6th European Forum on Quality Improvement in Health Care
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INTRODUCTION AND FRAMEWORK TO THE FORUM

Carlo Favaretti [1]

It is a great pleasure for me to introduce this 6th European Forum on Quality Improvement in Health Care.
First of all, I would like to welcome our foreign guests and, in particular, those who have contributed to the success of this event with their theoretical reflections and practical experience.
I also wish to welcome our numerous Italian colleagues: their presence is evidence for the many initiatives that have been carried out, as well as for our country's potential in respect of closing the gap that still divides us from the most advanced international experiences in this field.

Quality improvement in health care is a widely shared priority, although the many activities carried out vary according to the adopted approach and the evolution of the systems in which they are implemented.
Generally speaking, and adapting the definition given by the ISO (International Organization for Standardization), we may define the quality of health care as its capacity to meet, in a balanced manner, the legitimate needs and expectations of all the parties interested in the promotion and preservation of health.
First and foremost, among these parties, are of course patients and their associations; but to these we must add the other citizens interested in preserving and improving their health, the health care workers who draw professional, as well as financial, gratification from their work, those who finance and manage health care facilities and systems and, lastly, the providers of goods and services associated with health care.
Each one of these has specific (implicit and explicit) needs and expectations and, therefore, the quality of health care lies in its capacity to meet these needs and expectations in a balanced manner.

It is now clear to all that health care is a complex process, which must be analysed, managed and assessed in a multidimensional capacity. However, I would like to re-iterate three important prerequisites on which to ground quality improvement:

1. health care is a process with high level of professional content and technical specificity, which cannot be disregarded;

[1] General Director – Health Care Service Trust, Autonomous Province of Trento, Italy

2. health care is carried out in organized contexts, which heavily affect the health care relationship;
3. health care involves numerous interested parties, whose legitimate needs and expectations must be met in a balanced manner.

The technical and professional specificity of health care is related to a number of factors: the complexity of health care needs, the continuous evolution of biotechnologies, the particular qualification and skills of health care workers.
From this specificity there ensue a number of questions: are the adopted health care actions effective and safe? Have they had a positive effect on people's health? What can be done to improve their application? Do study and research suggest the introduction of more effective health care actions?
The more enlightened professionals have always attempted to give replies to these questions, consistently with the needs and expectations of clinical effectiveness and safety; this has already become a heritage of health care workers, even though it is necessary to make it more systematic.

However, we must keep in mind that most health care activities today are carried out in organized contexts. Regardless of whether they are public or private facilities, health care, as a rule, is delivered by networks connecting hospitals, general medicine outpatients' facilities, nursing services, specialist outpatients' facilities, professionals, etc..
This gives rise to two considerations. The first is that, within these organized contexts, the relationship between the individual professional and the patient, who must face, alone, the complexity of disease and the suffering it causes, is heavily affected by the organizational network around them. The second is that the improvement of health care necessarily entails the improvement of the health care organization, and the use of tools developed in more advanced contexts.
To the initial needs and expectations of clinical effectiveness and safety, therefore, we must add other equally legitimate needs and expectations: the efficient use of resources, appropriateness, simplifying of procedures, accessibility, equity.

Precisely because health care is increasingly delivered by facilities included within organized contexts, the network of the parties involved is becoming broader and broader and, consequently, the number of those who are interested in influencing the orientation and behaviour of the facilities themselves is increasing.
The experience adapted from other non-health care organizations shows that their relationship with the interested parties is based on an exchange of value, and that success is guaranteed by their capacity to apportion the value produced in a balanced manner.
Therefore, the quality of health care is not only based on effectiveness, appropriateness or efficiency, but is given also by the capacity to respond to new needs and expectations: humanization of the relationship between health care workers and citizens, equity, structure transparency, accountability, acceptability of the procedures, respect.

Why are we gathered here today? First of all, we will have the opportunity to learn about many experiences made at national and international level: the capacity to copy the best experiences and apply them in everyday work, perhaps further improving them, has always characterized health care professionals and I think that, in the forthcoming days, we will all have the opportunity to become acquainted with innovatory ideas and approaches.
Secondly, the interactive organization of the sessions will make it possible to build up together the methodological aspects of continuous health care improvement.
Lastly, I believe it is important to develop cultural and operating tools enabling us to grasp the unitary nature of the three dimensions - the professional, the organizational and the relational - and resulting in a unitary approach to improving the quality of health care.

In recent years we have witnessed a slow but gradual process of integration and contamination among the various models underlying the improvement of health care quality; these models applied to health care are turning out to be complementary, rather than mutually exclusive.
Health care based on effectiveness tests, professional and institutional accreditation systems, the contribution of the ISO, total quality and excellence management models are jointly contributing to increase our capacity to meet the needs and expectations of our interested parties, i.e. to improve our quality. To do this, we must overcome barriers and distrust, acknowledging that the complexity and globality of health care requires equally complex and articulated improvement tools.

The goal before us is to create a “quality system”, meaning a coordinated, explicit and widespread set of clinical behaviours, organizational arrangements, responsibilities, procedures, incentivation systems, equipment, processes and resources. This system shall be arranged according to various interdependent levels, concerning the individual professional, the health care facilities, the national and regional health systems, research, an intersectoral approach with other components of society. Within this system perhaps it will no longer be necessary to speak of quality, because quality will coincide with daily work.

And with this vision, which I think we all share, I welcome you all once again and wish you success in your work here.