

*Primary care in the United States***Profiling performance in primary care in the United States**

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Purchasers of health care in both the United States (governments, employers, health plans) and the United Kingdom (government) need to be able to measure the quality of services they are paying for.<sup>1</sup> Moreover, public concerns about the variable quality of health services have increased in both countries. Measuring the performance of primary care physicians and healthcare providers is one method of meeting these challenges.<sup>2,3</sup> We review the development of this approach (commonly termed "profiling") in the United States.

**Profiling performance**

Physician or provider profiling is an attempt to measure the performance of doctors and providers of health care by supplying interested parties with information on the structure, process, and outcomes of health care.<sup>4</sup> Its rationale is that analysing patterns of care will help to reduce the variation in performance among doctors and lead to improvements in the quality of health care.<sup>5</sup> Two main types of profiling are used in the United States. Clinical profiling examines doctors' styles of practice by looking at the types of treatment and services that they use and the outcomes of care. Economic profiling examines the financial aspects of a doctor's practice. Researchers in the United States have now developed many sophisticated tools for profiling physicians (see [bmj.com](http://bmj.com)).

Ideally, profiling should provide doctors with meaningful information on their clinical performance to help improve the quality of the services they provide. However, purchasers have largely developed physician profiling as a tool to control costs and ensure they are getting value for money, rather than as a method of measuring and improving the quality of care. Profiling has also been used for other purposes, including providing information to consumers to help in their selection of physician and healthcare plan (box 1).

One of the criticisms of profiling made by US physicians is its emphasis on measuring and reporting patterns of use of resources and costs of care. Doctors' professional bodies would like profiling to focus on measuring doctors' clinical performance. In contrast, health plans and regulatory bodies wish to extend profiling beyond cost data to include information such as patient satisfaction surveys and medical liability claims. Unfortunately, for a number of reasons (including the American Medical Association's focus on a system for profiling physicians that has now been abandoned), many doctors have been reluctant to become involved in developing profiling, and as a result its development has largely been determined by purchasers in both public and private sectors. Furthermore, most of the

**Summary points**

Physicians' performance is increasingly being profiled in the United States to release performance data to the public and make routinely collected data available to healthcare purchasers and regulators

The United Kingdom is likely to follow suit

To justify the burden and costs of profiling, close collaboration between physicians, healthcare organisations, and other stakeholders is needed

The performance measures used in profiling need to be standardised; duplication of effort needs to be minimised; and the objectives, measures, and methods used need to be transparent

Linking of hitherto disparate data elements such as diagnoses, pharmacy data, and laboratory results will increase the sophistication and coverage of physician profiling

physician profiles that are currently used in the United States do not meet the ideal criteria for profiles (box 2).

**Organisations involved**

Reflecting the structure of the US healthcare system, most of the organisations involved in profiling are private sector organisations. One of the most widely used profiling systems in the United States is the health plan employer data and information set (HEDIS), developed by the National Committee for Quality

**Box 1: How has physician profiling been used in the United States?**

- To provide physicians, medical practices, and hospitals with information on the cost and quality of their care
- To provide patients with information to guide their choice of doctor and to assess the quality of services they are receiving
- To provide health plans and health maintenance organisations with information to help them plan and monitor the utilisation, quality, network management, and accreditation of health services
- To provide employers and regulatory agencies with information to guide their decisions on issues ranging from publication of malpractice information to the choice of medical groups to serve in their networks



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Assurance. In turn, business groups, such as the Pacific Business Group on Health, often release profiling information on specific medical groups to the public. Other sources of information for profiling include medical records, clinical information systems, and patient surveys. For example, a standardised survey of health plan members, the consumer assessment of health plans, provides comparative data on health plans and is financed by the federal government.<sup>6</sup> Although the federal government may finance the development of such instruments, their implementation has been left largely to private sector organisations.

Collaborative efforts between clinicians represent another model, and one that may have particular relevance for the United Kingdom. Led by the Maine Medical Assessment Foundation, several organisations now provide mechanisms for clinicians not only to receive profiles but also to participate in their development and improvement.<sup>7</sup> Although these initiatives may lead to the development of more robust profiling, led by physicians in various specialties, securing funding may be difficult. For example, the project in Maine has now ended because it was unable to obtain sufficient support from doctors' professional bodies or from healthcare purchasers.

Such quality improvement programmes are likely to succeed, therefore, only when consumers are interested in the association between payments to healthcare providers and quality of care. The American Medical Association's physician led profiling programme foundered in 2001 because of cost over-runs and a questionable choice of profiling variables. The association is currently working with specialist societies to refocus its profiling efforts by specialty.

## Public disclosure

Some states and organisations in the United States have now started to make physician profiles available to the public.<sup>8,9</sup> The information published ranges from doctors' basic details—education, years in practice, any history of malpractice, etc—to patients' evaluations of physicians. This has generated considerable controversy about, for example, the scientific validity of listing malpractice claims (not verdicts)

against physicians and the impact of releasing information on patient satisfaction with medical groups.<sup>10</sup> Despite this, there have been calls to increase the amount of publicly available information by releasing all relevant clinical information on physicians' performance, together with data on mortality, patient satisfaction, and other important characteristics of clinical practice.

Public disclosure of comparative information on managed care organisations and hospitals is now well established in the United States, but until relatively recently data on individuals or small groups of physicians have not been released. Large organisations, such as hospitals and managed care organisations, have the resources to help deal with the adverse publicity that sometimes follows the release of profiling information, but physicians working alone or in a group practice may have to deal with the media or with concerned patients.<sup>11</sup>

## Impact of public release

Patients sometimes use the information contained in profiles to change their health plans or providers, including their medical groups.<sup>12</sup> However, a number of obstacles, ranging from the need to make information easier to read to the targeting of variables of interest to particular subgroups of consumers, continue to limit involvement of consumers in using profiling data.<sup>13</sup> Also, patients often are also more interested in the process of care (what will be done to them) than in the outcomes of care (what will happen to their health).<sup>14</sup>

The evidence for the effect of public disclosure programmes on the processes and outcomes of care is limited to observational studies. Most report improvements in care after state-wide or local programmes of public reporting have been introduced, but whether these changes were the result of the disclosures or due to other factors is not known. Public disclosure does seem to alter providers' behaviour, because providers may feel that their reputations are at stake or open to public scrutiny. Furthermore, while profiling may represent an opportunity to market their excellence, it may also encourage physicians to avoid more seriously ill patients.<sup>15</sup>

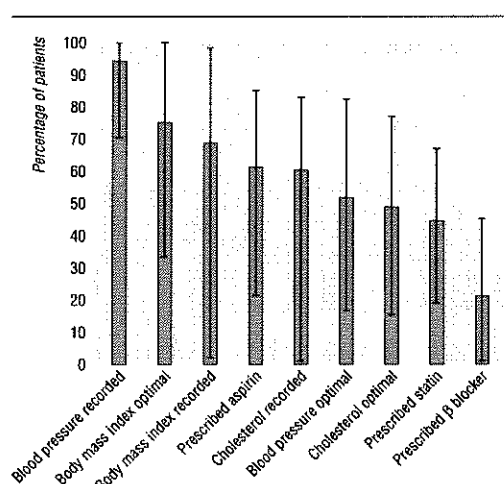
Despite the drawbacks, pressure for the public release of information about physicians will continue. Hence, the public disclosure of data on particular physicians will increase further, in spite of the unwillingness of the medical profession to participate in developing these profiles. Although researchers have often criticised particular profiling methods, this has not prevented the results being released to the public. However, because of the relative lack of interest in physician profiling among professional bodies, compared with their interest in other issues such as malpractice reform and the level of government payments to physicians, the pressure for public dissemination of profiling information is coming from the private sector.

