

Who defines quality in health care?

We're barraged today with logos, ads, and commercials about quality and excellence, but who really sets these standards? There was a time when quality stood for things that lasted—for dependability. Excellence was an "A" or 100%, or darn close to it. If we couldn't exactly define these terms, we at least knew them when we saw them. They were consistent and represented ideals to strive after. I'm not so sure today that we can all agree on what constitutes excellence and quality in spite of all the rhetoric in the media, education, and the workplace. This is especially the case with health care.

American industry has had a terrible time of late defining quality in a package the consumer will buy. What once appeared to be excellence and quality has proved inadequate in the competitive marketplace. Peters and Waterman, in their popular 1982 book *In Search of Excellence*, touted IBM as a paragon of excellence, but today, only a decade later, Big Blue struggles for survival, an example of an administratively bloated company providing a service few need or want.

The American automobile industry has had similar problems with quality and its dilemma goes deep to the fabric of a century-old adversarial relationship between labor and management and a near-fatal belief that it could tell consumers what they wanted. Today, the Japanese quality circle, joining all levels of industry to a common goal, reigns superior and continues to pressure Detroit with reliability and cost standards that define quality. Both these examples suggest that quality standards can't be imposed, but must emerge as a common thread from all involved in the process.

Health care is having similar difficulty lately when it comes to defining quality. Over the last several months, I've heard two national leaders—one, the chief administrative officer of a major university health science center and the other, a vice president of a national health accrediting body—state publicly that quality in health care can't be defined. What they are really saying is that quality is in the eyes of the beholder and can't be imposed unilaterally. Surprisingly, their admonitions come on the tip of a wave of quality measurement that is gaining momentum in managed care and impending health care reform.

How does dentistry stack up in terms of quality? Our leaders maintain that the system "ain't broke" and provides the highest quality care to those who have access to it. But what of those who don't? If they are thrown into an overall quality equation, then perhaps we fall short of excellence. A significant impetus in redefining quality in health care has been the recognition that the formula is skewed, with those with resources receiving the bulk of what is high-quality care.

As managed care gains momentum (and it is, even without the Clinton plan), we will have to wrestle with other changing elements of the quality definition. Capitation will challenge the all-American concept that "more is better" as health practitioners are asked to maintain health on a shoe string rather than an expense account. In dental school, we learn an "ideal" treatment plan, which is almost always the most expensive. In continuing education dentists are taught to "go for the gold" with the hidden message that what is good for the practice is good for the patient. In a system that is procedure based, the age-old concept of least invasive care seems to have been lost. It will be interesting to see if, in the long run, oral health benefits or suffers from a definition of quality that de-emphasizes procedures.

There once was a time when doctor and patient sat face to face and found the true "ideal" treatment plan—one that met the value system and out-of-pocket budget of the patient and the ethical standards of the dentist. What better definition of quality than satisfaction of provider and consumer? I dare say that a third chair is at many treatment planning tables today, with its invisible occupant influencing each of the other two participants to choose covered rather than needed benefits.

Perhaps the most profound and perplexing change to come will be the "soft" parts of the quality and excellence definitions. Some governmental agencies are already using terms like "family centered" and "culturally appropriate" to describe health services. These terms seem wide open for interpretation and they clearly apply to the overall care system and access to care as

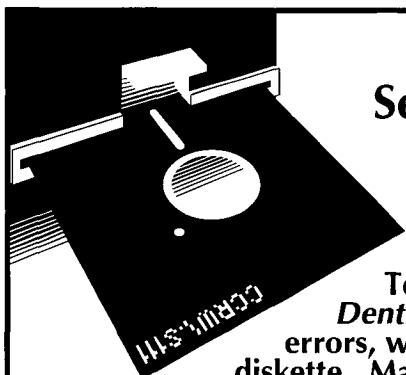
measures of quality. A potential trap in these terms is a dual standard of care that justifies itself without attention to parameters of oral health. Patient satisfaction is another quality measure talked about repeatedly, yet for some patients this means an ideal occlusion and for others, simply freedom from pain. For some patients, just being able to receive care when needed would be considered excellence in health care. Defining and reconciling these abstract and difficult-to-measure criteria with oral health status will be a challenge.

What is very clear in all this is that a profession-imposed definition of quality is rapidly becoming obsolete. While we in the health professions struggle over standards or parameters of care that are procedure or disease oriented, other partners in the health care equation are looking at outcomes, access, efficiency, and

patient satisfaction as measures of excellence and quality.

We should look at lessons from industry as we maneuver these changes. Several decades ago, Detroit developed a car that, according to automobile makers, was supposed to embody the latest in design and technology and capture the American consumer. That was the Edsel. About the same time, a simple little foreign car that you could fix yourself and ran forever on a tank of gas found its way into the hearts of American drivers—the VW bug. The rest is history.

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