

Quality Legislation: Lessons for Ontario from Abroad

Jérémy Veillard, Brenda Tipper and Niek Klazinga

Abstract

While the Excellent Care for All Act, 2010 (ECFA Act) provides a comprehensive approach to stimulating quality improvement in healthcare, there are other examples of legislations articulating strategies aimed at the same goal but proposing different approaches. This paper reviews quality of care legislations in the Netherlands, the United States, England and Australia, compares those pieces of legislation with the ECFA Act and suggests lessons for Ontario in planning the next stages of its healthcare quality strategy.

Notable among the commonalities that the ECFA Act shares with the selected examples of legislation are mandatory reporting of performance results at an organizational level and furthering quality improvement, evidence generation and performance monitoring. However, the ECFA Act does not include any elements of restructuring or competition, unlike some of the other examples. Key to successful transformation of the Ontario healthcare system will be to propose a package of changes that will deal systematically with all aspects of transformation sought (including structural changes, payments systems and elements of competition), will garner support from all the actors, and will be implemented consistently and persistently. Benchmarking on the implementation and impact of reforms with the countries presented in this paper may be an additional important step.

Quality of care is a key focus of health system reforms, and in recent years many countries in the Organisation of Economic Co-operation and Development (OECD), including Canada, have developed strategies aimed at improving healthcare quality and patient safety (OECD 2010). Øvretveit and

Klazinga propose that national strategies for quality of care can be targeted at different types of health system stakeholders: professionals, healthcare organizations, medical products and technologies, patients and financiers (World Health Organization Regional Office for Europe 2008). The generic elements of these strategies relate to legislation and regulation, monitoring and measurement; assuring and improving the quality and safety of individual healthcare services, and assuring and improving the quality of the healthcare system as a whole. Various combinations of quality improvement approaches (such as quality assessment, standards-based quality management, team problem solving, and patient and community participation) are suitable for these functions as part of the respective quality strategies.

In Ontario, the Excellent Care for All Act, 2010 (ECFA Act) (Legislative Assembly of Ontario 2010) proposes to address quality improvement in healthcare by (in addition to existing accountability relationships) mandating quality committees at an organizational level to monitor and report on the quality of healthcare services, tying the compensation of top executives to the achievement of targets linked to their quality improvement plans, mandating regular patient and staff experience surveys, and formalizing patient relations processes and healthcare organizations' patient declaration of values. Further, the legislation strengthens the role of an arms-length organization to government, Health Quality Ontario (HQO), in stimulating evidence-based healthcare reforms and quality improvement in the province. This new role comes in addition to the initial role of HQO, which was to report regularly to the public on the performance of the Ontario healthcare system. This legislation builds on other legislations such as the Public Hospitals Act (Ministry of Health and Long-Term Care [MOHLTC] 2012a) and the Local Health System Integration Act, 2006

TABLE 1.
Summary of examples of health system legislations directed at improving quality of care

Jurisdiction	Legislative initiative	Current status	Key features related to/mechanisms for quality improvement
England (NHS)	National Health Services Act (2006) Establishes Primary Care and Foundation Trusts and a framework for monitoring and regulating them	Implemented, with adjustments and changes to Quality Accounts and reporting each year developed by Monitor	Mandatory public reporting of performance measures by NHS Foundation Trusts, supervised by Monitor
	Health and Social Care Bill (introduced in 2011) Broad-scope initiative	Passed into law in 2012	Increased competition with patient choice Introduction of value-based payment Enhancing role of Monitor, including provision for regulating competition and supporting integrated care and continuity of services
Australia	Broad-scope reform built on the agreement of state and federal governments in 2010	Restructuring legislation passed (2010) Legislation establishing payment authority and defining the role of quality organizations passed (2011)	Restructuring of hospitals into small networks and, changes in funding arrangements between national and state governments Establishment of performance monitors and mandatory reporting regimes Establishment of funding and payment authorities
The United States	Patient Protection and Affordable Care Act (2010) Broad scope reform initiative to address access to health insurance, quality and cost of healthcare	Legislation passed in 2010 Implementation of many quality features begins in 2012	Combination of mandatory and voluntary performance measures reported to the public Structural delivery changes – piloting Accountable Care Organizations with mandated quality activities and incentives for cost control
The Netherlands	Health Insurance Act (2006) Broad scope restructuring building on market competition Objectives include improving efficiency, quality, innovation and responsiveness to consumers	Abolished Hospital Planning Act, removing central controls on capacity New law to license hospitals based on quality and transparency of hospital administration and financial management	Regulated competition and consumer choice to improve quality and efficiency Regulators/supervisory agents include a competition authority, a care authority and public health inspectorate Removes central control on hospital capacity Revisions to hospital payment system Plans to allow for-profit hospital care

(MOHLTC 2012b), and addresses the role of professionals, healthcare organizations and patients in improving the quality of healthcare services, when using the classification proposed by Øvreteit and Klazinga (World Health Organization Regional Office for Europe 2008).