## Implications for the United Kingdom

Patterns of care in general practice in the United Kingdom vary widely, as does the quality of practices' clinical information systems.<sup>16</sup> The performance of general

### Box 2: Ideal physician profiles

- Are of interest to as many consumers of physician profiles as possible
- Have a firm scientific basis while recognising that much of clinical medicine is still an art and contains many controversies
- Meet certain statistical thresholds of validity and reliability
- Involve the providers in developing and implementing the profiles
- Cost as little as possible to produce, with benefits outweighing costs of production
- Respect patients' confidentiality and obtain their consent to use of information from their medical records or similar sources
- Are adjusted for risk to allow for differing severity of illnesses



Measuring the performance of general practitioners—variation in management of patients with coronary heart disease in 47 general practices in London, 2001<sup>21</sup>

practitioners is already to some extent being measured to identify such variations (figure). It is unclear from US experience whether physician profiling will help to reduce wide variations in practice or lead to improvements in the quality of care. One reason for this is that little effort has been made to use profiles to change medical practice. The most important lesson we can glean from the US experience is that simply releasing information to the doctor will accomplish little. Release of profiling information must be followed up with intensive efforts to work with the members of the primary healthcare team to change the processes of care. Furthermore, as in the United States, the clinical and sociodemographic characteristics of patients have an important influence on performance.<sup>17 18</sup>

Another important lesson is that different patient groups do not benefit equally from the public release of profiling data. Vulnerable groups such as poor, less educated, or chronically sick people and members of minority ethnic groups are least likely to make use of these data.<sup>19</sup> Hence, the groups with the greatest need for health care make least use of performance data to

guide their decisions about their use of health services. Presenting profiling data in ways that vulnerable groups can make meaningful use of will be a major challenge for the NHS.

Finally, the range of data and the tools for measuring performance have increased substantially in recent years, but these improvements have not been used systematically to reduce the important variations in the US healthcare system. Physicians are often provided with profiles, but neither they nor purchasers generally use them to change clinical practice. It has always been much easier for purchasers of health care to pass on the inexorably increasing costs of care to consumers, employers, and government, the people and organisations who pay for health care. In contrast, trying to change physicians' practice requires a considerable, sustained effort, and the benefits are more long term.

### Future developments

In the United States, the development of physician profiling is mainly being influenced by the rapidly increasing costs of health care and purchasers' need to know they are getting value for money. Two other factors also have an important role: the pressure for profiles to be released externally; and developments in health informatics, leading to the integration of information systems, a considerable reduction in the costs of producing profiles, and a simultaneous increase in their sophistication.

Several policy considerations will guide the development and implementation of profiling in the United States. Firstly, although the American Medical Association has backed off from its ambitious plans to profile physicians' practice, specialists' societies have become more interested in this area. Secondly, profiles will need to have more scientific validity and will have to make use of new sources of data. In particular, the links with pharmacy and administrative data will soon lead to links with other important data elements, including information derived from patients and from laboratory results.

In Britain the pressures are in general similar to those in the United States, but the government also plans to introduce new regulatory and reaccréditation procedures. The United Kingdom may be able to take advantage of the tools that have been useful in profiling in the United States, and the NHS has set out an ambitious strategy for developing integrated health records, which could also be used in physician profiling. In both countries, the areas of clinical and professional activity covered by physician profiling are likely to be extended further. Finally, the US experience suggests that many patients, particularly those from disadvantaged groups, will find it difficult to make use of profiling data. Hence, consumer and patient groups, rather than individual patients, may well be the main targets of profiling for public use in the United Kingdom.

Although many questions about physician profiling remain unanswered (box 3), doctors in both countries need to work with governments and with purchasers of health services to ensure that well conceived physician profiles will result in useful improvements in care.<sup>20</sup> Otherwise, profiling may be developed mainly as a punitive and regulatory

#### Box 3: Research questions in development of profiles

- In what areas of performance are physicians, the public, purchasers, and other users of profiling data interested?
- What are the best methods of involving physicians and other users in the development of physician profiles?
- What methods of producing reliable and valid physician profiles at reasonable cost can be developed?
- What educational techniques can be used to enable all users of profiling data, including physicians and the public, to use them to improve the quality and appropriateness of clinical care?
- How can adjustment be made for clinical demographic and case mix variables when measuring performance and profiling physicians?

mechanism (for example, to "name and shame" individual doctors), resulting in a further deterioration in doctors' morale in both countries.

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## The instrument that determined my practice

We all have our reasons as to why we eventually settle in our specialties. Some reasons are short and straightforward; others are multiple and meandering. Some reasons are honest and honourable; others I daresay are false and forced. I have only one real (and ridiculous) reason—the reflection of my awestruck 5 year old face in a head mirror.

Twenty five years ago, I sat high on a red swivel chair, swinging my legs nervously and staring at a selection of shiny but scary instruments sprawled across a long wooden desk. I gripped my mother's hand while she spoke to a big voice from a big face from a big man in a big white coat. He suddenly stopped and turned his big eyes on me. I dug my nails into my mother's hand. He reached out his big hand over the menacing silver array on his desk. I closed my eyes tightly. He said something ... bigly.

I slowly opened my eyes. And there I was, staring back at myself, from a round mirror with a hole in its middle, strapped to his head. He was not a monster, he was a cartoon. I had seen a medical Mickey Mouse donning such a device. I remembered a doctory Daffy Duck sporting similar. My memory was then flooded with cartoon, comic strip, and television doctors, all gathering to reassure me in that ear, nose, and throat clinic. My subsequent nasal cautery was no longer a big deal.

Years later, as a clinical medical student, during my brief attachment in the ENT department, I found myself again reflected in a head mirror. I remembered that first encounter. Now, I found myself wearing a head mirror: it fitted so well, so perfectly. Like the stethoscope, a head mirror defines the doctor in the public mind. It felt so comfortable, so familiar. Like the white coat, a head mirror is melded to medicine in the public imagination. I knew then, as I know now, that I was going to become an otorhinolaryngologist.

Otorhinolaryngologists spend most of their lives peering down dark and deep orifices. The reflecting

head mirror with separate light source is the traditional method of illumination. In 1841 Friedrich Hoffman first described the use of a centrally perforated, handheld mirror to reflect sunlight into the ear. Anton von Tröltsch, a contemporary German otologist, popularised the concept and ultimately fastened a circular, concave mirror to his forehead, as is currently practised. Today, a standardised mirror is used for otoscopy, rhinoscopy, and laryngoscopy. Much practice is needed to use the instrument properly. An otorhinolaryngologist looks through the central aperture with one eye, the line of sight being effectively parallel to reflected light rays, and around the edge with the other. This eliminates head shadow and parallax, allowing all-important stereoscopic vision, not to mention brilliantly focused illumination.

