Components of Quality Health Care

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Four components that can affect quality health care are identified: organization, third-party payers, peer review, and the individual health professional. Emphasis is placed on the role of the individual health professional and on the participation of the professional organization in guiding and enhancing the quality of health care.

Health care has frequently been considered and appraised as if it were utilized in a vacuum. This approach may be appropriate and commendable on occasion, but has little immediate practical value. I will, therefore, set the following realistic dimensional limitations and make the following reasonable assumptions:

1. The care will be delivered in the United States under our present form of government and our present economic system.
2. Health care, although one of the largest industries of this country, will not change the economic system; therefore, any health-care system must adapt to the economic system.
3. The ultimate judge and jury of the health-care system will increasingly be the public, rather than the people and organizations who provide the care.
4. Our society has, by desire or default, made an irreversible determination that health care will be arranged for through a system (or nonsystem) of third-party payers, with government playing a major role.

On the basis of these limitations, four important components emerge which can particularly influence quality health care, both negatively and positively. They are: (1) organization; (2) third-party payers; (3) peer review; and (4) the individual health professional. In discussing these four, however, passing reference should be made to one other component: education. Discussion of education will be deferred, *not* because it has low priority, but rather because it has the highest priority and therefore could not be adequately considered in this paper. Education is a prerequisite, rather than a component, of quality health care.

ORGANIZATION

Our society is inherently motivated to organize anything we do. We also tend to overorganize to the extent that eventually the organization rules the service, instead of the service ruling the organization. Overorganization tends to weaken rather than improve the quality of service.

Furthermore, we structure our health organizations *not* to make them understandable to the public, but to make then understandable to the administrators at the top. The organization of the hospital complex is often more beneficial to the people working there and to the administrators than to the majority of patients. The Medicare concept of cramming all health service into three "provider" categories was developed not because such an arrangement would necessarily lead to a better system of health care, but because the administrators of the program found that structure more understandable. A group practice of medicine does not, in itself, ensure better medical care. Group practice is better only if the individual physicians in the group are superior practitioners. Health organizations will contribute to quality care only to the degree that they cause the other components to function better. The most fundamental question to ask is: Does the organization or the system bring patients in need into that system in the best way?

Regulations, procedures, forms, and even the physical place of entry into the system are often greater inhibitors to potential and needy patients than the fundamental fear of the treatment itself. Ask any patient what was the most irritating part of his hospital stay, and more often than not, he will cite his experience at the admission desk.

These comments are not meant to imply that organization is unnecessary. The hospitals of this country and their supportive and voluntary associations have been the bastion of stability in our health-care system for many decades. However, any organization that has a stabilizing influence can also have a stifling influence. If health organizations are to contribute to quality health care, they must develop: (1) more adaptability to health personnel and their needs; (2) more simplicity for ease of understanding by the patient; and (3) more flexibility in adjusting to local community needs. Health organizations should be like chameleons in conforming to their surroundings.

THIRD-PARTY PAYERS

With more and more third-party payers, with the federal government a third-party payer, with 80 percent of health care now involving a third-party payer, the inevitable result will be that more funds will be available and a greater quantity of health care will be purchased. Our society seems to feel that when a quality deficit exists, we must inject large doses of quantity. This method rarely works, but we seem determined to try it again and again. We pour billions of dollars into the system each year, and the amounts are increasing each year. Yet we are not even approaching that basic goal of bringing the people into the system; that is, all those who need care, at the time they need it, and for the services they need. Dollars are not the principal deterrent to people in need entering the health-care system; nor is the amount of health services available the principal impediment to attaining optimum quality health care. Rarely has our society wanted anything that we did not get, in a quantitative sense. We have apparently chosen the third-party payer as the method of paying for health care. More health care will probably be the result, but the patient will be less involved in determining the need for, and the quantity and nature of, the health care he receives.

But how do third-party payers influence quality? Certainly the most talked-about third-party payer these days is the federal government through the Social Security provisions. This program represents the greatest effort by any one third-party payer to enhance standards of care. Unlike so many third-party payers, the program is doing more than merely pouring dollars into the health-care system, and that is

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commendable. In time, the program will become the largest major influence on quantity, and could be a major influence on quality. In an effort to advance the quality of service, the program has introduced many important new concepts, but it has placed major emphasis on the institution or the agency as the guardian of quality. This approach will have a major beneficial effect on basic minimal standards, but quality will improve only when this emphasis is shifted to the individual health professional. The core, the center, the focal point must be the people who perform the services, coupled with a system of peer review.

