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In August 1990, The Robert Wood Johnson (RWJ) Foundation funded seven consortia of hospitals to begin systematic efforts to improve the quality of patient care. This event marked the culmination of a four-year process of exploration and program development that included the foundation’s first examination of other nations’ health care systems to extract lessons and potential models for the United States.

Before we embarked on this international comparison, foundation policy had long restricted grant-making activity to projects within the United States. The foundation’s trustees had to overcome the prevailing societal ethnocentrism, which contends that American health care has little to learn from other countries’ experiences. In 1987, foundation staff journeyed to Western Europe to explore geriatric care arrangements in Belgium and Scotland and quality assurance systems in the Netherlands and the United Kingdom. In this essay, we recount the lessons learned from one such experience: the development of a multisite program, called Improving the Quality of Hospital Care, which was based on a model originating in the Netherlands. Such lessons can inform others who are considering importing ideas and approaches from other nations’ health care systems.

In 1986, as concerns about the potentially adverse effects of cost containment mounted and as U.S. government and corporations grew more interested in quality assessment, The Robert Wood Johnson Foundation began to examine ways in which it might make a more explicit, visible investment in improving the quality of American health care. A review of the literature and consultation with knowledgeable individuals in the fields of quality assurance and quality improvement yielded several
observations: (1) Quality of care is a difficult issue to address, largely because of definitional problems and its interrelationship with cost issues; (2) numerous approaches and methods for improving quality abound, ranging from traditional quality assurance techniques to industrial quality control mechanisms (such as continuous quality improvement); (3) quality assurance efforts in hospitals have tended to be regulatory in nature and generally imposed by various external parties; and (4) many hospitals appear to lack the organizational framework and the resources for identifying or adopting new quality improvement methods.

In our search for new approaches to quality improvement, we encountered a Dutch physician, Evert Reerink, who had established a voluntary system of quality assurance in Dutch hospitals, based on ideas first expounded in the 1970s by John Williamson, then a physician at The Johns Hopkins University in-Baltimore, Maryland. The Dutch system seemed appealing for two reasons. First, it had a set of guiding principles that could complement already existing quality assurance and improvement approaches, and second, it possessed a framework for marshaling the resources necessary to assist hospitals.

The essence of the Dutch quality assurance model. At the center of the Dutch quality assurance program is the Dutch National Organization on Quality Assurance in Hospitals (known as CBO), which functions as a resource center, trainer, coordinator, consensus builder, and “trouble-shooter” for participating hospitals. Although membership is voluntary, more than 80 percent of Dutch hospitals participate. Each hospital develops its own quality assurance committee to identify quality concerns and to explore appropriate solutions. The program is physician-dominated—although other clinicians are involved—and has been implemented slowly so as to gain wide acceptance among staff. The Dutch fully expect that a generation will pass before this cooperative approach becomes institutionalized nationwide. The program’s activities are financed largely by participating hospitals.

Under the Dutch model, quality assurance is (1) the responsibility of professionals; (2) a voluntary activity; (3) problem-focused, rather than individual-focused; (4) organized as a continuous process within the institution, with the necessary resources and support to maintain it; (5) focused on increasing effectiveness and efficiency, not on fighting excessive costs or fraud; and (6) an open activity that, with certain precautions to protect privacy, can demonstrate positive results from quality assessment and improvement.¹

These principles seemed potentially applicable to quality of care issues in the United States. Specifically, hospitals are encouraged to see quality of care on their own terms; the process is continuous and proactive rather
than reactive; physicians are integrally involved and do not seem threatened; hospital participation is entirely voluntary; and hospitals can learn from one another without “reinventing the wheel.” By sharing financial responsibility for the program, hospitals can leverage their funds for quality improvement. Moreover, the basic approach and philosophy complement efforts already in use or being considered in the United States, from continuous quality improvement to clinical practice guidelines. Thus, on a theoretical level, the program appeared promising, but could it be adapted to the idiosyncrasies of American hospitals?

From Paradigm To Reality?

In contemplating how to adapt the Dutch model to the U.S. system, we considered several important organizational and cultural differences between the American and Dutch health care systems. The most obvious disparities were geography and the diversity of the two nations’ respective hospital markets. Clearly, a single national resource center modeled after CBO could not serve over 5,000 short-term general hospitals; regional centers would instead be necessary. Other key differences included the following. (1) In the Netherlands, the roles of hospital- and community-based physicians are more clearly delineated, with only the former group having admitting privileges, usually to a single institution. U.S. physicians often work in several hospitals or spend only a portion of their time in hospitals. The Dutch approach, therefore, would have to be adapted to involve physicians with multiple affiliations and competing demands on their time. (2) In the United States, local hospital competition can be fierce, making cooperative efforts seem more perilous than profitable. If the Dutch approach were to succeed in the United States, hospitals would have to be allowed to develop cooperative relationships in a way that encourages mutual trust. (3) American hospitals are under pressure to respond to payers’ and the public’s demands for information with which to judge quality. These forces are not at work in the Netherlands, where market share and external scrutiny of quality are not issues. The approach, therefore, would need to be flexible so that hospitals could judge quality in their own way and to the satisfaction of external parties. (4) The American preoccupation with technology and information is not prevalent in the Netherlands. Dutch hospitals have less complex information systems, and Dutch physicians use data less frequently for quality assurance than do their American counterparts. To be successful in the United States, the approach would have to rely more on data and on objective measures of quality.

With these issues in mind, we designed a consortium-based approach
in which hospitals would form cooperative groups and, with the assistance of a regional quality improvement resource center, would identify and solve problems as they saw fit. The resource center would act as an information clearinghouse, would provide data management capability, and would perform convening, technical assistance, and education functions consistent with the needs of consortium member hospitals.