Otorhinolaryngology is a small specialty. It has little exposure in undergraduate curricula, and even less to the public eye. I do not know how it is that an instrument exclusively used by such surgeons has become an emblem of "the doctor," embedded in minds as young as 5 years old. But I do know that I enjoy nothing more in busy ENT clinics than seeing children. I love slipping on my head mirror and then seeing wonder in their eyes and recognition in their smiles. Nowadays, I guess I am not so much their Mickey or Daffy, but their Dr Hibbert from *The Simpsons*. None the less, I wonder how many such children will, like my 5 year old self, be impressed enough to adopt a head mirror professionally.

S Alam Hannan ENT specialist registrar, London

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**COMMENTARY**

Hospital performance

**Impact of reporting hospital performance****M N Marshall<sup>1</sup> and P S Romano<sup>2</sup>**<sup>1</sup> National Primary Care Research and Development Centre, University of Manchester, Manchester, UK<sup>2</sup> Centre for Health Services Research in Primary Care, University of California Davis, School of Medicine, Sacramento, CA, USA

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**Is public disclosure a cost effective way to improve the quality of patient care?****Keywords:** accreditation; public disclosure

It doesn't seem long ago that many health professionals and managers were voicing passionate opposition to the public release of comparative information about provider performance. By and large, these voices have now gone quiet. In their place we hear more thoughtful discussions about how best to publish information in a way that engages the various audiences, maximises the benefits of disclosure, and minimises the potential for adverse consequences.

Why such a dramatic change? The argument in favour of publishing information about performance has been won in policy terms principally because of the contribution that disclosure can make to increasing the accountability of provider organisations. In more philosophical terms, many of the opponents of disclosure have been won over by arguments about the "right to know" of citizens in a democratic society.

Those who look for more instrumental reasons to justify the costly and complex task of publishing performance information have to search a little harder for supportive evidence. The original

expectation in the United States, the home of so-called "report cards", was that informed and empowered consumers would use comparative information to select high quality providers or to demand better performance from lower quality providers. In fact, there is little empirical evidence that consumers use data in this way, and even less evidence that purchasers do so on behalf of consumers.<sup>1</sup> In the UK it seems that most members of the public do not want to view health care as a market commodity and that they have a strong sense of responsibility for their local providers which leads them to distrust comparative information produced by external bodies.<sup>2</sup> Furthermore, since people tend to make decisions about providers only when they need services, they are less likely to feel empowered to make rational decisions.

In contrast, provider organisations do seem to be sensitive to the publication of comparative performance data.<sup>3</sup> For example, a report card on the structure and process of obstetric care was associated with the institution of car seat programs, follow up care, transfer agreements with tertiary care centres, and breastfeeding education at hospitals that were publicly reported not to offer these services.<sup>4</sup> In a non-randomised controlled trial, a public report card on hospital complications was associated with markedly increased quality improvement activity (relative to either a private report card or none at all), especially among hospitals that received poor ratings.<sup>5</sup> It is less clear whether the process changes stimulated by public report cards actually lead to improved outcomes. A now defunct public reporting program in Cleveland apparently shifted some deaths to post-discharge settings, leading to reduced 30 day mortality for two conditions, increased 30 day mortality for one condition, and no change for three conditions.<sup>6</sup> New York's cardiac surgery reporting program stimulated a dramatic decrease in risk adjusted mortality, largely through focused interventions at high mortality hospitals,<sup>7</sup> but northern New England achieved similar benefits through private reporting and sharing of best practices.<sup>8</sup>

The big question—which we are only just starting to address—is the nature of these associations and whether there is a causal and unidirectional relationship between the publication of comparative information and improvements in the quality of care. Put simply, is public disclosure a cost effective way to improve the quality of patient care?

While there are potential mechanisms to explain how public disclosure might drive improvement—refocusing providers' attention on quality of care rather than financial performance, capitalising on the sensitivity of providers to their reputations and the innate competitiveness of clinicians and managers—it has proved difficult to design evaluative studies. Most of the published research to date has used observational designs and most of this has been carried out in the United States.

In this issue of *QSHC* Ito and Sugawara<sup>9</sup> contribute to the mounting body of observational evidence linking disclosure to performance using accreditation data from the Japanese health system. They report that small and medium sized hospitals that self-disclosed their accreditation reports received significantly higher scores on "efforts to meet community needs" and "medical/healthcare" than non-disclosing hospitals; no such difference was observed among large hospitals. There are methodological flaws with the study, including the unrepresentative sample of hospitals that volunteered for accreditation and the lack of standardisation of quality measures based on accreditation assessments. Nonetheless, their findings are consistent with those of other studies which have reported uniformly lower "effectiveness of care" among health plans that allow the

National Committee for Quality Assurance to publicly disclose their Health Plan Employer Data and Information Set (HEDIS) scores than among health plans that do not, largely because poorly scoring plans withdraw from the public disclosure program.<sup>10</sup> Similarly, hospitals that participate in California's voluntary cardiac surgery reporting scheme have lower unadjusted death rates than non-participating hospitals.<sup>11</sup>

It is difficult to judge from these studies whether public disclosure is something that only good hospitals are willing to do, or whether it actually leads to improved performance. This is a critical question because of its policy implications. Should public disclosure be mandatory because we expect it to stimulate quality improvement? Or should it remain voluntary, with confidential efforts to share best practices across hospitals and public efforts to applaud volunteers for their honesty and courage?

The challenge now facing the research community is to produce experimental evidence of the impact of disclosure on quality of care. This is a complicated task. There are problems with optimising the intervention because the content and presentation format of many report cards are deficient, and in determining the most appropriate outcomes. Examining patient movements between providers or insurance groups is relatively easy, but examining the impact on quality of care is more problematic. Even the strongest advocate of disclosure must accept that the effect size of publishing information is likely to be small and hence the sample size and costs of an experimental study are likely to be enormous.

Despite the increasing commitment to public disclosure of provider performance data, there is still much that we do not know about its cost effectiveness, impact, and mechanisms of action. The paper by Ito and Sugawara gives us one more piece in the jigsaw, but there are still significant challenges for the research community.

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## Towards a more responsive health system?

T Smith

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# JournalScan

## Towards a more responsive health system?

Compiled by Tom Smith

"Responsiveness" has become a key aim of NHS policy, but what does it mean? The following articles show that there are a number of ways to approach the issue at different levels. Some seek to involve patients in the planning of care, others to reach out to groups who find it difficult to access health care. For many, responsiveness has economic connotations. Other articles consider ways to make clinical teams and organisational management more responsive.



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render them less willing and able to obtain emergency contraception." The authors suggest that ways should be found of providing emergency contraception that take these factors into account.

▲ Free C, Lee R, Ogden J. Young women's accounts of factors influencing their use and non-use of emergency contraception: in-depth interview study. *BMJ* 2002;325:1393

## Changing services based on understanding access from user perspectives

A paper in the *BMJ* explores "women's accounts of their use and non-use of emergency contraception". Although recent efforts have increased access "among teenagers in inner city areas, there has been low use of free emergency contraception provided by local pharmacies". The researchers highlight some barriers in the circumstances and minds of young women to taking up improved access, based on 30 in-depth interviews.

Women with the "strongest desire to avoid pregnancy"—and likely to use emergency contraception, if necessary—"tended to have strong aspirations for education, careers, travel, or lifestyle". Pregnancy for this group would be a "complete disaster".

