

GUEST EDITORIAL PREFACE

Special Issue on How to Introduce Health System Change Strategies to Policy Makers?

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When asked to edit this special issue of the *International Journal of Reliable and Quality E-Healthcare (IJRQEH)*, I wanted to gather together the wisdom and experiences from health services researchers who had made a difference in quality and safety of care improvement on a local, national or global level. I have been fortunate to know many of those researchers as colleagues and friends, and I welcomed the opportunity to organize an issue with a few of them.

The challenge was the topic I had in mind “*What are the strategies for involving policy makers in quality and safety improvement?*” Indeed, while many of us have measured, analyzed, shared and recommended ways in which healthcare performance can be ameliorated and continuously improved, few are the success stories where clinical, epidemiological, economic and ethical recommendations have been accepted by policy makers and incorporated into regional or national strategies. Thus, organizing an issue of the *Journal* around the above topic seemed warranted and exciting.

Upon discussion, we all agreed that the articles cannot be conceptual or hypothetical. We wanted to share experiences through specific projects by describing what has led to policy change, why, and through what stumbling along the way. Also, we wanted to share what has not succeeded. That is why the authors who contributed to this issue have a unique perspective to share, since each one of them has been a leader in national and global initiatives on healthcare quality and safety improvement, AND has been faced with the challenge of convincing governments or international coalitions on why a certain methodology, educational approach, technology or change in expectations was necessary to provide the best care to the populations they served.

This is not an issue about measuring healthcare performance, nor is it a compilation of articles about evaluation of healthcare quality and safety. Instead, we wanted an issue where measurement, evaluation, communication and sustainability were the necessary but not sufficient dimensions toward ameliorating

the quality and safety of care. Rather, that they were needed to make the case to the policy makers about the better ways to address systems' performance, be accountable for the services, and enhance patient and community expectations about the ultimate and universal social good—health care and caring.

The series of articles in this issue address the question of expectations for patients and providers. Interestingly, while the overarching theme is “policy-maker centered”, the expectations about quality and safety of care are specifically germane to patients seeking improvement in or restoration of their health. Moumtzoglou addresses this question in an editorial, approaching it from the multi-dimensional vantage point where social interaction between a patient and a healer has anticipated effects on both the healing process and the expectations regarding future care. One intriguing formulation, among a number proposed by the author is “the ‘healer’ is the environmental variable that triggers endogenous mechanisms of self-cure” because the patient had sought care (or even a specific doctor) based on his expectations of the benefits to his physical, psychological, mental and social health. One cannot resist wondering how an indicator-based performance measurement approach would comprehensively quantify these expectations.

For Brian Collopy, a pioneer in introducing clinical indicators to the Australian healthcare system in the 1980s and helping link performance measurement to accreditation, the overarching challenge during the introduction of performance improvement strategies to policy makers is in helping them make appropriate comparisons. He states that the policy makers' responses arose from “...comparisons, which followed from use of a study method, developed in one country with certain motivation and goals, and applied in Australia, with differing motivational aims.” Thus educating the users of information first about data that are relevant and appropriate to local/national goal on quality and safety, and that their collection is logistically feasible is as important as the science behind

the design and implementation of valid indicators of clinical performance. The longevity and national focus of the Australian experience in healthcare system performance improvement through indicators and professional standards should be considered a convincing aspect of its usefulness to patients, communities, the professionals providing care, and to the efficiency of the health care delivery national system. The Australian Council on Healthcare Standards (ACHS) and Collopy's continuous involvement and leadership over the past 20 years have demonstrated that while change does happen and can be measured, building the collaboration cross and among health care providers (specialty groups, societies), researchers, and communities are necessary and ongoing activities in parallel to educating policy makers and getting involved in new strategies for change.

The more than a decade-long experience reported in this issue by Ulrich et al, is more localized and shows the details of not only building a hospital-centered performance measurement and improvement system, but how to convince the health care professionals about the goodness of that system. The University Hospital Trust Ferrara, surnamed “Sant'Anna”, is a public healthcare provider situated in the Emilia-Romagna region in the north of Italy, and the case study for this article. The introduction of indicators and strategies for the adoption of better practices was contingent on reaching consensus among all healthcare professionals about the appropriate standards for quality and safety. As such, there are similarity in the experience in Australia described by Collopy, although the authors stress the power of comparative analysis as “In order for our indicators are as meaningful as possible, it will be necessary to carefully identify and disseminate the values we adopt as standard, whether they originate from the scientific literature or are ‘borrowed’ from other healthcare facilities recognized for their excellence.” Perhaps this brings us to ponder about the importance of universal relevance i.e., standards versus locally appropriate targets or norms. Do we need universal standards to

convince professionals and policy makers, or can local targets be justified even if they are different from those of other healthcare systems and countries?

And that brings us to the analysis Bourek shares with the reader based on his direct involvement, leadership and synthesis of initiatives in the Czech Republic and a number of European countries. In this article the successes and lesser-achievements of various initiatives in the domains of database building, introduction of clinical indicators, benchmarking across countries to learn about better processes of care and caring are placed within a practical philosophy of how change happens. The author distills from the various initiatives and his personal experiences by proposing that there may not be a single, or set of strategies, but that after the introduction of new ideas and new methods, our purpose should be "... to disturb a system and then see and wait with patience if the disturbance improved the function of the disturbed system." Theory of change or group behavior analysis, the frequent changes in governments, individuals in key policy positions, and the variations in expectations about healthcare effectiveness, the definition of health across societies and cultures may require this patience in assessing how the introduction of a new idea (the disturbance) affects the existing system. Unless, there is a "burning platform", a global disturbance that would accelerate the pace of change. The safety of care movement, which started in 1999 with the series of reports by the Institute of Medicine (IOM), is the most recent example of such a burning platform which caught fire in practically every healthcare system around the globe. But the question asked by Bourek remains valid, as after more than

a decade of focus on improving the safety of care, the findings about safety improvement are inconsistent across healthcare systems.

My goal in editing this Special Issue was to glean from the experience and knowledge of experts who have made a difference across continents. I use the term "glean" as for me it was necessary to gather information, bit by bit, from actual field experiences on strategies to influence health care policy by involving policy makers in the steps toward system improvement. But as I checked the Merriam-Webster Dictionary about the meaning of "to glean", I was left with a puzzling thought. Indeed, one of the definitions of "to glean" is:

To gather grain or other material that is left after the main crop has been gathered.

I cannot resist wondering if after 30 years of indicator, guidelines, evaluation methods and statistical analyses, *the main crop has been harvested*. Therefore, should our strategy for system change and quality and safety of care improvement still be heavily weighted toward tools and methods development, or through intra-disciplinary approaches focus on ways in which policy makers are incorporated in the phases of research and are most prepared to promote and support policies that would make things happen?

Is our field ready for new seeds and the resulting harvest?

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