Healthcare quality management in Switzerland – a survey among providers

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Summary

BACKGROUND: In the last decade assessing the quality of healthcare has become increasingly important across the world. Switzerland lacks a detailed overview of how quality management is implemented and of its effects on medical procedures and patients’ concerns. This study aimed to examine the systematics of quality management in Switzerland by assessing the providers and collected parameters of current quality initiatives.

METHODS: In summer 2011 we contacted all of the medical societies in Switzerland, the Federal Office of Public Health, the Swiss Medical Association (FMH) and the head of Swiss medical insurance providers, to obtain detailed information on current quality initiatives. All quality initiatives featuring standardised parameter assessment were included.

RESULTS: Of the current 45 initiatives, 19 were powered by medical societies, five by hospitals, 11 by non-medical societies, two by the government, two by insurance companies or related institutions and six by unspecified institutions. In all, 24 medical registers, five seals of quality, five circles of quality, two self-assessment tools, seven superior entities, one checklist and one combined project existed. The cost of treatment was evaluated by four initiatives. A data report was released by 24 quality initiatives.

CONCLUSIONS: The wide variety and the large number of 45 recorded quality initiatives provides a promising basis for effective healthcare quality management in Switzerland. However, an independent national supervisory authority should be appointed to provide an effective review of all quality initiatives and their transparency and coordination.

Key words: healthcare; quality management; patient safety; Switzerland

Introduction

Assessing the quality of healthcare has become increasingly important over time [1–5]. The demand for improvements in terms of transparency of healthcare quality from different stakeholders such as insurance companies, patient organisations and health policy-makers is increasing [1, 3–10].

Since the publication of “To err is human: building a safer health care system” in 1999, public interest in patient safety has been growing across the world. Patient safety has become a growing economic and political objective [4, 6, 10, 11]. Solid epidemiological data have shown that iatrogenic adverse events are a major problem [5, 9, 10, 12]. Adverse events are defined as unintended complications caused by medical mismanagement rather than by the patient’s underlying disease [11, 13, 14]. According to a study of the Swiss Patient Safety Foundation involving 3,983 patients, adverse events occurred in approximately 21.4% of all hospitalised patients [15]. In studies originating from France and Canada, adverse events were found in 2.9–16.6% of hospitalised patients and resulted in death in 20–57% of cases [11, 13]. In the United States, approximately 98,000–180,000 deaths per year are estimated to be caused by adverse events [3, 5, 15, 16], of which around 90% are thought to be due to failed control systems and procedures [11, 13, 16]. Approximately 37–51% of adverse events have been judged to be preventable [13]. According to Hayward et al., medical errors constitute the fifth most common cause of death in the United States [43].

In Switzerland, quality management originates in the health insurance act, which became effective in 1996 [18, 19]. Quality management includes organisational measures to improve products, processes and performances of all types. Healthcare providers and stakeholders are required to perform quality assessments, but no further specifications were made with regard to the time of introduction or the form this performance should take [18]. Up to now, the act has not been fully implemented due to a lack of coordination between the different actors [9, 18, 20].

To ameliorate patient safety, a systematic analysis of medical procedures as well as an organisation designed to coordinate quality surveillance is needed [2, 13, 16, 21, 22]. Switzerland currently lacks a detailed overview of how quality management is implemented and its effects on medical procedures and patients’ concerns [9, 18, 20]. Quality initiatives are performed by medical societies, the govern-
ment, hospitals, insurance companies and patient organisations [9].

The aim of the present study was to examine the systematics of quality management in Switzerland by assessing the actors and collected parameters of current quality initiatives.

Methods

In summer 2011, we contacted in writing all the medical societies in Switzerland, the Federal Office of Public Health (www.bag.admin.ch), the Swiss Medical Association (FMH, www.fmh.ch) and the head of Swiss medical insurance providers, in order to obtain detailed information on current quality initiatives. In addition, we conducted a web-based search using academic (Pubmed) and public search engines (Google) with the terms “quality initiative”, “patient safety programme”, “patient satisfaction assessment”, “quality project” and “Switzerland”. All quality initiatives featuring standardised parameter assessment were included. The exclusion criteria were inconsistent assessment of parameters (e.g., a random sample) and a short assessment period (less than one year).