The paper describes different kinds of "contraceptive behaviour" among women, ranging from "obsessive concern" to a sense of having a "low vulnerability" to pregnancy. "Evaluations of the risk of pregnancy conferred by different contraceptive behaviours were based on advice and experience. In particular, the women cited their own or friends' experience in becoming or not becoming pregnant", suggesting that women in different social circumstances build up quite different contraceptive behaviours.

Being in the position of needing emergency contraception was seen as "a personal failure" and shameful, particularly if it was the second or third time. Women are concerned about what people will think of their sexual behaviour, and this can prevent them from accessing emergency contraception. "A few women disassociated themselves from emergency contraception entirely, reporting that they were not the kind of person who would ever need it". There is a lack of knowledge about the treatment and fear of harmful effects. "One woman who had used emergency contraception was concerned that it was similar to having an abortion".

Sometimes women are concerned about meeting healthcare professionals and the judgement it may involve. Women prefer friendly and matter of fact exchanges. "Consultations that focused largely on the risks that had been taken made the women feel told off and reluctant to re-attend. A few women reported being angry about the way healthcare professionals had treated them."

The authors "identified links between a strong motivation to avoid pregnancy and the perception that the risk of pregnancy is high". They also draw attention to circumstance and situation and acknowledging differences in behaviour. "In public discourse the risks associated with particular courses of action are often discussed in a way that renders their situational and contingent character invisible". "Those women who thought it easier to avoid emergency contraception rather than face their own anxiety, sense of guilt, and concern about what others might think were teenagers who either lived in disadvantaged areas or were homeless. The concerns and personal resources of such women may

## Do initiatives to involve patients in the planning of health care make for a more responsive health system?

"Over the past 20 years, governments throughout western Europe and North America have encouraged patients to contribute to the planning and development of health services". "Underlying these changes is the belief that involving patients leads to more accessible and acceptable services and improves the health and quality of life of patients". This paper from the *BMJ* undertakes a "systematic review of involving patients in the planning and development of health care". Forty two papers were analysed qualitatively of which 31 (74%) were case studies.

Although "involving patients is becoming less discretionary and more compulsory for the providers of services, engaging patients is not an easy task, and no consensus on which methods are most effective under different circumstances exists". This paper aims to establish what is known about patient involvement. Because most papers relied on field worker reports (there were no experimental or comparative research designs), "data analysis was restricted to a narrative account of outcomes of involving patients and the nature of the evidence used to support these claims. Because no system for rating the quality of information in case reports exist, we could not assign quality ratings to the papers we included."

Several papers commented that patients who participated "welcomed the opportunity to be involved and that their self-esteem improved as a result of their contributions". Some studies describe tensions between patients and staff in negotiating changes although others comment that "staff involved in initiatives found the experience rewarding". One of the most common effects of involvement was "the production of new or improved sources of information for patients". Other examples of changes were in improving/simplifying appointment procedures for services.

Eight of the reports suggest that "initiatives had a more general effect on organisational attitudes to involving patients". "The culture of the organisations changed in a way that made them more open to involving patients". But there is little evidence offered to substantiate this claim and the authors note the concerns expressed by some researchers that "involving patients was used to legitimise decisions that would have been made whether or not patients supported them".

The overall impact of involving patients has been done through surveys of patients or those involved in an initiative. There is evidence that involving patients in decisions does generate ideas for change and, in some cases, these have been implemented. But, as the authors note, "the effects of involvement on accessibility and acceptability of services or impact on the satisfaction, health, or quality of life of patients has not been examined". There are a number of factors that might explain this. Initiatives may have had

broader aims: the process of involvement may have been seen as the end point. Although involving patients is presented as a democratic trend, it can be argued that it is a veil to legitimise otherwise unpopular decisions by managers and policymakers.

The central problem is the lack of methodologies to identify the impact of patient involvement; these are likely to be complex, affecting different aspects of service in different ways. "Patient involvement is not without its costs, and including outcome measures in future evaluations of involving patients could enable comparisons of different approaches and evaluation of the effects of suggestions made by patients".

▲ Crawford M, Rutter D, Manley C, et al. Systematic review of involving patients in the planning and development of health care. *BMJ* 2002;325:1263

## Does publishing clinical information to inform users make services more responsive?

A qualitative study in the *BMJ* examined the "attitudes of service users, general practitioners, and clinical governance leads based in primary care trusts to the public dissemination of comparative reports on quality of care in general practice". The paper set out to inform policy and practice of information disclosure in primary care.

The international trend to publish quality reports in "so called report cards" is "a central component of UK government plans for the reform of the NHS". The report cards are "expected to improve the accountability of service providers, stimulate improvements in quality and encourage service users and purchasers to access high quality providers". "Alongside these potential benefits are well recognised risks: a tendency for organisations to concentrate their efforts on the reported outcomes, a preoccupation with brief reporting cycles at the expense of long term strategic planning, and the potential for misrepresenting or even falsifying data". Quality reports are more usual in America, but "consumers tend not to value or make use of comparative data".

The initial reaction from the 12 focus groups (four of service users, four of GPs, and four of clinical managers based in primary care trusts) was strongly negative. "The dominant feeling expressed particularly strongly by the service users was that such reports were unnecessary, unfair and unwanted". The service users did not want to accept that there was an important variation in the quality of care provided by different practices; they thought differences were the result of factors outside the control of the practices themselves.

Over time, these negative reactions changed and became more positive. The initial negative reaction related to the practicalities—"the way government will use it"—and there was particular concern about the political motivation of disclosure. Doctors fear the profession will be undermined and users are keen to protect their local practices from political interference. People are unwilling to treat health as a commodity. "You don't change doctors like you change cars", said one service user. "The unwillingness to exercise choice related to the level of confidence they had in the comparative information. Even if the data suggested that their own practice or doctor was substandard, they placed greater trust in their own experience or that of friends and family."

"All three stakeholder groups expressed concern that general practitioners would distort their behaviour to improve their reported performance. The clinical governance leads supported the use of comparative information for internal purposes." They expressed concern that public release of information would encourage a "name and shame" culture in general practice.

The authors say that "it is perhaps inappropriate to expect members of the public in the UK, so long deprived of information about the performance of the health service, to suddenly behave like rational consumers, weighing up the costs and benefits, making judgments about relative performance, and refusing to access apparently poor practices". Because political initiatives are regarded with such caution, it is suggested that "non-governmental initiatives . . . might be seen in a more positive light".

▲ Marshall M, Hiscock J, Sibbald B. Attitudes to the public release of comparative information on the quality of general practice care: qualitative study. *BMJ* 2002;325:1278

## Does increasing market influence make health services more responsive?

In OECD Health's assessment of health systems, responsiveness is a key measure. Its inclusion has been criticised for overvaluing market based systems with economic conceptions of choice. But a paper published in *Pharmacoeconomics* defends and promotes market reform, arguing that greater exposure to the market coupled with the values of socialised systems is the shortest route to a responsive service.

Reform is needed because the traditional healthcare organisation "was not designed to accommodate a real consumer influence". In the welfare state "the patients' specific demands had to be neglected so that equality was not put at risk—need not demand was the key to the distribution of services". "Officially it still is, but in practice this policy becomes more and more difficult to maintain". Why?