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Still, if the ECFA Act provides a comprehensive approach to stimulating quality improvement in healthcare, there are other examples of legislations articulating strategies aimed at the same goal but proposing different approaches. This paper reviews legislations of quality of care in select countries (the Netherlands, the United States, England and Australia), using the framework proposed above, and suggests lessons for Ontario in planning the next stage of its healthcare quality strategy.

Quality Legislation Abroad

Over the past few years, a number of countries have embarked on high-profile reforms implemented through significant legislative initiatives. While the scope of some of these initiatives is often broad, many are driven by concerns about quality of care and include key features directly targeting healthcare quality. These broad-based initiatives seem the most appropriate source of lessons for future developments in Ontario, since the ECFA Act aims at driving system change through a quality improvement, evidence-based paradigm. The most significant examples selected by the authors are England, Australia, the United States (US) and the Netherlands, which present common features and a shared concern to drive change through multi-pronged policy interventions all related to quality improvement. We expand below on legislation in the four countries and present a summary in Table 1. In addition, there is also targeted legislation regulating many aspects of healthcare delivery including, for example, training and licensing of professionals, certification of organizations, and mandating the public reporting of specific performance indicator results such as hospital-acquired infection rates (Aiken et al. 2010; Halpin et al. 2011).

England

The National Health Service Act of 2006, which set up Primary Care and Foundation Trusts, established Monitor as the organization responsible for authorizing and regulating National

Health Service (NHS) Foundation Trusts (Parliament of the United Kingdom 2006). Since 2010, Monitor has required the Trusts to report annually both to Monitor and to the public on a set of quality accounts (Monitor 2010). The objective of quality accounts reporting was to encourage a focus on quality improvement and engagement with clinicians and patients. The reports were also intended to provide an opportunity for Foundation Trusts to describe performance and their improvement goals, supplemented by benchmarking information to identify quality outliers. Monitor's scope of reporting on quality of care was then limited to Foundation Trusts, those financially successful hospitals who had earned independence from central control, and to a particular activity – the regulation of the healthcare market.

Monitor's role will evolve significantly now that the Health and Social Care Act, which received royal assent on March 27, 2012, has passed into law (Parliament of the United Kingdom 2012). This act is a broad-based NHS reform bill covering a number of policy areas including promoting choice and competition, changing the emphasis of performance measurement to clinical outcomes, better integration of healthcare and services, reconfiguring services and improving quality of care, among others. As a consequence of the act, Monitor will now become an economic regulator, with objectives to promote effective and efficient providers of health and care, promote competition, regulate prices and safeguard the continuity of services (www.parliament.uk 2012). Therefore, regulation of healthcare in England is now comprised of two main elements: regulation of the quality and safety of care offered by healthcare providers, currently undertaken by the Care Quality Commission, and regulation of the market in healthcare services, currently the responsibility of Monitor (in relation to Foundation Trusts) and the Department of Health.

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Australia

In 2010, the most far-reaching reforms to the health system in Australia since Medicare were initiated through an agreement by the Council of Australian Governments (COAG 2012). The objective of the agreement is stated as “improv[ing] the health outcomes for all Australians and the sustainability of the Australian Health system.” The agreement provides for major structural reforms that include establishing the national government as the majority funder of public hospitals, formation of small hospital networks to be run by local clinicians,

and funding of these networks on an activity and performance basis. Changes to structures and governance were designed to be more responsive to local needs, provide for greater transparency and improve the quality of care. Although the federal government's initial restructuring proposal in March 2010 was highly controversial – it proposed to move both money and power away from an area traditionally controlled by the states – it was ratified at the COAG meeting in April 2010, and implementation of the agreement began soon after.

As part of the implementation, The National Health Reform Act was passed in 2011, implementing the changes in funding and establishing independent performance authorities – the Australian Commission on Safety and Quality in Health Care and the National Performance Authority – to oversee the national standards. The legislation also mandated reporting of nationally comparable performance data for local hospitals and health services.

The United States

The healthcare system reform effort in the US culminated with the passage of the Patient Protection and Affordable Care Act (PPACA) in early 2010. The act includes many features that are intended to support quality improvement throughout the system and improve healthcare efficiency and effectiveness. From a federal perspective, the notable features with respect to quality improvement are implemented using the federal government's Medicare program purchasing power. They include mandating public reporting of performance information by institutions caring for Medicare patients and provision for a pilot accountable care organization program for delivering care to Medicare patients. Accountable care organizations would include multiple care providers, be accountable for both the cost and the health outcomes of an assigned population, and be required to improve care to reach cost and quality targets set by the payer (i.e., Medicare) (Deloitte 2010). Key among the seven capabilities that an accountable care organization must demonstrate is the capacity to promote care quality, conduct quality improvement initiatives, measure and publicly report performance, report on costs and coordinate care (Singer and Shortell 2011). Accountable care organizations would be eligible for "shared savings" payments linked to performance on quality standards in five key areas: the patient/caregiver experience of care, care coordination, patient safety, preventive health and the at-risk population/frail elderly health (HealthCare.gov 2011a).