After completion of the search we sent a quantitative questionnaire to the person in charge of each identified quality initiative (fig. 1). Based on 15 free text questions on general information and 14 questions on the implementation of parameters (yes/no), information was obtained on the quality indicators, periodicity and type of statistical evaluation, permission to access the data and overall cost of each initiative (see supplementary material). The questionnaire was pretested among a small group of doctors for readability and acceptability. If incomplete or incomplete information was obtained, additional data were acquired by means of a telephone interview when possible. If an answer was refused, the data were entered on the basis of information from the quality initiative’s public website (registered accordingly in table 1). The person in charge was contacted a maximum of three times.

Information on scientific output was obtained from each quality initiative’s public website and the search engines Google and Pubmed with the terms “name of quality initiative” and “database”. Scientific output was defined as the publication of data in a peer-reviewed journal or a dissertation accepted by a university.

Results

In all, 51 quality initiatives were found, but six no longer existed, had been terminated in the planning phase, had ceased or were non-existent in Switzerland (table 2). A total of 45 quality initiatives remained available for the present report (table 1).

The oldest quality initiative was the Arbeitsgemeinschaft Schweizer Frauenkliniken (ASF), which was conducted by the Swiss Society of Gynaecology and Obstetrics and was founded in 1981 [29]. Most of the quality initiatives were instituted in the first decade of the 21st century (n = 31) [23, 26, 27, 31–34, 39–43, 45–53, 56, 58, 60–67], and 24 were initiated between 2005 and 2011 [23, 26, 31–34, 39–43, 45, 46, 48–53, 61, 63–66]. A quality control section featured in 27 initiatives for data monitoring purposes [23–30, 34, 35, 38, 41, 42, 44, 46, 47, 49, 52, 53, 58, 60–64, 66, 67]. The time required to register a patient’s data varied between the quality initiatives from half a minute [38] for an implant register to 5,760 minutes for a seal of quality [23].

Initiator and financing

Regarding the implementation of the 45 quality initiatives available for our study, 19 were powered by medical societies [24, 25, 28, 29, 31, 32, 36, 42, 43, 45–47, 55, 57, 58, 60–63], five were hospital-based [26, 44, 53, 64, 65], 11 were launched by non-medical societies [23, 27, 33–35, 38, 39, 48, 49, 51, 67], two by the government [30, 52], two by insurance companies or related institutions [37, 41] and six by non-specified institutions [40, 50, 54, 56, 59, 66]. The costs of 14 of the 45 quality initiatives were covered by the medical society or hospital in charge [24, 28, 29, 34, 42, 44–46, 49, 53, 60–62, 64]. Another two quality initiatives were funded entirely by the government [30, 52] and one by an insurance company [41]. Governmental co-funding existed in one case [27], whereas seven quality initiatives were partly financed by sponsors [32, 33, 37, 50, 57, 63, 67]. Two quality initiatives were funded entirely by private sponsors [25, 66], such as pharmaceutical companies and private hospitals. Self-financing existed in four cases [23, 38, 40, 51]. Two initiatives were financed by a non-medical society [35, 48]. For 12 out of 45 quality initiatives, the funding source remained elusive [26, 31, 36, 39, 43, 47, 54–56, 58, 59, 65].

Types of initiative and their specifics

In total, 24 medical registers [24–26, 28, 29, 36, 41, 42, 45–47, 49, 52, 53, 55, 57, 58, 60–66], five seals of quality [23,37,38,43,56], five circles of quality [32–34, 54, 59], two self-assessment tools [40, 51] and seven superior entities [27, 30, 35, 44, 48, 50, 67] were found. One checklist [31] and one combined project [39] were also found. Of the medical registers that were found, 13 were run by surgical or anaesthesiological societies [24, 28, 29, 36, 42, 46, 53, 55, 58, 60, 62, 64, 65], while eight were concerned with medical or psychiatric illnesses [25, 26, 45, 47, 57, 61, 63, 66]. Three initiatives were not associated with a specific specialty [41, 49, 52]. Over half of the medical registers (16/24) collected data on patients’ general characteristics (e.g., sex, age, diagnosis, comorbidity, therapies carried out and their related morbidity and mortality) [26, 28, 29, 41,
Table 1: Quality initiatives in Switzerland (ordered alphabetically).

