



Report Cards are here to stay: How can they be best used?

New Zealand, like many countries is moving along the path towards wider public reporting on the quality of healthcare service. Report cards represent one of the most publicly visible aspects of hospitals quality improvement efforts, and they are not without controversy. Media coverage often overreacts to low “grades” given to hospitals in a region. Providers look for ways to stack the decks, selecting the healthiest patients to improve scores.

Purchasers look only at the costs and consumers either can't figure them out or ignore them completely. At least, this is the popular perception. The need for basic research to develop accurate and useful quality related performance measures continues, but quality report cards are here to stay.

Quality report cards have been prominent in the United States for more than a decade and are a central feature of British health system reform. Martin Marshall, Paul Shelkelle, Huw Davies and Peter Smith examined the common challenges and differences in implementation of policy in two countries. Their report *Public Reporting on Quality in the United States and the United Kingdom* is published in *Health Affairs* 22(3) 134-148 2003. The report can be found at www.healthaffairs.org

They note that an interest in the public disclosure of performance is not new. In the 1860s Florence Nightingale highlighted differences in the mortality rates in London hospitals. However, the vision of Nightingale and others has only started to become a reality through the development of information technology and rising public expectations of patient choice and accountability. More recently the products of performance reporting have been variously described as ‘report cards’, ‘performance reports’, ‘provider profiles’, ‘quality assessment reports’, and ‘league tables’.

Advocates of the public release of performance data are often unclear about the objectives of reporting initiatives and how they expect the various stakeholders to respond. Broadly, there are two reasons for putting performance data in the public domain. The first is to increase the accountability of healthcare organisations, professionals and managers. This greater accountability offers patients, payers, and purchasers a more informed basis on which to hold providers to account, either directly through purchasing and treatment decisions or indirectly through the political process. The second reason is to maintain standards or stimulate improvements in the quality of care provided, or both.

A range of mechanisms are being used in the United States and United Kingdom to achieve this aim: economic competition, performance management with or without incentives, or appeals to the professional interest of those working in health care in doing a good job. Within each of these mechanisms, the stakeholders – patients, the insured, purchasers, managers, and health professionals are expected to play different roles.

In both countries quality report cards are seen as central to improving the accountability of health providers, a key lever to improving quality, and an important principle to pursue. However, both countries face similar challenges as they attempt to engage key stakeholders. Politicians and the media have embraced the idea with enthusiasm but there is a growing body of evidence to suggest that many consumers, purchasers, health professionals, and to a lesser extent provider organisations are ambivalent, apathetic, or actively antagonistic towards report cards.

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Florence Nightingale was an early leader in quality reporting

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The U.S. has led the modern public disclosure movement. Information is now readily available about the comparative performance of health insurance plans, hospitals and individual physicians. There has been ongoing and sometimes acrimonious debate about the content of the data, the process of disclosure and the associated merits and risks. Public reporting is market based and lacks an overarching organisational structure or strategic plan. Some exemplar organisations are:

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The National Committee for Quality Assurance (NCQA). Health plans participate voluntarily and comparative quality information is posted on their web site www.ncqa.org

The Pacific Business Group on Health (PBGH). A consortium of large employers in California that promotes public reporting at www.healthscope.org

The National Quality Forum. This group promotes core sets of quality measures and standardised measurement specifications, collection, verification, and audit tools at www.qualityforum.org

Leapfrog Group. A coalition of major business purchasers that encourages health care purchasers to meet certain standards as a condition of participation in health insurance plans. www.leapfroggroup.org

Healthgrades presents comparative information on hospitals for a range of health conditions, nursing homes, and home health agencies. Some of this information is available free and some must be purchased from www.healthgrades.com

States have also played an important role in driving public reporting forward. For example, New York State has produced and published what many regard as the most sophisticated report cards, focussing primarily on cardiac procedures.

In contrast to the U.S., there have been relatively few examples of purposeful release of information about quality of care in the U.K. The first reporting initiatives deliberately aimed at the public, known as the Patients Charter, focussed on waiting times rather than clinical quality.