It is because "new healthcare consumers" are fundamentally different from those in the past. "Not only are they better educated, more integrated into social networks, and better financially than previous generations, but in general they are also more accustomed to making long range decisions by themselves". In tandem, healthcare professionals are demanding increasing "self-governance in order to find better solutions for local problems and incentives that reward initiative and competence—qualities that are still often in opposition to traditional healthcare". Major reform is needed to meet the needs of consumers and professionals: "You cannot meet the expectations of future workers without dramatically revamping the organisational structure by breaking up big units into small ones, thus providing workers with more control and greater incentives to be problem solvers".

The author sees the development of a European healthcare market as inevitable. "When there are 'EU price tags' for hip replacement, heart surgery, or cancer therapies, the influence of the consumer will grow even more". (The author does not explain why or how.)

The "Stockholm revolution" is described—reform in Sweden's capital that has served as an inspiration to both Alan Milburn and Liam Fox. Diagnostic related groups (DRGs) have been introduced, hospitals are to be converted to publicly owned companies ("creating opportunities for a more entrepreneurial approach"), purchasers and providers have been separated, a maximum of 3 months waiting will be enforced, and personnel are being encouraged to start companies to take over the operation of primary clinics "and other contracted facilities". There has also been a "rapid expansion of the capacity to provide consumer information, in order to support active consumer behaviour".

Among the successes of the "revolution" have been increases in capacity and productivity (up by 19%), and a 22% reduction in waiting times within the first year. It is obvious why the Stockholm model has attracted political interest. Nevertheless, it is difficult to see from Hjertqvist's comments how the consumer's (or patient's) voice has become more influential. In what sense is the system more responsive? It seems responsiveness is equated with economic and managerial notions. An increase in responsiveness relies upon increasing economically rational consumer behaviour, which is difficult to imagine. Articles in previous JournalScans and the paper above by Marshall *et al* show that assumptions of economic rationality in the use of health care fail to engage with counter-rationality. There will no doubt continue to be much debate about the extent to which market based reform improves health care.

▲ Hjertqvist J. Meeting the challenges to European healthcare: lessons learned from the "Stockholm revolution". *Pharmacoeconomics* 2002;20(Suppl 3):47–53

## Becoming responsive to alternative and complementary health therapies?

A study in the *American Journal of Public Health* examines the health demographics of people using complementary and alternative health therapies in four English counties (Berkshire, Buckinghamshire, Northamptonshire and

Oxfordshire). Almost 9000 people completed a postal survey, detailing any chronic illness and consultations—alternative, complementary or traditional—they had had during the previous year.

More than half (60%) of those who visited an alternative practitioner had a chronic illness. Those who consulted complementary and alternative practitioners tended to visit their GPs more frequently than those who did not. "The most likely predictors of use of complementary and alternative health practitioners were long standing illness, non-manual social class, female sex, and high levels of GP service use". Users of alternative therapy who did not report chronic illness were also more likely than non-users of alternative therapies to consult their GP frequently through the year. Certain conditions predicted the use of particular therapies; "asthma and anxiety predicted visits to herbalists". The most common reason for seeking alternative therapy was for pain relief.

The authors ask whether the NHS should incorporate alternative therapies within its provision, given that people are prepared to pay out of pocket for these services. They think not. If the NHS were to incorporate such treatments, the authors estimate it would add a minimum of £450m to the NHS budget. There is no financial estimate placed on the improved health that might result, nor any discussion of likely trends in demand for alternative and complementary treatments.

▲ Ong C, Peterson S, Bodeker G, et al. Health status of people using complementary and alternative medical practitioner services in 4 English counties. *Am J Public Health* 2002;92:1653-6

## Making clinical teams more responsive

A paper from the *Health Care Management Review* evaluates an initiative to teach continuous quality improvement (CQI) methods to 25 teams of "nurses, physicians, medical trainees, and other health professionals" so that they improve problem solving skills and reduce fragmentation within teams.

"Teams are encouraged to begin by selecting a patient population based on high volume or some other need, as the focus for their improvement project". The project aimed to "lead to changes in team-problem solving effectiveness and patient outcomes". Teams were instructed in CQI methods and their behaviour in problem solving observed. The research team tested people in their retention of taught materials to gauge whether knowledge of CQI increased in the team. A team's ability to problem solve was judged according to its adherence to the models taught in collective practice. Finally, each team was asked to "collect data on the outcome indicators they had identified for their patient population as the basis for judging the success of their 'change idea'".

The unstated aim of the initiative was to make clinical teams more responsive to modernisation and to incorporate associated activities as part of their work. Nine of the 25 teams were adjudged to have had some success in achieving improvement. Why were some successful and others less so? "Successful and unsuccessful teams did not differ in their baseline level of CQI knowledge and dysfunctional groups interactions". However, "teams that demonstrated an improvement in an outcome or process indicator had significantly higher scores for problem-solving effectiveness". Although training led to improvements in CQI knowledge, this was nowhere retained after 9 months and, at this point, "most teams were no longer engaged in their improvement work in spite of the fact that we had hoped teams would continue to apply their knowledge as part of everyday practice". "What we actually found was that successful teams reported higher functional group interactions than unsuccessful teams, even at baseline".

The paper concludes with a couple of interesting ideas: firstly, that CQI training should be "just in time" and initiatives should focus on genuine concerns and collective aims and, secondly, that initiatives need to be owned more locally with team members themselves addressing the functionality of relations.

▲ Irvine D, Ross Baker D, Murray M, et al. Achieving clinical improvement: an interdisciplinary intervention. *Health Care Manage Rev* 2002;27:42-56

## Making management theory and practice more responsive to each other

An article written in *Health Care Management Review* considers the relationship between theory and practice in health management. The author has held academic and management positions and wants to see a greater bond and exchange between these activities. The problem is that it is difficult for managers to pursue academic interests, and virtually unheard of for academics to spend a portion of time managing. The demands of these roles are too great to be combined.

"In my own practitioner career, which includes a series of senior line management positions within increasingly large physician group practices, pursuing academic interests has been difficult. I was attracted to several management positions with academic faculty practices precisely by the proximity to the academic enterprise, and a number of faculty physicians over the years have been interested in collaboration with a 'management type'. I have found however, that the 60-80 hour week requirements (at least as I allow myself to perceive them) for effective executive performance . . . made research and writing time nearly impossible to schedule. Perhaps this was due to my preference for line management roles."

The article suggests that health service managers need to be more scholarly—"a discoverer, consumer, and disseminator of knowledge". It would aid research if "knowledge could be co-produced" by researchers and managers "synthesising the different and partial understandings that academics and practitioners learn by themselves".

"Many management faculties today have little or no management experience". Academics need to engage more with practitioner issues. "My practitioner career focus . . . very much influences my long-term research interests. In the manner that political advisers frequently chant 'It's the economy, stupid', my personal health management mantra is 'It's the doctors, stupid'. What gets done in healthcare delivery, which new models gain adherents, which CEOs achieve lengthy tenures, what technology diffuses rapidly, and a host of their process and outcome variables depend to a great extent on how physicians are educated in our medical schools, aligned with our systems, involved in leadership roles, compensated, and organizationally structured."