PEER REVIEW AND QUALITY

Peer review has existed for some time but it has been more of an exercise than a practical, meaningful force. The Medicare program has, indeed, recognized and provided for peer review; in the field, however, peer review is treated like the country cousin, superficially recognized but generally ignored. Nor has peer review received adequate attention from the health professions. We should do more than accept peer review; we should demand its full implementation. We have the most to gain from its implementation and the most to lose from its absence. Effectively and forcefully administered, peer review could justify the elimination of many of the generally ineffective and cumbersome regulations that surround our provision of services.

In the presence of third-party payers, peer review is more than desirable; it is mandatory. The time has passed, and appropriately so, when the provider of health care and the patient could get together, determine the quantity of care, the nature of the care, and the cost of the care, and then dictate all those determinations to the third-party payer. On the other hand, no one would accept determinations made solely by the third-party payer. Thus, the logical solution is neutral, voluntary peer-review bodies. However, peer review will be effective and valuable only when it is just that: a review of services by persons especially knowledgeable about the service. Physician services must be reviewed by physicians. Physical therapists must be involved in the review of physical therapy services.

Peer review will have a beneficial impact on quality when the present approach of simply reducing quantity is altered. Effective peer review must be involved not only with *over*-utilization, but must also give counsel on *under*-utilization. It must not only judge the appropriateness of care, but must also be the advocate of optimum care.

The physician-patient relationship will become a triangle of physician-patient-third-party payer, and a similar triangle must emerge for other health professions. The peer-review body must be the arbitrator, the proponent of temperate, value-defendable, quality health care.

Abdicating this role to anyone else, especially government, will paralyze the advancement of quality, and will destroy the motivation, responsibility, and initiative of the individual.

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THE INDIVIDUAL HEALTH PROFESSIONAL

The individual health professional is the only indispensable component of quality health care. This statement is not intended to downgrade the value of the other components. A review of organization standards reveals clearly that those standards are, essentially, a composite of the standards of the various health professions. But what are these standards of the professions? The obvious ones are laws and ethical principles. Although I recognize the need for these and will later emphasize their

value and importance, these standards are aimed principally at the bottom, at that "miserable 5 percent" of all health professions which, either by intent or lack of ability, fail to provide a reasonable, valuable, meaningful service. For the other 95 percent, these sometimes legal, sometimes voluntary guidelines serve as little more than occasional reminders. The vast majority of physical therapists are intuitively aware not only of right and wrong, but also of good and better. Our greatest enemy is being mesmerized by habit. The greatest inhibiting force to quality health care is individual acceptance of the status quo, of traditional methods as being adequate, let alone exceptional.

Before specifying some of the ways the individual physical therapist can influence quality health care, some comments should be made about the team approach. An ill wind blew this terminology into our vocabulary. The phrase *team approach* implies games, coaches, captains, and players. Interprofessional relations are hurt by this shuffle of determining who will be what. True professionals do not need such childlike motivations to work together. Interaction is what we are seeking: each professional group recognizing its need for, the special competencies of, and its dependence on, the other groups. Our goal will not be expressed on a scoreboard. Our goal is comprehensive health care. This goal will be achieved when each individual participant is given, and has the competence to accept, singular responsibility for the needs of the patient within his professional sphere.

How can physical therapists, as individual human components of quality health care, advance this elusive concept? Three of the many ways are: (1) self-exertion; (2) exemplary behavior; and (3) self-regulation.

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Self-exertion

The expression *self-exertion* does not mean that physical therapists should attempt to assume any role, any task, or any phase of service that exceeds their competence. On the whole, they do not display enough backbone in saying no when they witness and are involved in treatment procedures which are less than adequate. Physical therapists need to be more the masters of their service, responsible and liable for that service when it is not appropriate. Therapists too often lean on the phrases "It's what the doctor ordered" or "just following directions" to rationalize their activities. No sane interprofessional relationship can be based on performing or directing services which are inappropriate. But more than that, physical therapists should be the chief proponents of improving service. This activity will, on occasion, cause them to be in conflict not only with the medical structure, but also with the administrative structure. The conflict may even cost them their positions. But any situation that demands performance at less than optimum is not a worthwhile position. Physical therapists are collaborators in a form of fraud.