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of initiative</th>
<th>Foundation</th>
<th>Number of cases in 2009</th>
<th>Hospitals/ outpatient facilities involved</th>
<th>Quality monitoring</th>
<th>Acquisition effort approx. (minutes)</th>
<th>Scientific output</th>
<th>Response</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACREDIS</td>
<td>Seal of quality</td>
<td>2006</td>
<td>2,500</td>
<td>NR</td>
<td>Yes</td>
<td>5760</td>
<td>No</td>
<td>Yes</td>
<td>[23]</td>
</tr>
<tr>
<td>ADS (Anästhesiedatenbank der Schweiz)</td>
<td>Register</td>
<td>1996</td>
<td>249,399</td>
<td>36</td>
<td>Yes</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[24]</td>
</tr>
<tr>
<td>AMIS Plus</td>
<td>Register</td>
<td>1997</td>
<td>30,088</td>
<td>36</td>
<td>Yes</td>
<td>40</td>
<td>Yes</td>
<td>Yes</td>
<td>[25]</td>
</tr>
<tr>
<td>Anaphylaxie Register NORA</td>
<td>Register</td>
<td>2006</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>15</td>
<td>Yes</td>
<td>Yes</td>
<td>[26]</td>
</tr>
<tr>
<td>ANQ (Nationaler Verein für Qualitätsentwicklung)</td>
<td>Superior</td>
<td>2000</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[27]</td>
</tr>
<tr>
<td>AQC (Arbeitsgemeinschaft für Qualitätssicherung in der Chirurgie)</td>
<td>Register</td>
<td>1995</td>
<td>6,000,000</td>
<td>70</td>
<td>Yes</td>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
<td>[28]</td>
</tr>
<tr>
<td>Arbeitsgemeinschaft Schweizer Frauenkliniken (ASF-Statistik)</td>
<td>Register</td>
<td>1981</td>
<td>2,000,000</td>
<td>55</td>
<td>Yes</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td>[29]</td>
</tr>
<tr>
<td>Checkliste SGOT-SSOT (Checkliste Schweizer Gesellschaft für Orthopädie und Traumatologie)</td>
<td>Checklist</td>
<td>2010</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[31]</td>
</tr>
<tr>
<td>Cirdoc</td>
<td>Circle of quality</td>
<td>2006</td>
<td>NR</td>
<td>125</td>
<td>No</td>
<td>10</td>
<td>No</td>
<td>Yes</td>
<td>[32]</td>
</tr>
<tr>
<td>CIRIS (Critical Incident Reporting System)</td>
<td>Circle of quality</td>
<td>2006</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[33]</td>
</tr>
<tr>
<td>D-SENT (Database-surgical and endoscopic novel technologies)</td>
<td>Register</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[36]</td>
</tr>
<tr>
<td>EQUAM</td>
<td>Seal of quality</td>
<td>1999</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[37]</td>
</tr>
<tr>
<td>Good Medical Practice</td>
<td>Seal of quality</td>
<td>1983</td>
<td>NR</td>
<td>17</td>
<td>Yes</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[38]</td>
</tr>
<tr>
<td>H+ Qualität</td>
<td>Combined</td>
<td>2005</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[39]</td>
</tr>
<tr>
<td>Hippokratist</td>
<td>Self assessment</td>
<td>2007</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[40]</td>
</tr>
<tr>
<td>KIMSA (Kooperatives Integrationsmanagement der Suva mit Ärztennetzen)</td>
<td>Register</td>
<td>2008</td>
<td>NR</td>
<td>380</td>
<td>Yes</td>
<td>10</td>
<td>No</td>
<td>Yes</td>
<td>[41]</td>
</tr>
<tr>
<td>Mammaproject</td>
<td>Register</td>
<td>2010</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td>[42]</td>
</tr>
<tr>
<td>MDSi (Der minimale Datensatz der SGI)</td>
<td>Seal of quality</td>
<td>2007</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[43]</td>