In September 2001 the Department of Health published a new system for rating the performance of all NHS non specialist hospitals in England. Each was classified annually into one of four categories from three to zero stars, depending upon their performance against a range of indicators and the outcome of their clinical governance review by the Commission for Health Improvement.

While most reporting schemes in the U.K. have been led by the health ministry, in late 2000 an independent initiative entered the arena. Dr Foster, established by two Sunday Times journalists, makes hospital performance data available on the web and sells its information to the media www.drfooster.co.uk. They have published two Good Hospital Guides. The second explicitly ranks the hospitals in terms of their relative performance. It is currently focussing its resources on local rather than national reports and intends to publish data on individual specialists and primary care practices.

The NHS has also initiated a series of surveys designed to monitor NHS performance from a patient's perspective. An example is the survey of heart disease patients, involving 194 NHS hospitals and more than 84,000 patients, published at www.doh.gov.uk/nhspatients/chdsurvey2a.htm

Although one of the two broad reasons for public disclosure of quality information is to maintain standards or stimulate improvements in the quality of care, there are few published studies on this subject. Observational studies of short term mortality and morbidity following cardiac surgery indicate that the U.S. states that have public reporting systems have experienced declines in cardiac surgery mortality that are more rapid than declines in states without public reporting. Some observational studies show a greater improvement over time in the process of obstetrics care for those hospitals reported as low quality outliers compared with other hospitals.

Several studies have demonstrated that U.S. consumers want more information about providers' performance and are willing to identify the content and the format of the information of greatest use to them. However, most of the evidence from the U.S. and Scotland suggests that when this information is published the public do not search it out, does not understand it, distrusts it, and fails to make use of it. In the U.K., recent focus group data indicates that some members of the public consider public reporting to be a punitive tool used by politicians to punish hard working professionals. Those who did not respond well to the report cards were more likely to be young and well educated. Where user interest has been demonstrated it appears to decline over time, suggesting that the public responds primarily to new information.

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Published evidence from the U.S. suggests that the early interest in report cards quickly waned and most purchasers were more interested in costs, or in gross indicators of quality such as accreditation, than in detailed comparative information. There is little evidence that U.K. health care purchasers are using the comparative hospital performance data to guide their contracting decisions to any great extent.

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While physicians in both countries are more aware of report cards than consumers are, they too make little use of report card information. Evidence suggests that physicians distrust and attempt to discredit the data and there are some examples of their responding defensively by demanding that their managers performance be judged using report cards. Both U.S. and U.K. provider organisations are the most sensitive of the various stakeholder groups to report cards and can respond in ways that improve the quality of care they provide.

The media have played a leading role in promoting the use of report cards. Considerable anxiety has been expressed about the media coverage of comparative information: in particular a propensity to be alarmist, to engender a culture of blame, and to present complex data as overly simplistic league tables. Evidence suggests that these claims are probably exaggerated, particularly when those responsible for the release of the data work closely with the reporting journalists.

The debates over the merits of the merits or deficits of reporting health care quality have been extraordinarily heated. On the one hand, advocates of public reporting see the current reservations as a necessary evolutionary step and think that report cards will soon become an integral and accepted tool in a modern health care system. Opponents see the report cards as largely unproven and a distraction, with potentially unhelpful side effects. Marshall et al, believe that whatever the merits of the two arguments, the imperatives of accountability and quality improvement make the wider development and implementation of health cards inevitable.

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How should policy on public reporting evolve? To be effective, reporting may need to be mandatory otherwise health care organisations may simply withdraw from the scheme if they perceive that participation is not in their interest. There will be increasing pressure to tailor reports more closely to the needs of users with new data collection mechanisms and increased use of outcome data. For public health it is likely that reporting schemes will have to rely on measures of process.

The main scope for increased engagement with the public seems to be among provider and purchaser organisations. Providers need help if they are to respond positively to public reports. The benefits will be maximised in an environment that values learning and improvement. The trend toward increased disclosure of quality information is irresistible and, therefore, determining what style of reporting works best and in what circumstances is a major policy task.

