The 30 years of ISQua’s existence and efforts have witnessed dramatic increases of knowledge about, and attention to, quality of health care. The ISQua founders had a vision of what was needed to promote quality and how this could be achieved through international cooperation and collaboration. And, the founders have continued to work to make this vision a reality. However, while much has been achieved in 30 years, there is still much more to be done. There is still need for vision for the future and visionaries who will carry things forward.

Eight founders and early members of ISQua summarized what they had learned about quality in health care since the first Udine meeting 30 years earlier. There was a remarkable consensus, based on 240 years of practical experience and empirical evidence, that the problems lie less in defining and measuring visions, expectations and standards than in effective change management. It is important to recognize that the weakness of improvement strategies usually lies not in the strategies themselves, but in how they are implemented in a local context.

From personal experience of what does and does not work, and often supported by formal publications, the ISQua veterans proposed pointers for improvement at institutional and system level.

**Culture**

Policymakers and managers should involve patients and users of health services wherever possible in defining, measuring and improving standards of performance. Experience has shown that patients and users can contribute valuable information to be used for performance improvement. Caution needs to be exercised to ensure that patient and user involvement is not just a pre-election promise or a token gesture but is truly harnessed for healthcare improvement.

Clinical professions should accept responsibility for professional accountability, self-regulation, clinical governance, and contribute to creating effective management systems. Clinicians, especially doctors, must fully understand the importance of this responsibility and contribution to the quality of the healthcare system.

Organizations should develop a culture of quality in which responsibility for quality and quality improvement threads throughout the organization—from bottom up to top down. Quality must be everyone’s implicit responsibility.

The culture of quality within an organization cannot be built overnight but must be carefully constructed through education, discussion and cooperative actions to achieve full organizational commitment.

**Policy**

Theoretical models are important for a comprehensive view of the system. Avoid the distraction of relabelling and transient fashions in quality; planning, organization, direction and control require the same cycle of feedback and improvement, whatever the label. Beware rebranding committees, journals or associations, reinventing wheels and forgetting corporate learning.

Beware of envisaging technical solutions as a panacea for complex behavioural problems. For example, the electronic patient record has been touted as the solution for documenting patient care data. However, such solutions can also accelerate failures in documentation. Similarly, published clinical guidelines on their own may have little effect on clinical practice. And, performance indicators, while often fairly easy to establish, cannot function (and are often useless) without reliable, accessible, timely source data.

Health ministries and international donors should follow up on action plans that have resulted from major health system projects, often focused on the improvement of quality. They should evaluate the impact of policies and strategies and publish findings to promote learning and avoid replicating failures in other countries.

**Incentives**

Financing is the most powerful driver of improvement; beware of service strategies driven by healthcare insurers and purchasers rather than by evidence of effectiveness.

Avoid perverse incentives; align financial, regulatory, professional, educational and public pressure on individuals and organizations.

Question whether more funding always equals better quality. Some emerging international evidence appears to indicate that decreased funding may not result in decreased quality based on data from quality indicators.
Organization within institutions

Beware of labelling an individual with total responsibility for quality (e.g., the quality officer); quality is everybody’s business and must clearly be seen to be part of each individual’s responsibility.

Integrate clinical practitioners in the quality management system. They must be included in a meaningful and practical way, and their accountabilities must be clearly established. Integrate working within and between teams, specialties, and disciplines; errors and safety issues most often occur in communication and handover between shifts, teams, and departments.

Move the organization’s quality efforts to focus as closely as possible on the patient–provider interaction. Though global activities are needed at the organizational level to ensure policy adoption and decrease variability within the organization, patient–provider interactions and related quality activities seem to be more effective at the department level where most interactions actually occur. Patient-centred care strategies are not widely systematized, and more evidence is needed on how to implement them effectively in practice.

Organizations and governments need quality leaders if they are to have quality healthcare organizations and systems. The need for leadership for quality is an issue that is receiving increasing international recognition. All the major international quality/safety reports call for leadership able to lead effectively for the creation of quality organizations that deliver quality care and that implement ongoing quality improvement.

Relationships

Differentiate the responsibility, authority, and interaction of healthcare regulators (to enforce basic safety in all institutions) and voluntary programs (to promote continuous improvement and recognize excellence). Competition and overlapping between them are counterproductive, confusing, and often destructive. It is also a feature of many health systems.

Resources

Ministries and donors should agree realistic timescales for changing culture, behaviour, and health systems; health reform may need years of technical assistance and usually outlasts ministers and governments. Health reform needs ongoing, long-term commitment if desired results are to be achieved.

Clinicians need protected time to participate effectively in internal audit, peer review, and continuing education. As well, they need time to participate in other more general quality improvement activities.

Universities and academics should introduce relevant knowledge, attitudes, and skills related to quality and quality monitoring in undergraduate and postgraduate curriculum. This should extend into continuing professional development and medical education. Many medical schools have yet to begin preparing the workforce of tomorrow.

Managers and designers should ensure that data and information systems are integrated and accessible to staff for multiple applications, including internal audit and performance management; many institutions have systems that are devoted to finance and reimbursement rather than to feedback and improvement.

Health ministries and insurers should avoid collecting and hoarding routine data related to quality which they do not use or share with the institutions which provided the reports.

Addressing the challenges

In many countries, governments look for quick-fix solutions for health systems, achievable within the parliamentary life cycle; in many countries—especially lower and middle income countries—international donors and technical agencies willingly offer ‘deliverables’ defined by time and money. Rarely does that investment extend into systematic implementation, follow-up, and evaluation of impact of injectable solutions. Rarely is the degree of knowledge transfer assessed as part of the outcome. Rarely is there careful assessment of the impact of the investment on quality of care.

Journals and conferences celebrate completed studies that demonstrate improvement, but they give less attention to analysing and learning from past failures, or to scanning the horizon for future challenges. The Udine reunion suggests that the hierarchy of evidence in health care should acknowledge the power of systematic anecdote.