"Of course, medical sociology, sociology in general, social psychology, political science, health economics, organizational behavior and other theoretical and disciplinary underpinnings help us to understand how physicians choose to behave and participate in various delivery systems, [but] much of how this all takes place . . . is quite local, deterministic and pragmatic."

One of the problems is that managers do not read journal articles. "I am sure there are some . . . but I have not met them." I suspect there are at least two reasons. "Once out in the field, striving in their careers, constantly interrupted, nurturing families, and active in their communities, practitioners simply do not have the time to read lengthy, often dense academic studies". "The second reason is what some colleague managers and I call the 'R-square phenomenon', the best model the researcher can test explains 0.22 of variance". "The bright manager does not come away with much of a take-home for her reading efforts".

"A very interesting model to help bridge the practitioner-academic gap might be a health management equivalent of the *Harvard Business Review*, with readable articles summing up streams and threads of important research primarily for consumption by health management practitioners".

▲ Lunn R. Balancing careers in health management practice and the academy: issues, synergies, rewards and pitfalls. *Health Care Manage Rev* 2002;27:69-75

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# Public reporting of comparative information about quality of healthcare

Martin N Marshall and Robert H Brook

MJA 2002; 176 (5): 205-206

A greater degree of public reporting of information about healthcare quality is an inevitable and desirable way forward

THE AUSTRALIAN COUNCIL for Safety and Quality in Health Care (ACSQHC) plans to publish data about the performance of the Australian healthcare system. It is probably inevitable that this kind of information, which is actively disseminated and reported in such a way as to encourage readers to draw comparisons, will be used in the near future by the media, the public and politicians to make public judgements about the relative performance of individual hospitals or even individual doctors or groups of doctors. Initiatives such as these will therefore be perceived as a threat by some health professionals and some organisations. Would this negative response be justified? What might be gained from public disclosure and how can the policy be implemented successfully?

We believe that a negative response to public disclosure in Australia would be counterproductive. Greater openness in healthcare is inevitable. Information is freely available about most areas of modern life and many believe that healthcare is one of the last bastions of protectionism. When millions of dollars are spent on healthcare, those who pay have a right to know that the money is being spent effectively, and the publication of comparative data sends a strong message about the willingness of health professionals and organisations to be accountable.

In addition, public disclosure appears to be an effective way of improving quality.<sup>1</sup> There is a growing body of evidence that the current level of quality of care is unacceptable<sup>2,3</sup> and that quality-improvement initiatives using confidential data have

been largely ineffective at changing the behaviour of health professionals.<sup>4</sup> When comparative data are released to the public, it appears to remind providers of the issues and refocuses them towards taking action.<sup>5</sup>

Arguments in support of the status quo — that the data are inadequate, the public won't understand them and the media will misuse them — are not sustainable if public disclosure is introduced properly. There are lessons that can be learnt from other countries to guide the process of disclosure in Australia. The United States has nearly 15 years' experience of publishing data in the form of "report cards", or "provider profiles". The initiative was launched by the federal government and the momentum has been maintained by a variety of public, private, commercial and not-for-profit organisations. Consumers and purchasers of healthcare were expected to play a key role by selecting high-performing providers, but recent evidence suggests that the providers themselves make greater use of the data than the service users.<sup>6</sup>

There are some notable examples of improvements in both the processes and outcomes of care associated with the publication of performance data.<sup>1</sup> Public reporting in Europe is less well established than in the United States, but hospital "league tables" have been published in the Netherlands for several years, and the UK government plans to introduce incentives linked to a range of publicly reported performance criteria.<sup>7</sup>

What can we learn from the initiatives that have already been introduced?

- First, a backlash from some doctors, professional groups and institutions (particularly those seen to be performing badly) is predictable. Some criticisms were justified in the early days of report cards but lessons are being learnt. For example, we know that forcing new initiatives on reluctant

professionals is not the most effective way of changing attitudes, and the introduction of report cards is more likely to be successful if doctors are encouraged to take a lead, particularly in selecting the performance measures. Bringing the media on board at an early stage to ensure fair and balanced coverage also helps. In addition, delaying publication for a short period to allow providers time to look at and act upon the data is a useful strategy.

- Second, it is important that those who publish the data show a commitment to investing in the process and progressively improving the quality of the data and the validity of comparisons arising from the data. However, it makes little sense to "wait for better data" — data will always be imperfect and, as one commentator stated, it is important not to let "perfect be the enemy of good".<sup>8</sup> Experience suggests that the process of publication can in itself act as a catalyst for data improvement.

- Third, the utility of comparative data comes less from making absolute judgements about performance than from the discussion arising from using the data to benchmark performance. There is therefore a strong educational component to the effective use of comparative data, and resources are required to facilitate this process.<sup>6</sup>

- Finally, it is important to be cognisant of the risks of publishing comparative data.<sup>9</sup> The danger of institutions refusing to treat certain disadvantaged groups in order to



improve their apparent performance is well recognised, although probably overstated,<sup>10</sup> and can be reduced by careful adjustment of risk and casemix. A tendency to focus on what is being measured at the expense of other areas of practice can be minimised by publishing a wide range of quality indicators. The risk of "short-termism" — an inappropriate focus on annual reporting cycles — can be reduced by ensuring a balance between short-term targets and long-term strategic aims.

A greater degree of public reporting of information about healthcare quality is an inevitable and desirable way forward. Practitioners and policymakers in Australia have an opportunity to ensure that the policy is implemented in a manner that is most likely to produce positive change.

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## COMMENTARY

Hospital performance

# Impact of reporting hospital performance

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## Is public disclosure a cost effective way to improve the quality of patient care?

**Keywords:** accreditation; public disclosure

It doesn't seem long ago that many health professionals and managers were voicing passionate opposition to the public release of comparative information about provider performance. By and large, these voices have now gone quiet. In their place we hear more thoughtful discussions about how best to publish information in a way that engages the various audiences, maximises the benefits of disclosure, and minimises the potential for adverse consequences.

Why such a dramatic change? The argument in favour of publishing information about performance has been won in policy terms principally because of the contribution that disclosure can make to increasing the accountability of provider organisations. In more philosophical terms, many of the opponents of disclosure have been won over by arguments about the "right to know" of citizens in a democratic society.

Those who look for more instrumental reasons to justify the costly and complex task of publishing performance information have to search a little harder for supportive evidence. The original

expectation in the United States, the home of so-called "report cards", was that informed and empowered consumers would use comparative information to select high quality providers or to demand better performance from lower quality providers. In fact, there is little empirical evidence that consumers use data in this way, and even less evidence that purchasers do so on behalf of consumers.<sup>1</sup> In the UK it seems that most members of the public do not want to view health care as a market commodity and that they have a strong sense of responsibility for their local providers which leads them to distrust comparative information produced by external bodies.<sup>2</sup> Furthermore, since people tend to make decisions about providers only when they need services, they are less likely to feel empowered to make rational decisions.