Public reports are here to stay, and the debate should now be moving on from whether to use them, to how best to deploy them in particular circumstances. In this respect, public reporting should be treated like any other technology or policy option. Its benefits against stated objectives should be evaluated in the light of its costs, including both direct costs and inadvertent side effects.

LOGICAL CONCLUSION

- (A) The Japanese eat very little fat and suffer fewer heart attacks than the British or Americans.
- (B) On the other hand, the French eat a lot of fat and also suffer fewer heart attacks than the British or Americans.
- (C) The Japanese drink very little red wine and suffer fewer heart attacks than the British or Americans.
- (D) The Italians drink excessive amounts of red wine and also suffer fewer heart attacks than British or Americans
- (E) Conclusion: Eat & drink what you like. It's speaking English that kills you.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at admin@nzihm.org.nz

Report Finds Health Care Systems "Quality Gaps" Cause 57,000 Deaths Annually

A new report shows that the U.S. health care system is riddled with "quality gaps" that prevent millions of Americans from receiving "best practice" care. These gaps, the result of factors such as poor use of technology and irrational payment systems, lead to more than 57,000 avoidable deaths each year. NCQA's annual *State of Health Care Quality* report also documents the enormous financial toll of commonplace failures to deliver appropriate care—nearly 41 million sick days and more than \$11 billion in lost productivity could be avoided annually if well known "best practices" were more widely adopted. The observed "quality gaps" were not equally prevalent throughout the system. Among health plans that measure and report on their performance, clinical quality was higher and showed strong gains.

"It's not a question of knowing *how* to treat heart disease, diabetes or mental illness," said NCQA President Margaret E. O'Kane. "We know how. We're just not doing it. We're literally dying, waiting for the practice of medicine to catch up with medical knowledge. More than 57,000 people will die this year because there is a huge gap between what we know and what we do."

Why Is There a Quality Chasm in healthcare?

Because of the pervasiveness with which competition winnows out firms whose products do not justify their price, economists have devoted only modest efforts to quantifying the degree to which industries and firms do not get as much as possible from the resources they employ. By contrast, much more of the health services research literature has gone into documenting the shortcomings of the medical care industry in producing health. A much quoted 2001 report from the Institute of Medicine (IOM) termed the gap between the actual and potential performance of the U.S. health care system the "quality chasm." In a paper published in *Health Affairs* 21(4):13-25, 2002, Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management at Harvard University, Professor of health care policy at Harvard Medical School, and vice-chair of the Medicare Payment Advisory Commission (MedPAC) assumes that medical care is inefficient and that it fails to produce as much health as it might with the resources it uses. He asks why.

Newhouse argues that both economists and non-economists assume that if better mousetrap is built, consumers will stop buying the old one unless the additional price for the new one is unjustified. This is simply an extension of the standard competitive assumption into competition among products. In short, economists believe that most industries, most of the time, get as much as they can for the quantity and quality of inputs that they use.

Medical care seems to obtain less value from the resources it uses than other industries do. One can raise two immediate and related important questions about this indictment of medical care. First, perhaps health is the wrong output. One could ask only whether physicians and hospitals are efficient at producing narrowly defined medical services such as office visits and hospital stays rather than health. For example, the efficiency of computer makers is judged by how cheaply they make computers of varying power; one usually does not ask whether users need the additional power. But if one assumes that consumers who choose to pay more for more powerful computer value the additional capacity more than its cost, the relevant issue is whether the computer was made in least-cost fashion. Because of the consumer's ignorance and the resulting agency relationship with physicians, the same deference is not as readily given to consumers' preferences in medical care.

Second, one may grant that medical care is not performing well, but is it really performing markedly worse than other industries perform? Although high rates of negligent error and repeated tests, as well as long waiting times, paint picture of poor performance, they scarcely constitute summary measure of efficiency, let alone measure that can be compared against other industries.

