Improving the Quality of Health Care
Who Is Responsible for What?

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SUBOPTIMAL HEALTH CARE QUALITY IS AN URGENT NATIONAL concern. Recently, policy makers have sought to improve quality by providing bonus dollars to physicians whose patients achieve certain health goals. The privatized US health care system has engendered decentralized quality improvement approaches and an unintended consequence has been ambiguity regarding who is responsible for quality and the scope of stakeholders’ obligations. For example, some pay-for-performance arrangements effectively pay physicians less if their patients with diabetes miss appointments and fail to take prescribed medications. Pay-for-performance also does not typically assess diagnostic skills or clinician empathy, traits that patients value highly. These measurement flaws have frustrated physicians and a backlash could derail potentially valuable improvement efforts.

In this Commentary, the stakeholders responsible for improving health care quality are identified and their shared and unique obligations are outlined. The resulting framework may help promote valid quality measurement, coordinated improvement efforts, and systems rewarding genuine quality rather than isolated “performance.”

Quality Health Care: What Is It and Who Is Responsible?

One prominent definition of health care quality is “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Although broadly valuable, this and other frameworks fail to identify the stakeholders responsible for improving quality or their obligations. Furthermore, the definition leaves unclear whose “desired health outcomes” should be promoted. Health outcomes desired by administrators, insurers, and pay-for-performance architects may differ substantially from those of patients. A definition of health care quality grounded in the fundamental moral purpose of medicine could clarify these shortcomings and help illuminate a framework of accountability for quality improvement.

Quality Health Care for Individual Patients. The central act of health care is a response to the needs of individual patients whose inherent human dignity engenders an obligation to provide respectful, compassionate, and competent care. Fulfilling these essential patient-level obligations is the fundamental component of quality health care. As Aristotle stated,

The doctor does not treat ‘man’ except accidentally; he treats Callius or Socrates or someone else described in this way, who is accidentally ‘man’. So, if someone has grasped the principles of the subject without having any experience, and thus knows the universal without knowing the individuals contained in it, he will often fail in his treatment; for it is the individual who has to be treated.

Quality for individuals therefore equates with how well the central act of health care is accomplished (ie, the degree to which appropriate health care obligations to the individual patient are fulfilled). As key advocates for patients, physicians have a central role and institutions facilitating patients’ health goals such as physician groups, hospitals, insurers, and political entities also have crucial responsibilities.

Quality Health Care for Populations. Because health care is fundamentally individualized, the essential indicator of quality population care remains high-quality patient-level care. Although seemingly obvious, this view contrasts sharply with current approaches to population-level quality.

Resources for maximizing patient-level quality will be limited in the short term, introducing key obligations engendered by the central act of medicine. First, health systems ought to maximize efficiency before engaging in explicit rationing. Second, savings should be distributed broadly across the population to facilitate the achievement of patient health goals, perhaps reserving a portion as an incentive for those individuals achieving these efficiencies and distributions. Third, systems ought to promote equitable resource allocation.

Importantly, resource limitations do not preclude a patient-centered understanding of population-level quality; they merely imply that the extent to which care obligations can be fulfilled must be adjusted in light of immediately avail-

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able resources. Population-level health care quality is thus the degree to which care obligations to individual patients are fulfilled while accounting for the degree to which they are fulfilled efficiently and equitably across the population. Processes that facilitate the just fulfillment of substantive obligations to individual patients are therefore crucial.

Because disproportionate resource consumption by particular stakeholders reduces equity and efficiency, the activities of all parties using health care resources affect population-level quality. Physicians and health care institutions have clear effects on utilization. Patients also affect resource use, and a seldom-discussed implication is that patients also have obligations to promote quality population care. This is why, for example, patients are not ethically justified in demanding that health systems “do everything” to facilitate their individual health care preferences.

**Health Care Quality: Definition, Obligations, and Implications**

These insights lead to a patient-centered definition of health care quality that also accounts for the needs of the population—health care quality can be defined as “the degree to which physicians and health care institutions fulfill their care obligations to individual patients, and the degree to which patients, physicians, and health care institutions enable these obligations to be fulfilled justly across the population.”

Based on this definition, a framework can then be developed describing the quality-related obligations of patients, physicians, and health care institutions (TABLE). This framework and its associated obligations have implications for both pay-for-performance and the wider quality movement.

**Pay for Performance as a Quality Improvement Approach.** In contrast with the patient-centered definition, pay-for-performance typically equates quality with achievement of several predetermined health targets by populations. For example, some systems require that more than 65% of patients with diabetes reach systolic blood pressure levels of less than 140 mm Hg. Concerns have been raised that this “one-size-fits-all” approach might be motivated by expediency or financial priorities. In addition, for performance targets to be truly “population” goals (rather than those of a few experts), physicians and population members would have to collectively endorse them using fair processes. In reality, policy makers, health care executives, disease advocates, and scientists with clinical or epidemiological expertise effectively choose population-level goals and thus impose obligations in a manner that might infringe on patient and physician autonomy. Without fair deliberation, such goals, however wise, cannot claim legitimacy.