The PPACA also establishes a value-based purchasing



program for Medicare that is intended to provide a financial incentive to hospitals to improve quality of care. It requires public reporting of performance measures, starting with quality of care measures related to hospital-acquired infections and patients' perceptions of care among other areas for all patients receiving services from the hospital, not only Medicare patients (HealthCare.gov 2011b).

The Netherlands

Broad-based system reform legislation (The Health Insurance Act) became effective in 2006. While the structural changes addressed in this legislation focused on the operation of the health insurance market and contracting with care providers, these steps were taken with the objective of improving quality, efficiency and responsiveness to consumers through increased competition and loosening of some central government regulation (Maarse 2009). This legislation was set within the broader context of other pre-existing quality-focused legislation that includes regulation of the provision of care by profes-

sionals – revalidation, disciplinary processes and peer review. A pre-existing Quality Act also established four requirements that all providers of care must fulfil and that echo some features of the ECFA Act, including publishing both an annual report detailing the quality control policies they have applied and reports on the quality of care they have delivered (Legido-Quigley et al. 2008). Current policy debates address the introduction of performance payment in various healthcare sectors and the merging of several quality-related agencies in a new National Quality Institute that should be functioning by January 2013.

Common Themes in Recent Quality Legislation and Lessons for Ontario

There are a number of common themes among the examples reviewed:

- They contain elements of mandatory public reporting of quality performance measures.
- They include the establishment of new or empowerment of existing authorities to supervise or regulate reporting and to provide centralized support for quality improvement.
- They include changes to payment and funding methods for healthcare organizations, specifically rewarding or incenting quality.

In addition, some of these pieces of legislation include requirements to establish and meet specific performance targets. Two of the broad-based initiatives (England and the Netherlands) also have measures that promote increased competition among providers of care, while the US provision for accountable care organizations requires different providers to cooperate to coordinate care.

The Affordable Care Act mandat[es] public reporting of performance information by institutions caring for Medicare patients...

Finally, reforms in England, Australia and the Netherlands all have means of promoting or supporting patient choice to improve quality. They also speak to lessening centralized, bureaucratic control of health systems and increasing local and organizational autonomy (with provision for public reporting and accountability for results) as a way to stimulate quality improvement.

It is important, though, to recognize that leadership and governance arrangements (comprising elements of priority setting, performance monitoring and accountability) have little commonality in a study of seven countries – including

two of the countries presented in this paper (England and the Netherlands) (Smith et al. 2012).

The ECFA Act aims at ensuring that appropriate structures and processes driving quality improvement at a system level are in place and requires mandatory public reporting of results and outcomes to drive improvement. It shares a number of common features with the legislations presented above, notably mandatory reporting of performance results at an organizational level and furthering the quality improvement, evidence generation and performance monitoring role of an existing organization (Health Quality Ontario). However, it does not include any elements of restructuring or competition, unlike some of the other examples. What appears to be unique in the ECFA Act is a repeated emphasis on the use of data, information and, in particular, evidence in supporting planning, quality improvement and performance measurement. More importantly, perhaps what is unique in this legislation is the wide support it received from a variety of health system stakeholders and from political parties (Canadian Patient Safety Institute 2010; Ontario Hospital Association 2010; Ontario Medical Association 2010).

The broad-based legislations presented above share the same objective of implementing and sustaining a culture of continuous quality improvement but include larger structural changes than the ECFA Act. In some of the examples reviewed, the structural and funding changes proposed made the legislation controversial and were contentious, as in the cases of the US and England and, to some extent, Australia. In contrast, the ECFA Act received broad support from system stakeholders and a renewed commitment from health system actors. In a context of hard budgetary constraints, some of the plans to deal with structural changes to the healthcare system in Ontario will have to be delineated to define a path that would improve patient-centredness, build on the culture of quality improvement nurtured by the ECFA Act and drive efficiency gains. Ontario's Action Plan for Health Care (Government of Ontario 2012) and the report of the Commission on the Reform of Ontario's Public Services (also called the Drummond Report) (Ministry of Finance 2012) propose a number of ways that could build on the ECFA Act and help design a full package of reforms required to transform the system into one that is patient-centred, focused on quality improvement and affordable. The key – and the difficulty – in successful transformation will be to propose a package of changes that will deal systematically with all aspects of transformation sought (including structural changes, payments systems and elements of competition), will garner support from the actors, and will be implemented consistently and persistently. Benchmarking on the implementation of reforms with the countries presented above may be an additional important step toward a successful transformation of the Ontario healthcare system. Indicators supporting this international benchmarking function may include change in clinical outcomes for indica-

tors related to governments' priorities, support of reforms by clinicians and healthcare leaders, progress in the area of patient safety, and progress in reducing avoidable hospitalizations and hospital readmissions. **HQ**

About the Authors

Jérémy Veillard, PhD, is the vice-president, research and analysis at the Canadian Institute for Health Information.

Brenda Tipper, MHS, is senior program consultant, health system performance at the Canadian Institute for Health information.

Niek Klazinga, MD, PhD, is professor of social medicine, Academic Medical Center, University of Amsterdam, the Netherlands.

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