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Editorial

Are we sufficiently aware of the complexity of systems and the need for a systemic approach to evaluating quality?

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These days, the term 'quality assurance' can be found in any presentation of a private or public healthcare institution, and primary health care is no exception. However, one often forgets to emphasise that the evaluation of quality is the result of assessing a given subject (e.g. a treatment outcome) or phenomenon (e.g. a treatment process). Quality assessment is thus a procedure that shows to what extent the properties of products, services and systems meet the quality criteria of the auditor (i.e. the user, consumer or participant). Therefore, quality assessment always contains the auditor's subjective opinions, which means that, in evaluating quality, certain differences and contradictory findings regarding individual elements, processes, and the entire healthcare system are inevitable and legitimate. This must be taken into account at the very outset of designing quality audit projects and in managing various aspects of healthcare quality.

In primary health care, quality improvement is a necessary and inevitable process. This initiative and demand is also presented in the World Health Organization (WHO) strategy 'Health for All by 2000', as well as in the healthcare plans of many countries.

Unfortunately, the paths to improving quality are often fragmented, not only along the vertical axis, where different criteria apply for the primary, secondary and tertiary levels, but also along the horizontal axis. Thus, one encounters projects intended to evaluate the quality of work performed by individual subgroups of primary healthcare providers – that is, from nurses, occupational therapists, physiotherapists and physicians to managers of healthcare organisations. In this, too little attention is paid to systems theory, which studies complex phenomena. One of the features of this theory is that it demands an interdisciplinary and transdisciplinary approach to evaluating quality elements – that is, the simultaneous and synergetic application of expertise, methods and tools of various disciplines. This theory also emphasises that by taking a partial approach (even though scholarly) one loses insight into the true essence of phenomena.

Another key premise of this theory is that any individual observer or researcher actually studies the image of a given phenomenon through his or her own perception and not merely the objective reality of the phenomenon itself. In line with this premise, observers must be aware of the impact of their values, knowledge and expertise on their research. They can best reduce this impact by identifying it and clearly defining the subjective background of their observation.

One cannot overlook another dimension of health care: that it is essentially a service. In the service sector, the market mechanism of regulating demands is extremely important; this mechanism adapts to the financial abilities of users, the community and the state. In designing quality-evaluation projects, quality assessment must be planned along the following three axes: economic, social and professional. The economic aspect of quality primarily refers to ensuring accessibility and availability of a specific form of healthcare service, and to the ability of an individual or a group of people to financially afford this service. Social quality can primarily be assessed by the users of healthcare services themselves. Professional quality remains in the domain of healthcare providers with various forms of self-monitoring and team quality control.

How can one handle everything described above in everyday practice? Take the example of treating a cancer patient at the primary healthcare level. Problems crop up even in reviewing the data, especially if one seeks to prepare a comprehensive analysis that covers all of Europe. It is well known that more than one in three people living in Europe develop some form of cancer during their lifetime and that the incidence is slowly on the increase, mainly due to ageing of the population. What percentage of this third of Europeans will significantly use primary healthcare services? Is it true that one general practitioner on average sees only one

new case of lung cancer each year (the same is said to apply to colorectal carcinoma)? What is the number of the first and subsequent contacts connected with treating cancer patients at the primary care level? One can quickly establish that insufficient research is conducted at the level of primary care, and that the workload assessment arising from the existing figures may be biased.

In the case of a cancer patient, the economic quality component can be evaluated by analysing national plans for managing cancer patients. These generally include a comprehensive approach to cancer: prevention, early diagnosis through screening, treatment, and continuing care, including self-care and palliative care. Building of institutions, including research capacity and surveillance systems, is part and parcel of most policies. Many policies emphasise the patient perspective by describing (desired) patient pathways. Unfortunately, studies of national plans show that progress in cancer control is uneven across Europe. In addition, while the important contribution of primary care is generally acknowledged, variations between and within countries occur. To some extent, this may be a natural result of system differences: some health systems are predominantly hospital led and others are mostly primary care led. In assessing the economic component, it is necessary to highlight some features of treatment and management of cancer care (the clinical and organisational part of health care). By analysing national plans, is it possible to distinguish between primary healthcare-led countries and hospital-centred countries with a specialist orientation? To what extent do the national plans incorporate multidisciplinary issues such as cancer teams and the relationship between primary care and specialist care?

An important issue that should be discussed as part of a comprehensive evaluation of cancer patient management is how different European countries anticipate the shift in care needs for cancer patients, who will live longer due to improved treatment methods; whether these countries use a new policy or introduce care innovations in primary care – with or without ample medical support, but in almost all cases from the home situation of the patients. In other words, the main issue is the organisation or reorganisation of cancer care, with questions about decentralised or centralised, multidisciplinary, or transmural co-operation, and so on. Does the prediction that these developments will result in an extension of the tasks of primary health care and will therefore appeal to the knowledge and ability of primary care professionals reflect reality? How close is the co-operation between primary health care, secondary health care, and specialist care? The answers to these questions are vital to interpreting the social quality component.

The professional quality component can be assessed by studying the content and application of clinical guidelines and other tools to improve the quality of cancer care. Guidelines for palliative care at the primary level represent a special area. In which countries are the guidelines for co-operation between caregivers and cancer patients available, and what is their content? In addition, it is necessary to carefully study how communication with the patient takes place at the primary level and, last but not least, evaluate to what extent self-care is practised.

The process of producing this Position Paper can be read on the website www.euprimarycare.org/. We are well aware that, without extensive study or only on the basis of selected literature, we risk studying the image of this phenomenon through our own perception rather than studying its objective reality. We can be affected by our values, knowledge, experience and acquired expertise. In order to analyse cancer-patient treatment at the primary level as comprehensively as possible, we would like to invite readers to convey information on methods for treating cancer patients in individual European countries. We will be pleased to receive any answers to the questions posed in this editorial. Anyone who wishes to actively participate in this situational analysis can write to us at kdrmed@mf.uni-lj.si. On behalf of all of the authors, I would like to thank everyone who will help provide a comprehensive view of care for chronic cancer patients in Europe.

The purpose of this editorial is to draw attention to the importance of understanding the complexity of healthcare systems in quality assessment, and to the inevitability of using a systemic approach to evaluating the quality of primary health care. This first and broadest level of meeting patients and users in health care will be valued and respected only if as many analyses as possible are available, on the basis on which the quality of processes and treatment outcomes will be assessed in a comprehensive manner. Let us apply this perspective in writing reports and research abstracts on projects taking place at the primary level.

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