<table>
<thead>
<tr>
<th>Quality-Related Obligations With the Best Reasonable Effort and Consistent With Current Professional Knowledge</th>
<th>Physicians</th>
<th>Health Care Institutions and Political Leaders</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>To the Patient</td>
<td>To the Population</td>
<td>To the Patient</td>
<td>To the Population</td>
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<tr>
<td>Be accessible for timely patient encounters or arrange appropriate coverage</td>
<td>X</td>
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<tr>
<td>Accurately identify the patient’s goals within a trusting, compassionate, and communicative clinical relationship</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Guide or help shape the patient’s goals in a beneficent manner that is respectful of patient autonomy</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Determine how to achieve the patient’s goals in a manner that maximizes benefit and minimizes risk</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Initiate and skillfully carry through processes of care that enable achievement of the patient’s goals</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Measure effects of care processes to enable an iterative reevaluation of the patient’s goals</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Advocate for or provide fair resource levels to maximize the patient’s access to existing services</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Facilitate coordination and continuity of care for the patient among appropriate health care facilities</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Advocate for improving existing services or implementing new ones to enable achievement of the patient’s goals</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Facilitate or participate in ethical care interventions enabling equitable, efficient, or greater distribution of health care resources</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Facilitate or participate in fair deliberation processes enabling equitable, efficient, or greater distribution of health care resources</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Facilitate or participate in monitoring physician and health care institution quality</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Health care institutions include physician groups and practice associations, clinics, hospitals and hospital networks, private health insurers, and public payers such as Medicare and Medicaid.*
This external and even “forced” population-level approach implies, at best, improved health and reduced costs for patients whose goals match those of policy makers. At worst, physicians could overlook urgent patient goals, provide inappropriate care, and increase costs via excess testing. Unmeasured domains of quality, such as communication, compassion, and trust could deteriorate as clinicians divert attention to limited sets of performance targets.

Even if population goals were decided in a manner fair to physicians, most current pay-for-performance systems would still be flawed. Today’s arrangements primarily assign responsibility for quality improvement to individual physicians, physician groups, or hospitals. Truly valid measurement must include input from and evaluation of all stakeholders responsible for ensuring quality.

In conclusion, current pay-for-performance arrangements can be understood as holding a single class of stakeholders (physicians) accountable for a small set of population-centered goals chosen in a top-down manner. The continued expansion of such a limited approach seems inadvisable. Given the urgency to improve quality, however, a prudent short-term strategy might be to increase emphasis on quality assessment from the patient’s perspective (eg, through surveys such as the Consumer Assessment of Healthcare Providers) and institute safeguards to protect vulnerable patients. Ultimately, comprehensive and valid measures should replace these temporary approaches. Fair processes, such as deliberative democracy (either to set population goals or allocate resources), would be essential to achieving population quality under any ethically defensible understanding of the term.

Quality Improvement in General. The definition of quality and clarification of care obligations offered herein make clear the extreme complexity of developing valid quality measurements. This results from the high degree of interdependence among stakeholders needed to achieve individualized health goals, the large number of obligations that must be assessed, the necessity of using biased observers such as physicians to assess key measures, and inherent difficulties in measuring equity. Although this may portray quality improvement as impossible, this complexity is highlighted so that, in the haste to measure, policy makers do not rashly make mistakes through oversimplification.

Is truly valid quality measurement even asymptotically approachable? Although the answer may remain unclear for some time, focusing on this ideal goal will at least improve measurement. Comprehensive assessment would account for contributions from physicians, patients, and health care institutions. It would require the refinement of techniques such as in-depth interviews and standardized chart review. New measures would assess patient goals, shared responsibility for care, humanistic physician values, available resource levels, and the inherent tension between patient-level and population-level health care perspectives.

On a practical level of more immediate importance for physicians, this framework demonstrates the difference between quality physician care and quality health care in general, concepts that may mistakenly be conflated. To measure physician quality, only obligations within the physician’s control should be measured. The disaggregated quality framework could at least facilitate isolated measurements of key stakeholders and either exclude or adjust for domains beyond their control.

Additionally, by specifying general obligations for quality care, new avenues to explore in improvement efforts have been suggested. Patient advocacy groups, health care institutions, and physician specialty groups could use this general framework to develop more specific lists of care obligations tailored to particular clinical settings or diseases.

Achieving valid measurement of quality does not settle the question of whether financial incentives will improve quality. The success of the health care system depends largely on professional virtues, such as honesty, thoroughness, and skilled communication, essential signs of quality that seem difficult to improve with financial incentives. Balancing carefully designed incentives with systems that promote professionalism might ultimately lead to the highest quality health care.

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