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<tr>
<td>MECON</td>
<td>Superior</td>
<td>1998</td>
<td>48,914</td>
<td>28</td>
<td>Yes</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[44]</td>
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<tr>
<td>Nephrologie Register</td>
<td>Register</td>
<td>2006</td>
<td>6,200</td>
<td>78</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
<td>[45]</td>
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<tr>
<td>OP-Statistik Plastic Surgery</td>
<td>Register</td>
<td>2009</td>
<td>NR</td>
<td>35</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td>[46]</td>
</tr>
<tr>
<td>Outcome Messung in der Psychiatrie</td>
<td>Register</td>
<td>2002</td>
<td>9,000</td>
<td>28</td>
<td>Yes</td>
<td>30</td>
<td>NR</td>
<td>Yes</td>
<td>[47]</td>
</tr>
<tr>
<td>Q-Monitoring</td>
<td>Superior</td>
<td>2009</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
<td>[48]</td>
</tr>
<tr>
<td>Q-Reporting(Qualitätsreporting)</td>
<td>Register</td>
<td>2008</td>
<td>1,500,000</td>
<td>120</td>
<td>Yes</td>
<td>0</td>
<td>Yes</td>
<td>Yes</td>
<td>[49]</td>
</tr>
<tr>
<td>gools</td>
<td>Superior</td>
<td>2008</td>
<td>105</td>
<td>4</td>
<td>NR</td>
<td>0</td>
<td>No</td>
<td>Yes</td>
<td>[50]</td>
</tr>
<tr>
<td>Quali-med-net</td>
<td>Self assessment</td>
<td>2005</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>NR</td>
<td>Yes</td>
<td>Yes</td>
<td>[51]</td>
</tr>
<tr>
<td>Qualitätsindikatoren der Schweizer Akutpatient</td>
<td>Register</td>
<td>2009</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>0</td>
<td>No</td>
<td>Yes</td>
<td>[52]</td>
</tr>
<tr>
<td>Quoex</td>
<td>Register</td>
<td>2006</td>
<td>600</td>
<td>1</td>
<td>Yes</td>
<td>10</td>
<td>Yes</td>
<td>Yes</td>
<td>[53]</td>
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<tr>
<td>Réseau Delta</td>
<td>Circle of quality</td>
<td>1992</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[54]</td>
</tr>
<tr>
<td>SALTC (Swiss Association of Laparoscopic and Thoracoscopic Surgery)</td>
<td>Register</td>
<td>1990</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>No</td>
<td>[55]</td>
</tr>
<tr>
<td>sanaCERT</td>
<td>Seal of quality</td>
<td>2001</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[56]</td>
</tr>
<tr>
<td>SCQM (Swiss Clinical Quality Management in Rheumatic Diseases)</td>
<td>Register</td>
<td>1996</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>No</td>
<td>[57]</td>
</tr>
<tr>
<td>SIRIS</td>
<td>Register</td>
<td>2002</td>
<td>10,000</td>
<td>10</td>
<td>Yes</td>
<td>0.5</td>
<td>No</td>
<td>Yes</td>
<td>[58]</td>
</tr>
<tr>
<td>SIS (Störungen im System)</td>
<td>Circle of quality</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>[59]</td>
</tr>
<tr>
<td>Spine Tango</td>
<td>Register</td>
<td>2002</td>
<td>7,061</td>
<td>1</td>
<td>Yes</td>
<td>1.5</td>
<td>Yes</td>
<td>Yes</td>
<td>[60]</td>
</tr>
<tr>
<td>Swiss Noso</td>
<td>Register</td>
<td>2009</td>
<td>28,097</td>
<td>NR</td>
<td>Yes</td>
<td>NR</td>
<td>Yes</td>
<td>Yes</td>
<td>[61]</td>
</tr>
</tbody>
</table>
25, 26, 28, 29, 34, 35, 49, 51, 53, 55, 57, 60–65, 67), while 14 of the 18 academically active projects were medical registers [25, 26, 28, 29, 49, 53, 55, 57, 60–65], of which eight were launched by groups specialising in surgery [28, 29, 53, 55, 60, 62, 64, 65].