We all know that some hospital departments are little more than day-care centers for malingerers and that some home-care agencies do little more tangibly than the local welcome wagon. Some nursing homes have 40 to 50 percent utilization patterns for direct physical therapy service. Some physical therapists work full time in extended-care facilities with fewer than one hundred beds, which is about as justifiable as Clark Kerr teaching in a nursery school.

The fact that these situations are legal, and that third-party payers, such as Medicare, may inadvertently encourage these patterns, does not justify physical therapists who participate

in them. Collectively, therapists can only decry them. Only the individual therapist can stop them, in his situation, in his community, and, more specifically, in his own work situation. Some forces, supposedly legitimate organizations, agencies, and government components, demean and detour therapists from quality care. But poor physical therapy service occurs only in the presence of the therapist, and without him will cease. He, and only he, can cause poor service to stop—or to improve.

Exemplary Behavior

One purpose of a profession is to propagate itself, in order to improve the breed. If therapists are to be participants in advancing quality health care, they must be sure that those who follow them are not merely as good as they are. They must be better. Education is not the end, but just the beginning of this process. The continuing education, the habit patterns, the motivation to make good practices better among those entering the profession will originate with today's therapists. The question is, Are they individually that exemplary?

Physical therapists have more reason to display leadership in the area of rehabilitative and restorative services than anyone else. They have every reason to be the hub rather than the spoke of the wheel, not for the purpose of self-gratification but simply because they have more to offer than anyone else. As a general rule, they have more accrued experience and knowledge in this area, and yet they share that knowledge with others less than most other groups. The cause of quality health care would be richly enhanced if therapists shared some of their knowledge. Much of the knowledge they take for granted would be interpreted by many other health professionals as significant edification.

Self-regulation

Self-regulation and laws are vital ingredients, and each profession must promote them.

Whether organized medicine or any of its components, or anyone else, carries the impression that they were responsible for establishing physical therapy's high standards, ethical principles, or legal limitations is unimportant. What *is* important is that therapists know that those groups had little to do with it. The physical therapy profession's high standards of competency and practice are high because therapists caused them to be. Their ethical standards are stringent because they and they alone chose this level of self-discipline. The practice acts that include the requirement for a referral relationship with physicians and careful delineation of scope of service, consistent with educational preparation, were not inflicted upon therapists. They themselves *chose* that these laws exist and insisted on their restrictive provision.

Physical therapists have also provided the practical leadership in the development and maintenance of educational standards. This fact is stated not to cause friction with the honorable and respected profession of medicine, a group with whom physical therapists enjoy exceptionally amicable relations, but to emphasize the fact that therapists have a rich heritage of fulfilling their professional obligation to provide competent, appropriate, high-quality care. This heritage places the demand on therapists, collectively, to continue the promulgation and enhancement of optimum standards of practice and, individually, to recognize extraordinary self-discipline and conduct as part of belonging to a learned profession. The health professions cannot protect the weak or tolerate the incompetent and unscrupulous.

The institution is but a shell, and its value depends on the people who fill it. The shell must be flexible, able to adapt to the community and the health personnel who function in it. Third-party payers can help or hinder quality health care. They should not have to do either.

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This responsibility belongs to, and should be totally assumed by, the health professions through collective peer review, professional standards, and individual competence.

Physical therapists can organize, interact, form teams, institutionalize, regulate, subordinate, cooperate, spend more, administer more. All these activities may have some value in providing high-quality health care. However, the only one indispensable component of high-quality health care is the competent individual therapist. He must, however, work in an atmosphere that does not group him into a faceless maze. High-quality care will occur when each participating individual can function to the capacity of his competency. Equally important, he must constantly be exposed to the scrutiny of the public and his peers, so that he is individually and personally challenged to function at his best.

Physical therapy is a relatively young profession, and must learn the meaning of the word *competency* before authority, and of the word *service* before status. The prime mover of quality health care is the individual health professional exerting his maximum potential under judicious restraint. What can the individual health professional do? The words of Nathan Hale answer that question well: "I am only one, but I am one. I can't do everything, but I can do something. What I can do—*that* I ought to do. What I ought to do, by the grace of God, I will do."

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