In contrast, provider organisations do seem to be sensitive to the publication of comparative performance data.<sup>3</sup> For example, a report card on the structure and process of obstetric care was associated with the institution of car seat programs, follow up care, transfer agreements with tertiary care centres, and breastfeeding education at hospitals that were publicly reported not to offer these services.<sup>4</sup> In a non-randomised controlled trial, a public report card on hospital complications was associated with markedly increased quality improvement activity (relative to either a private report card or none at all), especially among hospitals that received poor ratings.<sup>5</sup> It is less clear whether the process changes stimulated by public report cards actually lead to improved outcomes. A now defunct public reporting program in Cleveland apparently shifted some deaths to post-discharge settings, leading to reduced 30 day mortality for two conditions, increased 30 day mortality for one condition, and no change for three conditions.<sup>6</sup> New York's cardiac surgery reporting program stimulated a dramatic decrease in risk adjusted mortality, largely through focused interventions at high mortality hospitals,<sup>7</sup> but northern New England achieved similar benefits through private reporting and sharing of best practices.<sup>8</sup>

The big question—which we are only just starting to address—is the nature of these associations and whether there is a causal and unidirectional relationship between the publication of comparative information and improvements in the quality of care. Put simply, is public disclosure a cost effective way to improve the quality of patient care?

While there are potential mechanisms to explain how public disclosure might drive improvement—refocusing providers' attention on quality of care rather than financial performance, capitalising on the sensitivity of providers to their reputations and the innate competitiveness of clinicians and managers—it has proved difficult to design evaluative studies. Most of the published research to date has used observational designs and most of this has been carried out in the United States.

In this issue of *QSHC* Ito and Sugawara<sup>9</sup> contribute to the mounting body of observational evidence linking disclosure to performance using accreditation data from the Japanese health system. They report that small and medium sized hospitals that self-disclosed their accreditation reports received significantly higher scores on "efforts to meet community needs" and "medical/healthcare" than non-disclosing hospitals; no such difference was observed among large hospitals. There are methodological flaws with the study, including the unrepresentative sample of hospitals that volunteered for accreditation and the lack of standardisation of quality measures based on accreditation assessments. Nonetheless, their findings are consistent with those of other studies which have reported uniformly lower "effectiveness of care" among health plans that allow the

National Committee for Quality Assurance to publicly disclose their Health Plan Employer Data and Information Set (HEDIS) scores than among health plans that do not, largely because poorly scoring plans withdraw from the public disclosure program.<sup>10</sup> Similarly, hospitals that participate in California's voluntary cardiac surgery reporting scheme have lower unadjusted death rates than non-participating hospitals.<sup>11</sup>

It is difficult to judge from these studies whether public disclosure is something that only good hospitals are willing to do, or whether it actually leads to improved performance. This is a critical question because of its policy implications. Should public disclosure be mandatory because we expect it to stimulate quality improvement? Or should it remain voluntary, with confidential efforts to share best practices across hospitals and public efforts to applaud volunteers for their honesty and courage?

The challenge now facing the research community is to produce experimental evidence of the impact of disclosure on quality of care. This is a complicated task. There are problems with optimising the intervention because the content and presentation format of many report cards are deficient, and in determining the most appropriate outcomes. Examining patient movements between providers or insurance groups is relatively easy, but examining the impact on quality of care is more problematic. Even the strongest advocate of disclosure must accept that the effect size of publishing information is likely to be small and hence the sample size and costs of an experimental study are likely to be enormous.

Despite the increasing commitment to public disclosure of provider performance data, there is still much that we do not know about its cost effectiveness, impact, and mechanisms of action. The paper by Ito and Sugawara gives us one more piece in the jigsaw, but there are still significant challenges for the research community.

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# FACTORS THAT INFLUENCE FRONT-LINE MANAGERS' PERCEPTIONS OF COMPARATIVE REPORTS OF HOSPITAL PERFORMANCE

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*The work described here is based on a dissertation completed in the Department of Health Policy, Management & Evaluation at the University of Toronto. Members of the dissertation committee include Ross Baker (chair), Whitney Berta, and Martin Evans. The author would like to thank the hospital managers who completed a survey for their time and responses.*

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## ABSTRACT

The recent conference, *Measuring Up: Improving Health Systems Performance in OECD Countries*, hosted by Health Canada in November 2001 underscores Canadian health policy makers' commitment to try to use health system performance measurement to improve the delivery and outcomes of health care. However, in other jurisdictions there is little evidence to suggest that health care managers and providers are making use of performance data that is being generated. The objective of this research was to explore the factors that influence front-line hospital managers' perceptions of usefulness of hospital performance data / reports in a Canadian setting. The findings demonstrate that, in addition to the characteristics of performance reports (e.g. perceived data quality, perceived relevance, and report complexity), there are important cultural aspects of the organization that influence front-line managers' perceptions of usefulness, and ultimately use, of these data. Accordingly, if scarce health care resources are going to be allocated to measuring health system performance, this research shows that in order to maximize the utility of these data, careful attention must be paid to the way performance initiatives are structured.

## DESCRIPTION OF RESEARCH

The measurement of health outcomes and, more broadly, the phenomenon of performance measurement have emerged as important public policy issues in health care. Data gathering on the performance of health care organizations, the health system, and individual care providers is presently being undertaken on a large scale. These efforts tend to focus on measuring clinical performance, financial performance, and / or performance in the area of patient satisfaction. There are a variety of stated purposes for performance measurement.

cardiac managers ensured that managers in the smallest hospitals would be included in the study. In addition, *Hospital Report '99* contained performance indicators specifically related to these managers clinical areas of responsibility (e.g. stroke Length of stay and access to cardiac diagnostic technologies were 2 of the indicators in *Hospital Report '99*). The 202 respondents, on average, worked in their organization 15.8 years (s.d. = 9.9) and worked in their current job for 5.9 years. 19% of respondents are physician managers, 66% of respondents have a nursing background, with two-thirds of that group prepared at the Baccalaureate level or higher. Twelve percent of respondents have an advanced health administration degree (MHSc / MHA) or MBA.

The study questionnaire surveyed these front-line managers regarding their familiarity with *Hospital Report '99*, perceptions of the report's data quality, relevance and complexity, intensity of the report's dissemination in their hospital, and the improvement culture of their hospital. Two kinds of analyses were performed in order to test the relationships between each of these variables and perceived usefulness of performance data. First, the questionnaire data were analyzed to determine whether the questions designed to measure the variables in the model were reliable and valid (exploratory factor analysis was used). Once reliability and validity were established, the relationships between variables in the conceptual model initially outlined could be tested using a different kind of analysis (hierarchical regression analysis).

*Study Findings.* The key findings from this study reveal a significant gap in the percentage of line and mid-level managers who are even *familiar* with the comparative performance report that was the focus of this study (35% of respondents in organizations who participated in HR99 reported being unfamiliar with the HR99 results). Although somewhat disconcerting, this finding is consistent with data from the U.S showing that only 69% of nursing directors "received or discussed" the California Hospital Outcomes Project report (Romano et al., 1999). Other studies, reporting on the *use* of comparative reports of hospital performance for simple process changes, have shown that only about 30% of organizations report using the data (Longo et al., 1997; Rainwater et al., 1998). As we try to gain insight regarding the impact of comparative reports of hospital performance, data from this study and data from the U.S. suggest that while hospital performance reports may land at the door of 100% of organizations in a certain jurisdiction, they find their way to the front-lines in only a subgroup of those organizations, and the data are put to use in an even smaller subgroup – as O'Connor et al. (1996) and Eddy (1998) have pointed out, simply generating performance data will not, in and of itself, lead to improvement.