**Discussion**

In Switzerland, healthcare quality management is conducted by a wide variety of operators with different backgrounds and goals. Of the parameters assessed, only a few studies focused on patient satisfaction, post-treatment care and cost evaluation. There has been very little scientific evaluation of the data they obtained.

In agreement with the current literature, we found a wide variety of quality initiatives, conducted by various institutions and lacking adequate safety policies [68–70]. Measuring quality is important in improving medical care and preventing adverse events [1, 2, 4, 13, 70–73]. During the last decade, efforts to improve the quality of care have been increasing across the globe [2, 73, 74]. The concept of continuous quality improvement arose and has become more and more important [75, 76], as our findings confirmed. Care is growing increasingly complex as patients are treated by several providers. Structural changes which allow better communication and coordination are assuming growing importance [13]. Similarly to our study, the methodological approaches and objectives of quality initiatives are highly variable [68, 72, 77]. Quality initiatives may share a name but use totally different methods, measurements or resource investments [77, 78]. The effectiveness of quality improvement interventions is therefore variable, depending on the context in which they are used [78]. This makes it difficult to interpret the results in terms of a comparison of the effectiveness of quality initiatives [77]. The literature on the standardisation of quality improvement is divided in terms of its possible benefits. Walseh et al., for example, state that standardisation would still lead to highly variable outcomes [78]. Nevertheless, a framework of baseline components should be implemented in all

| Swiss Spine | Register | 2005 | 10,000 | 10 | Yes | 2 | Yes | Yes | [62] |
| Swissvasc Registry | Register | 2003 | 25,000 | 22 | Yes | 5 | Yes | Yes | [63] |
| TARC (Traumaregistry of acute care) | Register | 2008 | 800 | 1 | Yes | NR | Yes | No | [64] |
| TARN (Trauma Audit & Research Network) | Register | 2009 | 400 | 1 | NR | NR | Yes | No | [65] |
| Ticino Cancer Registry | Register | 2010 | NR | NR | Yes | NR | No | Yes | [66] |
| Verein Outcome | Superior | 2000 | 600,000 | 80 | Yes | 60 | Yes | Yes | [67] |

Response = answer obtained from the person in charge of the quality initiative. NR = not reported.

**Table 2: Quality initiatives inexistent/ceased/aborted.**

<table>
<thead>
<tr>
<th>N°</th>
<th>Name</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ARPAZ (Arbeitsgemeinschaft für Patientenzufriedenheit)</td>
<td>Ceased</td>
</tr>
<tr>
<td>2</td>
<td>Autopsie</td>
<td>Inexistent in Switzerland</td>
</tr>
<tr>
<td>3</td>
<td>Betriebsinterner Umgang mit Zwischenfällen</td>
<td>Ceased</td>
</tr>
<tr>
<td>4</td>
<td>Collaborative Breakthrough Series</td>
<td>Inexistent in Switzerland</td>
</tr>
<tr>
<td>5</td>
<td>Reanimationsdatenbank der Schweiz</td>
<td>Ceased</td>
</tr>
<tr>
<td>6</td>
<td>Schweizer Brustkrebsregister</td>
<td>Aborted in planning phase</td>
</tr>
</tbody>
</table>
quality initiatives if they are to be made more comparable [77, 78].

As national quality indicators are lacking in Switzerland, there is, according to the Organisation for Economic Co-operation and Development [79], a want of transparency and effectiveness with regard to quality. This may be the result of the many individual care providers who are conducting their own quality management programmes. There is still a deficiency in terms of coordination between the individual projects, despite the growing importance of coordination in the light of increasing healthcare costs [79].

We showed that the potential of registers as a quality control tool has been widely recognised in Switzerland. Medical registers are known to improve care and outcomes for patients with specific diseases while implementing evidence-based and well-researched guidelines [69, 71, 75]. They make it possible to analyse patterns of care and monitor patient safety [69, 71]. Also, they can be used to evaluate the effectiveness of healthcare interventions [69, 76]. Fonarow compared American registers of heart failure and detected a trend towards reduced in-hospital mortality, post-discharge deaths and rehospitalisation rates, as well as a significant reduction in the length of hospital stay due to the use of registers [69]. Often the same Web-based platform is used by different hospitals or practices [69, 71, 73]. This makes it possible to provide continuous feedback to each operator, as well as progression reflection and improvement on the internal quality of care [76].

Furthermore, it provides the option of benchmarking personal results against other participating institutions [14, 69, 76]. In order to optimise quality of care it is important to capture post-discharge outcomes, as the continuous adoption of treatment guidelines improves long-term clinical outcomes [13, 71]. We found that post-discharge care and outcomes are barely assessed in Switzerland. Further efforts in the context of primary care in the hospital setting are needed.

Patients’ satisfaction with their treatment is rarely assessed. Patient feedback evaluation has two main objectives: first, to monitor performance, and second, to improve the quality of care [80]. However, the effects are inconsistent. Whereas a study in the United Kingdom found an improvement in the quality of care through patient feedback, a French study showed that a patient-centred quality improvement initiative did not lead to systematic amelioration of care [80–82].

The most common problem lies in the non-specificity of patient declarations [80]. Evaluation of patient satisfaction might contribute to an improvement in the quality of care, but it needs to be combined with other measurements [80].

