Continuous Quality Improvement: Does It Make a Difference?

HELEN DARLING

Watson Wyatt Worldwide, Stamford, Connecticut

DAVID BLUMENTHAL AND CHARLES M. KILO HAVE concisely summarized the evolution and current state of the continuous quality improvement (CQI) movement in the U.S. health care industry, based on interviews with informed health care leaders and on their own considerable experience in the field. Their article strikes a reasonable balance between an overstatement of the impact of CQI that its supporters may wish for and read into the evidence and an overly pessimistic assessment of its value, both now and in the future. They capture the strengths and weaknesses of CQI and refuse to give in to despair, despite the reality that progress has been slow and much needed, seemingly obvious changes, to medical practice have either not occurred or have been confined to pockets of the industry. Both their article and that by Steven M. Shortell, Charles L. Bennett, and Gayle R. Byck confirm what we all suspect and wish were not so, but both also offer useful suggestions on how to increase the likelihood that new attempts will succeed, that proselytizers will reach a wider audience, and that their efforts will take hold and lead to more permanent results.

Newcomers to quality-of-care research and policy will particularly benefit from Blumenthal and Kilo's contextual information, their discussion of the shift from the old world of quality assurance to the new

one of CQI, with its fundamentally different approach and assumptions, and their examples of successful applications. Corporate or government purchasers who might think that CQI has great potential but have not yet tried it would do well to read these two thoughtful articles.

Both underline the painful reality that, in a trillion-dollar industry, even obviously beneficial changes are occurring infrequently and unevenly across the country. Blumenthal and Kilo note that there are no organization-wide success stories.

There is another sobering and disturbing fact. Despite computer technology, the Internet, rapid global communication, and the relative universality of much evidence-based medicine, different standards of clinical practice still apply around the nation. On the cusp of the 21st century, it is even strange that we are having a debate at all about whether every plan or provider should be benchmarked against a clinical practice gold standard. Where scientific evidence unequivocally supports certain clinical practice patterns, the diffusion of that treatment should be rapid and unhesitating, but we know it is not. CQI is helping, but not nearly enough. Both articles offer explanations for its limited success.

Whatever the reasons, however, E.A. Codman, the Boston surgeon who espoused the measurement of surgical outcomes in the early part of the century, would undoubtedly be disappointed to see how little progress has been made since his time. Frankly, purchasers who have been exposed to this issue have a hard time understanding why a science-based industry continues to perform clinical practices in a way that either is not based on science or, worse, is contrary to well-documented evidence. The optimism that nevertheless characterizes the perspective of the authors of the two articles published here, despite their litany of limitations and accounts of meager success, should inspire the reader to believe that there is still hope for CQI to expand. This view is plausible. As serious health care cost pressures reemerge after four years, during which time many large purchasers experienced a significant drop in their active medical claims costs and saw others flatten out and fall, we may once again see significant changes in purchasers' behavior. Large purchasers will resist a return to the increases that occurred before 1993. They will renew their demands for value and will try to force the health care industry to focus on quality and to employ CQI, with the goal of achieving a "defect-free" health system. Manufacturers can point to the model of "Six Sigma Excellence," which was pioneered by Motorola and

was later adopted by General Electric and Allied-Signal. Although health care is a complicated and protean industry, it can still benefit from the steps taken toward improvement in manufacturing and elsewhere. Most corporate purchasers are convinced that a focus on quality improvement will help to eliminate costly errors and cut out inappropriate care, resulting in a less expensive system.

The article by Shortell and coauthors draws on a comprehensive review of the literature to provide more detail on CQI studies. Their assessment of the situation, though balanced, may be even bleaker than Blumenthal and Kilo's. They too suggest ways to increase the number and scope of CQI projects, describe the circumstances that would promote its impact, and warn of situations to avoid.

As a purchaser and benefits consultant who works with a number of medium- and large-sized employers, I am not completely objective on this issue. I believe that purchasers will have to continue to press hard for changes in the health system in order to facilitate and accelerate the continuous improvement of health care. There is every reason to believe that, left to its own devices, the health industry, for the many complicated reasons that are discussed by Shortell and his colleagues, will not move far or fast enough to satisfy purchasers.

My work in a large CQI-driven corporation leads me to conclude that the most important factor for ensuring successful change would be the installation of a relentlessly driven, high-level chief executive or financial officer, who would act as a powerful champion of the process. Such a scenario is most likely to play out when a new person is hired to transform the organization. For it to succeed, the very survival of the organization must be at stake, and enough board members and senior managers must understand that this is the case. Shortell's article offers excellent examples of ways to make health care work better, but the best ideas in the world will bear fruit only if there is a serious, severe threat to the short-term survival of the organization and if a wise, skilled, and powerful leader has been appointed to deal with it.

Address correspondence to: Ms. Helen Darling, Practice Leader, Group Benefits and Health Care, Watson Wyatt Worldwide, 1055 Washington Boulevard, Stamford, CT 06901-2216.