Open-ended comments provided by study respondents indicating that (1) poor access to the report from within the organization, (2) a lack of resources, (3) competing priorities, (4) lack of time and support to understand the data, and (5) lack of specificity in many of the results, together, posed significant barriers that prevented people from being able to use the data in their organization.

In terms of the relationships hypothesized in this study, the key findings demonstrate that both the characteristics of performance reports (including perceived data quality, perceived relevance of the data, and report complexity) as well as organizational/contextual variables (including dissemination intensity and improvement culture) are significantly related to front-



measurement has been identified as a tool that can help in all three of these areas. For instance at the federal level, Health Canada recently hosted the OECD Conference on health systems performance measurement where it was noted that in order "to improve health care for their citizens while containing costs, OECD countries need to use the best approaches to develop and apply performance measures". At the Federal/Provincial/Territorial Health Ministers' Meeting in September 2001, health ministers agreed to work on comparable performance indicators that will measure health status, (such as life expectancy) health outcomes (such as reduced burden of disease and illness), and quality of service (such as patient satisfaction and hospital re-admissions). Emphasis on performance measurement is also evident at the provincial health policy level. For instance, the Fyke Commission in Saskatchewan (April 2001) clearly supported the use of performance indicators, a new Health Care Report Card and performance measures are a central feature in New Brunswick's recent efforts to redesign the health care system, and the Mazankowski report recently outlined ten areas where health reform needs to take place in order to improve quality in Alberta's healthcare system. One of these ten areas involved the introduction of a new Outcomes Commission to monitor and measure health outcomes, track progress and results, and report findings publicly.

The research described here can help inform future policy decisions by making clear to those who fund and design performance reports the need to recognize that simply generating the data is not enough. If performance measurement in health care is going to be an effective tool for promoting accountability, improvement, better resource allocation decisions, or evidence-based health care, then considerable attention must be paid to (1) determining who is the key audience for performance measurement information (and the audience will be different if the aim of performance measurement is improvement or if it is accountability), (2) ensuring the data are generated in a supportive, non threatening way, and (3) providing resources and support to help the target audience make use of the information. The absence of evidence demonstrating that performance reports are being widely used for improvement purposes means it is critical that we pay attention to the factors that influence health care managers' perceptions of and responses to these reports, many of which have been identified in this research.

Additional factors such as whether performance measurement reports are publicly released, and whether an organization or region performs well or poorly in the report have also been found to significantly influence whether people believe and make use of the data, or disregard the results altogether (Marshall et al., 2000; Blais et al., 2000; Romano et al., 1999). Accordingly, unless a significant amount of attention is paid to questions of how performance data are collected, how reports are structured, for what purpose and for which audience, spending large sums of money on performance measurement may be an ineffective use of scarce health care resources.

Finally, potential users of this research include (1) policy makers who are encouraging the development and use of performance measures in health care, (2) funding bodies and developers of health care performance measurement reports, and (3) senior health care leaders whose organizations and regions are the subjects of performance measurement reports. All three of these groups of decision makers have a unique, perhaps equally important role to play if the potential of health care performance measurement is going to be realized.

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## Editorials

# Public reporting of comparative information about quality of healthcare

Martin N Marshall and Robert H Brook

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A greater degree of public reporting of information about healthcare quality is an inevitable and desirable way forward

THE AUSTRALIAN COUNCIL for Safety and Quality in Health Care (ACSQHC) plans to publish data about the performance of the Australian healthcare system. It is probably inevitable that this kind of information, which is actively disseminated and reported in such a way as to encourage readers to draw comparisons, will be used in the near future by the media, the public and politicians to make public judgements about the relative performance of individual hospitals or even individual doctors or groups of doctors. Initiatives such as these will therefore be perceived as a threat by some health professionals and some organisations. Would this negative response be justified? What might be gained from public disclosure and how can the policy be implemented successfully?

We believe that a negative response to public disclosure in Australia would be counterproductive. Greater openness in healthcare is inevitable. Information is freely available about most areas of modern life and many believe that healthcare is one of the last bastions of protectionism. When millions of dollars are spent on healthcare, those who pay have a right to know that the money is being spent effectively, and the publication of comparative data sends a strong message about the willingness of health professionals and organisations to be accountable.

In addition, public disclosure appears to be an effective way of improving quality.<sup>1</sup> There is a growing body of evidence that the current level of quality of care is unacceptable<sup>2,3</sup> and that quality-improvement initiatives using confidential data have been largely ineffective at changing the behaviour of health professionals.<sup>4</sup> When comparative data are released to the public, it appears to remind providers of the issues and refocuses them towards taking action.<sup>5</sup>

Arguments in support of the status quo — that the data are inadequate, the public

won't understand them and the media will misuse them — are not sustainable if public disclosure is introduced properly. There are lessons that can be learnt from other countries to guide the process of disclosure in Australia. The United States has nearly 15 years' experience of publishing data in the form of "report cards", or "provider profiles". The initiative was launched by the federal government and the momentum has been maintained by a variety of public, private, commercial and not-for-profit organisations. Consumers and purchasers of healthcare were expected to play a key role by selecting high-performing providers, but recent evidence suggests that the providers themselves make greater use of the data than the service users.<sup>6</sup>

There are some notable examples of improvements in both the processes and outcomes of care associated with the publication of performance data.<sup>1</sup> Public reporting in Europe is less well established than in the United States, but hospital "league tables" have been published in the Netherlands for several years, and the UK government plans to introduce incentives linked to a range of publicly reported performance criteria.<sup>7</sup>

What can we learn from the initiatives that have already been introduced?

- First, a backlash from some doctors, professional groups and institutions (particularly those seen to be performing badly) is predictable. Some criticisms were justified in the early days of report cards but lessons are being learnt. For example, we know that forcing new initiatives on reluctant professionals is not the most effective way of changing attitudes, and the introduction of report cards is more likely to be successful if doctors are encouraged to take a lead, particularly in selecting the performance measures. Bringing the media on board at an early stage to ensure fair and balanced coverage also helps. In addition, delaying publication for a short period to allow providers time to look at and act upon the data is a useful strategy.
- Second, it is important that those who publish the data show a commitment to investing in the process and progressively improving the quality of the data and the validity of comparisons arising from the data. However, it makes little sense to "wait for better data" — data will always be imperfect and, as one commentator stated, it is important not to let "perfect be the enemy of good".<sup>8</sup> Experience suggests that the process of publication can in itself act as a catalyst for data improvement.
- Third, the utility of comparative data comes less from making absolute judgements about performance than from the discussion arising from using the data to benchmark performance. There is therefore a strong educational component to the effective use of comparative data, and resources are required to facilitate this process.<sup>6</sup>
- Finally, it is important to be cognisant of the risks of publishing comparative data.<sup>9</sup> The danger of institutions refusing to treat certain disadvantaged groups in order to improve their apparent performance is well recognised, although probably overstated,<sup>10</sup> and can be reduced by careful adjustment of risk and casemix. A tendency to focus on what is being measured at the expense of other

areas of practice can be minimised by publishing a wide range of quality indicators. The risk of "short-termism" — an inappropriate focus on annual reporting cycles — can be reduced by ensuring a balance between short-term targets and long-term strategic aims.

A greater degree of public reporting of information about healthcare quality is an inevitable and desirable way forward. Practitioners and policymakers in Australia have an opportunity to ensure that the policy is implemented in a manner that is most likely to produce positive change.

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