In spite of increasing efforts to improve patient safety, only a few systems exist for reporting of errors and adverse events [70], which is in agreement with our results. As data are generally scarce, an evaluation of current patient safety or trends over time is impossible [70]. Medical errors are often under-reported due to fear of reprisal and concerns regarding lawsuits [12, 73, 76]. An open culture of discussion in an open-minded environment might therefore be a first step towards increasing the incident report rate [70, 73].

According to Farley et al., the reporting system should capture both adverse events and critical incidents [70]. A wide range of staff throughout hospital or practice should participate in the reporting and discussion process with guaranteed anonymity [12, 70].

The public release of performance data is becoming increasingly common [4, 8]. We found that more than half of the initiatives disclosed their data. In the literature, contradictory opinions regarding public release of performance data are discussed [1, 4, 8, 74]. According to Lester et al., publication of performance data can lead to measure fixation, tunnel vision or misinterpretation if the indicators measure a specific process while missing the larger objective [83]. Even if the data represent the reality, differences in the external environment make misinterpretation likely [84]. Nevertheless, according to Fung et al., public release of performance data improves quality by providing greater transparency and accountability of healthcare providers through two approaches [74]: first, by improving the providers’ motivation to increase the quality of care, and second, by allowing comparison between the different initiatives on offer [74, 85]. However, public disclosure of performance data is rather insignificant as a factor influencing consumer choice [8, 85]. Personal experience or recommendations by neighbours or friends have been found to be more important [1]. An argument in favour of the public disclosure of performance data is its use as a tool to control costs and regulate the healthcare system [8, 85].

According to Rubenstein et al., promoting quality management programmes to improve the scientific approach to healthcare delivery is important [68]. In addition, a scientific advance is required with regard to cost containment [68]. We found that scientific evaluation and the publication of the data assessed are scarce in Switzerland. Similarly, quality projects throughout the world are currently underrepresented in the literature [68]. Although the results of such research would be of vital interest, evidence from clinical practice is lacking [16, 86].

There are some limitations to our study. As data were collected using a public search engine, it cannot be determined with certainty whether or not all of the existing quality initiatives were included and how representative the sample is. With regard to the voluntary basis of the replies, incompleteness of information cannot be excluded.

We collected no data on whether the initiative was performed in the outpatient care setting or the hospital setting. Therefore, no further specifications regarding improvements to specific settings can be made. As our questionnaire was based mainly on hospital-derived quality initiatives, it is possible that important features of programmes in the outpatient setting have not been assessed. It was not determined whether data were disclosed publicly or internally. Therefore, no conclusions can be drawn regarding the amount of public data disclosure in Switzerland. Even though our questionnaire asked about financial contributors, it is possible that not all sponsors were declared.

Conclusion

The wide variety and the large number of 45 recorded quality initiatives provides a promising basis for effective healthcare quality management in Switzerland. However, only a part of the quality initiatives assessed are coordinated by superior entities, while the specifics are rarely
known and difficult to explore. Swiss healthcare costs are still increasing, meaning that quality management and evaluation of the effectiveness and cost of all types of treatment has become increasingly important. Only a few of the existing quality initiatives focus on cost evaluation. Moreover, while barely any initiatives conduct post-hospitalisation follow-ups in order to measure long-term outcomes, this would be of great importance in evaluating long-term efficiency of care. Finally, emphasis should be placed on the hitherto inadequate scientific output of quality initiatives, as research is a means to improve patient satisfaction and quality of care. A continuous comparison of the results obtained with the current literature would facilitate continuing medical progress.

In short, an independent national supervisory authority should be appointed to effectively influence all quality initiatives and their transparency and coordination.

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Figure 1. Study design.

Register
[24-26,28,29, 30,41,42,45-47, 49,52,53,55,57, 58,60-66]
(n = 24)

Circle of quality
[32-34,54,59]
(n = 5)

Seal of quality
[23,37,38,43,56]
(n = 5)

Self assessment
[40,51]
(n = 2)

Superior entity
[27,30,35, 44,46,50,57]
(n = 7)

Checklist
[31]
(n = 1)

Combined
[29]
(n = 1)

Quality initiatives
(n = 51)

Quality initiatives available for evaluation
(n = 45)

Inefficient/delayed/abort ed
Table 2
(n = 6)