Public reporting on the quality of healthcare providers: international experience and prospects

Prof. Dr. Mirella Cacace, Leuphana University Lüneburg, LSE Health and Social Care Formal Seminar Series, Wednesday, 09th May 2012
Overview

- What do we mean by public reporting?
- The pathways of change
- Public reporting in Europe / the US
  - Hospitals
  - Physician practices
- Effectiveness
- Considerations for implementation
Definition of public reporting

Performance-related information about non-anonymous providers disclosed to the general public by applying a comparative approach

It is not

- unsystematic feedback and open comments by single healthcare users in the mass media, e.g. qype, google
- data with paid access
- anonymous reporting, e.g. information bundled at the regional or national level

Public reporting is a

- strategy to promote transparency and informed choice of provider
- to stimulate quality improvement
- to hold providers accountable for the care they deliver
Pathways for improvement through public reporting

**Improvement through selection**

Comparative information enables the user

- Patient empowerment
- Informed choice, i.e. selecting providers according to quality criteria

=> Consumers ‘vote with their feed’, i.e. they select good performers and discard bad ones

‘Exit’ option, i.e. choice of provider required

**Improvement through change**

Comparative information enables the provider

- Comparison with peers
- Identification of the ‘expected’ level of quality and of areas of under-performance
- Avoidance of reputational damage
- Stimulus for quality improvement

‘Voice’ is complementary/alternative to ‘exit’

Source: Berwick et al. (2003)
Pathways for improvement

- Linked through provider’s self-awareness, reputation, market share
- Intrinsic motivation and appeals to professionalism vs. reputational damage => role for public reporting

Source: Shekelle (2009)
# Public reporting strategies in Europe and the US

## Information provided by the major reporting systems

### Denmark Sundhed.dk
General information for citizens and health professionals, Quality information on therapists (no GPs/specialists) and hospitals, development of indicators for selected conditions in The National Indicator Project

### England NHS Choices
General health information and information for patients how to navigate the healthcare system Quality information on GPs, hospitals, consultants, dentists

### Germany Weisse Liste (‘White List’)
General health information by Institute for Quality and Efficiency in Health Care Quality information on hospitals, physicians, nursing homes, and dentists (new) Patient Experience Questionnaire

### The Netherlands KiesBeter (‘Chose better’)
General health information, patient information on the healthcare system Quality information on hospitals, homecare, disability and nursing home care, maternity care, physiotherapy, medical care centres

### United States Medicare.gov
General health information, information about the Medicare programme Quality information at Hospital Compare, Nursing Home Compare, dialysis facility, home health, physicians (address only)
Regulatory frameworks for public reporting

- Framework regulation in quality assurance in all European public health insurance programmes, also in the US

- **Mandatory** public reporting in specific sectors and/or on single indicators, e.g. in the Netherlands and Germany

- Sickness funds in Germany obliged to make information understandable and comparable

- **Pay for reporting** in the public US-Medicare programme

- Incentive for public reporting through GPs’ participation in **pay for performance** in the UK (voluntary, almost 100% participate)

- **Voluntary** reporting in the Scandinavian countries, often initiated by government institutions
Dimensions of quality according to Donabedian

- **Structure: Attributes of the care settings.**
  - refer to the settings in which care occurs, including material resources (facilities, equipment); human resources (availability/qualification); administration structure.

- **Process: Use of resources.**
  - refer to the interaction between patient and provider, e.g. intervention rates/referral rates; treatment according to guidelines.

- **Outcome: Effects of care.**
  - denote the effects of care on the health status of patients and populations, such as morbidity or mortality; includes patient satisfaction/experience and satisfaction of staff.

Source: Donabedian (2005)
# Publicly reported indicators on hospital care quality

<table>
<thead>
<tr>
<th>Country</th>
<th>Website</th>
<th>Structure</th>
<th>Process</th>
<th>Outcomes</th>
<th>Composite Indices</th>
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a= feature is separate from the website  
b= not yet fully in operation
## Publicly reported indicators on physician practices

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<thead>
<tr>
<th>Country</th>
<th>Website</th>
<th>General information (i.e. size, language spoken, amenities)</th>
<th>Information about doctor(s)</th>
<th>Patient ratings: satisfaction /experience</th>
<th>Clinical indicators</th>
<th>Feedback option</th>
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Public reporting hospitals vs. physician practices

**Hospital care**
- Public sponsorship very common, data frequently complete
- Partial as well as comprehensive approaches to quality reporting

**Physician practices**
- Private non-profit or profit-oriented sponsors => advertisement
- Number and diversity of quality indicators restricted
- Patient perspective as the sole outcome indicator; self-selection versus systematic surveys
- Difficulty of reporting health outcomes (risk-adjustment) at the physician practice level => QOF ‘intermediate outcomes’
Effectiveness of public reporting

- Few evaluations from European countries, mainly from the US
- Difficult to isolate as it coincides with other quality measures, e.g. improved documentation

Selection pathway

- Low utilization rates of information, the referring physician and family & friends are the most important source
- New York State Cardiac Surgery Reporting System (NY CSRS) as an early example
- Information easy accessible (newspaper) and not complex or difficult to understand (mortality/volumes), but no effect on market share (Chassin 2002)
- Selection pathway might not be working particular well
Consumer choice model

Awareness Stage
Recall of receiving and seeing quality information
=> Patients often unaware of information

Knowledge Stage
Ability to interpret information correctly
=> Patients have difficulties in understanding information

Attitude Stage
Beliefs regarding quality information e.g. trust, value
=> Patients do not change, even when quality scores are low

Behaviour Stage
Selecting, switching
=> Less than 5% of patients acknowledged that information has influenced their choice

Need to better understand consumers’ choice behaviour.

Source: Faber et al. (2009)
Effectiveness of public reporting

Behaviour change pathway

- Providers have been most responsive to the publication of data
- Evidence pointing towards improvements in health outcomes, review studies e.g. Fund et al. 2008; Marshall et al. 2000
- E.g. Hannan et al. (1994) found a fall of risk-adjusted mortality in the NY CSRS of about 40% between 1989 and 1992
- Second pathway, threat of reputational damage, seems to be the more important driver for change
- However: incentive for gaming, e.g. poor performance in areas where quality of care is not measured, ambiguity in reported data, fabrication
Implementation of public reporting

- **Accessibility**
  - Most information is available on the Internet
  - Adapt to users needs, e.g. through interactive features
  - Access to the WWW varies across European countries
  - People with lower levels of education and elderly less likely to use the Internet

- **Indicators**
  - Quality of data: e.g. valid, reliable, sensitive to change, consistent
  - Comprehensive, e.g. coverage; mix of clinical indicators and patients’ view
  - Indicator needs to be fully under provider control

- **Consumer needs**
  - Bounded rationality vs. consumers’ desire for more information (maximum ≠ optimal)
  - Composite indices, aggregates at different levels
  - Tailoring to individual needs (search sequences, weighting options)
Implementation of public reporting

- Involve stakeholders: patients/ patient organisations and staff at all levels of organisation.
- Ensure that both clinical outcomes and patient satisfaction is measured.
- Search for options to aggregate to keep the number of indicators small (composite indices).
- Make use of independent benchmarks and averages.
- Take a longer term perspective and keep the system under constant review.
- Educate the users! Highlight the importance of continuous learning over one-off judgements about performance.
- Trust the users! Users have different preferences and they are able to weight trade-offs.
- Improve accessibility of information.
Many thanks for your attention!