as to ensure that all people have access to health services, while being protected against the financial hardship associated with paying for them. The experiences of service users, service providers and clinicians in different countries, as well as new research, form the basis of the recommendations. The report also provides an agreed action agenda for countries at different stages of development, which suggests how the international community can better support low income countries to achieve universal coverage and improve health outcomes. In addition, President Barack Obama in his Health Care Reform Bill highlights the need to address and minimise health inequalities as a driver for changes to the provision of health care in the USA.¹³

The funding system in the USA and other countries differs from that in Britain and as a result many of the reforms sought by the Obama government relate to making health care more affordable for those living with the highest levels of deprivation. However, the underlying sentiments in the Obama reform bill and the WHO 2010 report are the same – that achieving high-quality care for all in the 21st century requires policies that safeguard and legislate for the vulnerable as much as ensuring innovation and advancement in healthcare practice. The examples above highlight that recognising and addressing inequalities (or indeed other health challenges) through policy must account for the realities of peoples' lives in society. This has resulted in new healthcare policies and directives which span the health and social care divide, identifying and embedding measures of quality within both spheres.^{10,12} Practitioners working in primary care are therefore required not only to take into consideration the social contexts of their patients and communities when determining appropriate care, but to also embed these aspects into their measurement of quality. The challenge then is to develop health policies and associated new quality measures which reflect and address the social realities of peoples' lives and health chances, alongside the clinical judgements of healthcare practitioners whose role it is to deliver against these policies and measures, not just the quantifying of treatment regimes.

The White Paper *Equity and Excellence: liberating the NHS* identifies that the principle of shared decision making should become the norm in healthcare planning, provision and quality assessment. This challenges health professionals to negotiate and engage with service users and populations at a level where there is 'no decision about me without me' (p. 13). The rationale for this approach lies in more than the changing expectation or expertise of patients about their own health. There is a significant and growing

body of international evidence identifying that involving patients in their care and treatment improves individual health outcomes,¹¹ optimises patient satisfaction with the care received and increases treatment adherence¹⁶ due to patients' improved knowledge and understanding of their health.

To some degree primary care has a head start in the engagement of patients and the public in health care. Many primary care services are not only well placed to understand the everyday contexts in which patients manage their health but are also well versed in direct liaison with the communities they serve. However, in future the policy drivers will demand a much more sustained and strategic approach to liaison with individuals, groups and communities to assess and deliver the requirements of quality with equity. At a pragmatic level for healthcare professionals, whether GP, nurse or other community practitioner, this may involve continuation of good practice in discussing and negotiating health and health care with patients.^{7,10,15} In addition, practitioners may be required to underpin discussions with identification of the cost benefits of the recommended treatments, as well as disclosure of the alternative options available – even from outside their usual professional realm of operation. This could include discussion of complementary therapies, which may be less problematic for practitioners, but could also include identification of options available in the private sector, social care or from other health and social care professions.

Instruments need to be developed and embedded in quality assessments which will enable clinicians to assess these diverse aspects of 'quality' in a way that is both effective and appropriate. We need to be able to take account of the personal, professional and public impact of efforts to achieve quality with equity in the measures we use. Our current quality measures accounting for the quality of clinical (primary care) services allow for the qualitative and quantitative measurement of appropriateness and effectiveness differently. To some degree the different rationales compete for 'validity' in the eyes of clinicians and patient groups.^{16,17} Problems of community engagement, harnessing marginalised perspectives and what counts as 'appropriate' may compete with more 'concrete' measures of clinical effectiveness or disease efficacy as measures of quality on a philosophical and practical basis. In addition, at a time of worldwide recession and financial constraints, there is a question as to whether or how timely development of these essential new instruments to fulfil such a task will be secured. Here lies the biggest challenge in delivering the quality with equity agenda which lies at the heart of the health policies for the 21st century. There is no question that the rationale of focusing future health care on improving equity and quality across populations is the right way to go in optimising community health.

However, useful, effective and appropriate instruments and processes of assessment are needed in order to be able to adequately assess how far we are able to achieve these aims for a larger number of people in every society. Without this, the policies are at best at risk of remaining as laudable rhetoric, or at worst pipedreams.

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

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