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The Quality of Children's Health Care Matters — Time to Pay Attention

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High-quality health care matters for all children — and is critically important for some. In many ways, health care for children serves the same function as health care for adults. For example, the incidence of chronic illness in children is increasing, resulting in a substantial illness burden with a substantial cost.¹ How well chronic conditions are managed profoundly influences both short-term and long-term outcomes, not only for common diseases such as asthma but also for rarer conditions such as cancer, cystic fibrosis, and sickle cell disease.²

Many aspects of children's health care have no parallel in adult health services.³ The disproportionate rates of poverty among children and adolescents mean that children's health services must address health needs despite limited resources. Because children are dependent on caregivers and community resources, providers of child health care must enhance the competency of these caregivers and coordinate a broad array of community services. Children's health care settings typically involve developmental surveillance; the identification of sensory, learning, and behavioral disorders; and monitoring for family violence

and child abuse. Optimally, such programs provide evidence-informed counseling that promotes positive behaviors related to individual health, family functioning, and psychological and developmental well-being — all of which are beyond traditional health care services — with effects that last for the rest of a child's life.

The article by Mangione-Smith et al.⁴ in this issue of the *Journal*, although addressing traditional health care services and ambulatory care only, nonetheless presents sobering findings. The authors examined hundreds of indicators of quality, developed according to complex but well-established methods from RAND and UCLA, emphasizing the most common reasons for which children use the health care system. They intentionally studied a full spectrum of ambulatory services — at least within the traditional health care domains of preventive care, care for acute conditions, and care for chronic conditions — for children of all ages.

Their observations are shocking: the right services appear to be carried out less than half the time. Services are not delivered when they should be, or they are delivered when they should not

be. In general, the same dismal story was apparent in all aspects of pediatric ambulatory care examined.

But can we be confident that these results accurately reflect the quality of services currently delivered to children? The research has limitations. The percentage of parents willing to allow the researchers access to their child's medical information was low and probably not random. The methods, by necessity, excluded less-prevalent conditions, even though such conditions may carry a higher risk and may account for substantial rates of disability and death. In addition, the study did not address the broader public health functions of child health care we describe above.

Mangione-Smith et al. relied on the written medical record. The much higher adherence rate for medication use (which clinicians are more likely to chart accurately) than for other modes of care might suggest that the lower adherence rates reflect failures in charting rather than in performance. In addition, the panels developing the quality criteria did so nearly a decade ago, and the data reported are from the period 1996 through 2000.

The investigators worked hard to minimize the effect of potential shortcomings on the validity of their overall findings. They used sophisticated statistical methods to adjust for nonresponse. They focused on indicators likely to be documented in medical records. The consistency of the findings and the care with which the study was done overall indicate that the general observations are indeed valid. Although one could challenge the precise 46.5% value for the percentage of overall care delivered, one cannot avoid the main observation that there exists a yawning chasm in the quality of health care provided to children.

The prevalent view of children's health care is that problems related to quality occur much less often than in other fields. The dramatic improvements in outcomes — the near-elimination of many vaccine-preventable illnesses and vast improvements in the survival of children with severe conditions such as cancer or congenital heart disease — perhaps have lulled us into the belief that all is well. But these new data, together with those from many other studies across both inpatient and outpatient settings, make it clear that problems with the quality of children's care are

as severe as those occurring elsewhere in our health care system.⁵⁻⁹

Improvement of the performance of the children's health care system will require systemwide change; entreaties to hard-working and deeply caring pediatricians, family physicians, nurses, and hospital staff to work harder and care more will not succeed by themselves. Effecting change will require leadership across all levels and systems involved in children's health care and a wholehearted commitment by those who deliver care, pay for care, and receive care. Leaders must recognize that the current system does not meet children's needs and must take action.

A complete application to pediatric care of the approaches outlined by the Institute of Medicine in its report *Crossing the Quality Chasm*,¹⁰ which are increasingly applied by Medicare and other agencies, might begin to address the glaring deficiencies noted by Mangione-Smith et al. These approaches include a systematic focus on patients with chronic conditions, the effective application of health information technology, an emphasis on patient-centered and family-centered care, organizational transparency and improved capability, and the more appropriate alignment of incentives coupled with the use of valid quality measures. Publicly financed insurers and health plans for children have given much less attention to quality than has Medicare — in large part because Medicaid and the State Children's Health Insurance Program (SCHIP) are joint federal-state programs. Indeed, states have been highly reluctant to consider using common health care standards in the Medicaid and SCHIP programs. SCHIP is currently up for renewal; fortunately, some of the recent bills call for enhanced efforts toward quality of care in SCHIP and companion Medicaid programs.¹¹ These proposals include the development of common measures; support for children's health care information technology; and execution of demonstration projects addressing obesity and the medical home.

This concerted effort is necessary but not sufficient to address the broader context and role of children's health care and to address the most pressing challenges of diagnosis and treatment — such as for obesity, mental health, and disparities in access to care. Even more innovation is needed in new models of care and in the substantive redesign of the organization, human re-

sources, finance, and delivery of health services underlying the children's health care system.^{12,13} Although these strategies extend far beyond the data in the article by Mangione-Smith et al., the data themselves may provide a clarion call for action.

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