

Value of quality indicators for cancer services

Ulrich Wagner

Bern University of Applied Sciences, Business School/Health Services Management, Bern, Switzerland

A quality indicator (QI) can be defined as a measurable parameter which constitutes an image of indirect quality. With this instrument it is possible to direct the attention to specific circumstances of interest – in general, the meta types structure, process and outcome of cure and care – but not exclusively. An indicator is always to be looked at through, and embedded in, its specific context and can have different meanings in different contexts. Several suppliers of quality indicator sets are listed in Table 1.

Summarised, it can be stated that the development and use of indicators and indicator sets in English speaking countries (Beveridge or market models of health services) seems to be more necessary and is therefore more advanced than, for example, in continental Europe (Bismarkian models).

Table 1
Suppliers of quality indicator sets

Verein Outcome, Switzerland (www.vereinoutcome.ch)
NHS National Health Service Executive (www.doh.gov.uk)
UK Clearing House on Health Outcomes (www.leeds.ac.uk/nuffield/infoservices/UKCH/home)
Danish Indikator Projekt (http://www.nip.dk/)
AQUA-Institut for Outpatient Care in Germany (www.aqua-institut.de)
FACCT Foundation for Accountability (www.markle.org/resources/facct/index.php)
The German Physicians Quality Center (http://www.aezq.de)
Department of Human Services, Victoria, Australia (www.health.vic.gov.au)
National Quality Forum (www.qualityforum.org)
RAND Corporation (http://www.rand.org/health/tools/qualist.html)
Association of Maryland Hospitals and Health Systems (http://www.qiproject.org)
AHRQ (http://www.ahrq.gov , www.qualitymeasures.ahrq.gov)
AMA (www.ama-assn.org)
JCAHO (www.jointcommission.org)
NCQA (http://www.ncqa.org)
Quality Health New Zealand (www.qualityhealth.org.nz)

QIs are influenced generally by information needs of different participants or participating groups with different functions, purposes and goals in the field of health services. Treatment, research and teaching, as well as controlling processes, behaviour and systems, are possible intentions. Inter- and intra organisational relationships are objects of imaging through indicators. Figure 1 shows the simplified market situation in Switzerland, where every participating group is part of a special relationship and uses indicators for internal purposes too [1].

Beginning with the growing number of multi modal medical treatment possibilities, the demands and needs of patients (for optimisation of the medical treatment processes) could be identified through quality of life indicators (i.e. EORTC QLQ-C30) and their supplements (i.e. PR-25 for prostate cancer). In recent years, these have developed to assess the more personal and individual needs of the patient from a care point of view and the payers/policy makers point of view (i.e. access to care).

The further evolution/development and differentiation (i.e. quality of life measures for women with endometrial cancer [2]) of classical QIs have been complemented by the optimisation procedures

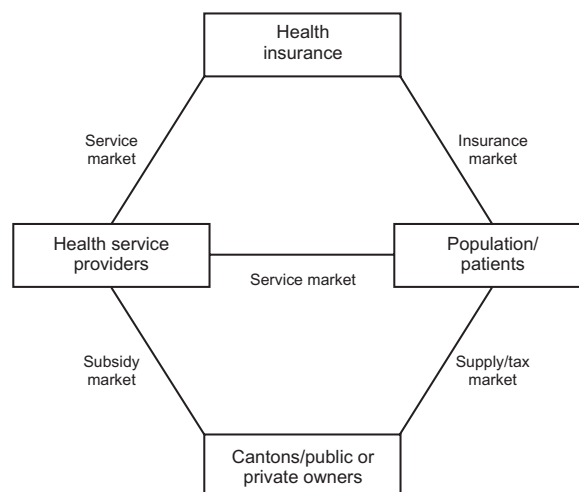


Fig. 1. Market situation in the Swiss health system [1].

Table 2
Customers according to their role definition

Role	Description
Therapists	those who make a (the) diagnosis those who treat the patient
Users	those who will use the products or services (i.e. the patient or the therapist)
Initiators	those who initiate the “buying” process
Influencers	those who affect the “buying” process (i.e. referrer, or HTA agencies)
Buyers	those with the formal authority to “select” (are often the therapists)
Deciders	those who actually make the final decision (i.e. policy makers)
Approvers	those who own the formal authority to veto the deciders (i.e. medical bodies or professional societies)
Purchasers	those who do the actual “buying” without having the authority to decide (i.e. public health insurance companies)
Gatekeepers	those who control the flow of information, indirectly influencing the selection process

of different instruments that are currently underway. These perform an integration of formerly different perspectives and create new information that mainly serves players like payers/policy makers, who are enjoying an increasing importance (i.e. in prostate cancer [3]) These indicators and their contextual interpretations, which are performed by newly built up Health Technology Assessment agencies, support informed decision making.

In Table 2, supplementing the work of Ossel [4], a lot of different “customer” roles can be identified in the field of cancer services.

These different roles differentiate in different professions with different information needs. E.g.:

- Epidemiology: Single events (sentinel) and aggregated data for monitoring purposes;
- Public: mainly appropriateness, access and safety targeted on segmented providers;
- Service perspective: functional, individual, interactive indicators;
- Clinical: Structure, process and output/outcome data, latterly patient safety too.

However, these change and develop over time.

According to a life circle approach of products – which is valid for organisations, branches, empires and, of course, quality indicators – we can distinguish between new and old indicators, from indicators which are in the first “introduction” phase, the second “growth” phase, the third “maturity” phase, the fourth “saturation” phase, right up to the last “degeneration” phase. Their values change because the dimensions

and focuses of the indicator sets develop. The values of safety, effectiveness, efficiency, timeliness, patient-centredness and equity are floating, whereas the value of the indicators per se remains stable and indispensable i.e. for treatment [5].

However, unlike most products, there seem to be indicators that do not degenerate, but, on the contrary, build a more or less solid foundation on which the whole system can be based. We will also take a closer look at these too.

Conflict of interest statement

None declared.

References

- 1 Wagner U. Value Added Services in Health Organisations; EHMA Annual Conference (European Health Management Association), The politics of health – Policy, Organisation, Community: changing contexts, managing relationships, www.ehma.org, 2008.
- 2 EORTC 2009 (www.eortc.org).
- 3 Penson DF. Assessing the quality of prostate cancer care. *Curr Opin Urol*, 2008;**18**(3):297–302.
- 4 van Ossel G. Measuring customer satisfaction. In: van Looy B, van Dierdonck R, Gemmel P (editors), *Service Management – An Integrated Approach*. London: Financial Times – Pitman Publishing; 1998. Chapter 8, p. 130.
- 5 Cheng SH; Wang CJ, Lin JL, et al. Adherence to quality indicators and survival in patients with breast cancer. *Med Care* 2009;**47**(2): 217–25.