QUALITY OF HEALTH CARE FOR THE DISADVANTAGED

Robert H. Brook, M.D., Sc.D.,* and Kathleen N. Williams, M.A.

ABSTRACT: Literature review points out that: (a) differentials in health status between the disadvantaged and the nondisadvantaged persist, often to a large degree; (b) differentials in the overall amount of care received are less striking now than heretofore, but standardization by level of need demonstrates measurable discrepancies in health services provided to the disadvantaged compared with the nondisadvantaged; (c) the quality of health care for the disadvantaged is not strikingly poorer than care for the nondisadvantaged, but, in view of demonstrable shortcomings in the quality of health care in general, this is not viewed as a positive statement; and (d) attempts to improve quality of care for the disadvantaged have not had the hoped-for impact. Four new avenues are suggested for possible further research: increased patient responsibility, increased consumer knowledge, financial accountability, and quality assurance activities. Because of the likelihood of only marginal changes in health status, rigorous evaluation of any experimental program is emphasized.

During the last decade, many attempts have been made by private and governmental bodies to improve the health of the American people. In general, these efforts have focused on improving the health of members of disadvantaged groups and have included such diverse activities as building OEO health centers, developing maternal and infant care programs, and financing care for the elderly. During the last few years, a different movement, concerned with assuring high quality care for all people, has produced efforts such as quality assurance activities in health maintenance organizations, the Professional Standards Review Organization program, and the medical care evaluation program of the Joint Commission on the Accreditation of Hospitals. Consideration of these two issues, i.e., improving the health of disadvantaged groups and improving the quality of care for all people, has led to two policy-relevant questions: "Can the health of disadvantaged groups be substantially improved by assuring that a high level quality of care is delivered to them?" and "Can the quality of care delivered to disadvantaged groups be improved?" The purpose of this paper is to review some available data pertinent to both these issues and to suggest some ideas for future research.

THE MEASUREMENT OF QUALITY OF HEALTH CARE

What is quality? The impact of the quality of care on health must be placed in perspective. Health is influenced by five factors: genetics, environ-
Quality of care is in turn influenced by two other sets of variables: system characteristics and provider competence. System characteristics include patient knowledge, health care financing and organization, and the number, kind, and distribution of providers as key variables. Provider competence includes the provider's personality, knowledge, and behavior as important variables. Although quality care is a necessary element to achieving good health, it is by no means sufficient; indeed, improving the technical quality of care to its maximal level may produce only marginal benefits, in view of the impact on health of other variables.

For research purposes, quality of care should not be equated with the quality of life; achieving quality of life ideals (such as happiness, individual autonomy, or liberty) is not the sole responsibility of the personal health care system. Neither should quality of care be equated simply with the manpower and the facilities produced or available; more physicians per population does not necessarily guarantee better quality of care. Rather, quality of health care might better be defined as the sum of the technical