To judge the practicality of this approach, we held a “reality testing” meeting that involved representatives of the American College of Physicians, American Medical Association, American Hospital Association, Joint Commission on Accreditation of Healthcare Organizations, Institute of Medicine, Council of Teaching Hospitals, and investor-owned multihospital systems, as well as scholars and clinicians interested in quality improvement. All expressed both strong interest and caution. Competitive forces would be formidable, they believed. Physicians would have difficulty accepting this approach with open minds and investing their limited time in such efforts. A voluntary, bottom-up approach amidst a regulatory environment might not have the leverage necessary to change practices. Hospitals are so entrenched in their traditional quality assurance activities that they may be unable or unwilling to implement such an approach requiring organizational change and the development of new norms for addressing quality. Despite these cautions, they nevertheless encouraged us to test the concept.

We next visited a cross section of American hospitals to hear their opinions of the proposed approach. We met with chief executive officers (CEOs); directors of medicine, nursing, and quality assurance; trustees; and staff of large and small hospitals in urban and rural areas. Almost unanimously, they were enthusiastic. Small community hospitals and academic medical centers were especially optimistic because, with this approach, hospitals could begin to address quality in ways meaningful to clinicians and patients and, by sharing resources, could avoid costly, duplicative efforts. They did not view competition, physician resistance, and congruence with other quality improvement activities as insurmountable obstacles. After considering both the enthusiasm and the caution expressed, the foundation’s trustees authorized an eighteen-month pilot program that, they hoped, would challenge the hospital industry in a positive way.

**Adapting The Dutch Model To U.S. Hospitals**

The Robert Wood Johnson Foundation’s announcement of the program specified a basic structure (the consortium and resource center) and a process (cooperative efforts with involvement of professionals at all
levels). It was deliberately nonprescriptive on other issues, such as content (that is, how quality is to be defined, the problems to be addressed, the tools to be used, and the solutions to be undertaken), organizational arrangements, the size of the region, and consortium composition. The more the program conformed to the demands of its own environment, the better would be its chances for viability.

Participation in the program required visible commitment from the chairman of the board, the CEO, and the directors of medicine, nursing, and quality assurance in each hospital. To assure that the projects would be truly voluntary, regulatory bodies were excluded from participation in the consortia or the resource centers. Participating hospitals also were required to move beyond their existing quality assurance activities to undertake new approaches to improving patient care.

The program is slowly evolving, with the recognition that a “culture of cooperation” requires a long gestation period. We expect no quick answers to the questions of whether hospitals can work together and how they may best improve the quality of patient care. However, we hope to see the roots of this approach take hold, and we intend to learn about the advantages and pitfalls of transplanting a framework from another system, as the program moves into a five-year implementation phase.

Seven consortia of hospitals were selected for the pilot program from a pool of 111 applicants representing over 1,500 hospitals nationwide. The seven funded consortia are diverse, ranging in size from six to sixteen hospitals and covering regions both within and across states. Some are established entities that have worked together on other issues; others are forming for the first time. Consortium leaders include representatives of hospital associations, academic medical centers, and newly established free-standing organizations. Many hospitals are considering adopting variants of industrial quality control models to improve quality of care, but application of these concepts is not uniform, largely because hospitals vary in level of interest and readiness to undertake this approach.

The program’s eighteen-month planning phase was designed so that each consortium could develop cooperative relationships among its member hospitals, build up its resource center, and allow its members to begin pilot quality improvement projects. Even at this early stage, there are lessons to be learned about the viability of this approach and the challenges facing those who wish to work together on improving the quality of hospital care. For example, it appears that the organizational form and history of each consortium may dictate the relative emphasis that it is likely to place on various activities during its planning phase. Those with well-established expertise in resource centers, as is the case in academic medical centers, have devoted less effort to building resource capacity.
and instead have devoted greater effort to forging relationships among members. Conversely, those who have worked together in the past have spent less time on building relationships and relatively more on establishing a resource center.

The pilot quality improvement projects undertaken to date illustrate both the diversity of hospital interests and the breadth of concerns hospitals face in providing high-quality care. Examples include (1) comparison of blood transfusion reaction rates among hospitals to identify problems and the best practices; (2) assessment of ventilator use in small rural hospitals to develop guidelines; (3) multidisciplinary examination of statewide delivery of chemotherapy and radiation to oncology patients; (4) review of existing indicators of quality to identify those most relevant to the circumstances of member hospitals; (5) review of organizational structures within hospitals that facilitate or impede quality improvement efforts; and (6) assistance to member hospitals in examining and using mandated severity-of-illness measures in ways that improve delivery of patient care.

These activities have permitted member hospitals to identify both the benefits of consortium participation and the obstacles to collective action. Early lessons gleaned from these experiences are that access to other hospitals’ expertise can be of enormous benefit to individual institutions; ready access to a resource center can help hospitals avoid time-consuming information retrieval; sharing data among institutions is a complex but not insurmountable task; organizations change slowly and require skilled assistance in that process, even in the presence of tremendous enthusiasm; and the cooperation required to balance diverse needs and requests of many hospitals is easier to obtain than expected.

So far, the U.S. version of the Dutch model has some unique features. It is developing faster, although there is no evidence that the process of change can be hurried successfully. Physicians are central but not the sole actors in this approach. And true to U.S. technology-worshiping culture, the use of data is key to quality improvement efforts in each U.S. consortium. These features suggest that the approach initiated in the Netherlands has already taken on many distinctly American traits. We await clear evidence that this hybrid has adapted well enough to survive in the United States without losing the properties that make it a potentially viable and effective means of improving quality of care in hospitals.

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