For Newhouse, finding measures with which to compare the efficiency of industries is difficult. Comparisons are somewhat easier if medical care services rather than health are the relevant outputs. Then one might employ variants on the notion of best practice: Ascertain the quantity of output (for example, hospital stays) cross various firms and the quantity of inputs each firm uses, and determine how much more could be produced from the same total inputs if all firms produced at the level of the best-performing firms. Then determine if medical care in the aggregate falls short of best practice by more than other industries do. But such comparisons require accounting for differences in the quality of different firms' output and inputs. Further, the market for most medical services is local; inherent differences in scale and modes of treatment complicate comparing the efficiency of small rural hospital with that of large teaching hospital, not to mention solo general practitioner with sub specialist in large group.

If health rather than medical services is the output, problems are magnified. Health cannot be measured in units that are commensurate with outputs of other industries. One would want to know the value added of medical care, something not likely to be known with much precision. Despite the lack of summary measure of its efficiency, many seem convinced that the medical industry's performance falls short.

One of the first indications of inefficiency came from the vast literature on geographic variations in use of treatment, with an implied assumption of little or no variation in outcomes. These variations cannot be accounted for by differ-

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ences in health status. Although variations in patients' preferences and factor prices have been less studied, it seems implausible that they could differ by enough to explain the magnitude of differences in utilization cross areas. As result, the usual interpretation of this variation is that many, perhaps all, areas are producing health inefficiently.

In the mid-1980s, Mark Chassin and others brought forth more compelling evidence of inefficiency than had hitherto existed. Chassin and his colleagues defined procedures to be appropriate if the "expected health benefits of procedure exceed its expected negative consequences by sufficiently wide margin that the procedure is worth doing." Conversely, inappropriate procedures had little or no expected benefit, or even negative benefit. Physician panels assigned appropriateness ratings for patients with varying indications, and then information from sample of charts was used to ascertain each patient's indications.

The initial studies showed that a sixth to third of the procedures performed were inappropriate. An additional number were equivocal. These magnitudes certainly suggest substantial problem. The bad news was not limited to the United States. In the Trent region of the United Kingdom, the rate of inappropriate coronary angiography was 51%, and the rate of inappropriate coronary artery bypass graft (CABG) was 42%. In four Israeli hospitals the rate of inappropriate or equivocal cholecystectomy was 29%. High rates of inappropriateness have not been found in all studies, but they do predominate. Moreover, an economist would find even higher rates of inefficiency, since the economist would consider medical care whose marginal benefit was positive but less than marginal cost to be inefficient, whereas the Chassin definition considers such care to be appropriate.

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Five possible causes of poor performance have been identified: consumers' ignorance; the rate of technological change; the role of administered prices; the difficulty in assessing the performance of given provider; and the role of the public sector and objectives other than efficiency.

Consumers may not be able to distinguish whether bad medical outcome is attributable to poor-quality care or to the underlying disease. Furthermore, for many acute medical problems there is little or no repeat buying, so consumers may have little experience with their specific problem or provider. For both reasons consumers may continue to use providers or delivery systems that give inferior results rather than gravitating toward those with better results and leaving others to fail.

Three types of evidence suggest that the Darwinian process found in most markets does not operate as ruthlessly in medical care. Publishing the results of substantial variation in cardiac surgery mortality among New York and Pennsylvania hospitals did not provoke patients to change hospitals. Poorly performing hospitals and their medical staffs often did respond constructively to the information, but their responses appeared more motivated by professional ethics than by any actual loss of business. Because of their ignorance, patients rely on physicians to act as their agent, so the issue becomes why some physicians apparently do not carry out this role in exemplary fashion.

The pace of new drug development and new procedures is swift. Between 1990 and 2000 nearly 1,000 new drugs were introduced into the U.S. market, and the number of new molecular entities introduced exceeded 300. Just since 1990 the number of cancer drugs in the pipeline has increased from 28 to 402; in 1990 there were six cancer agents in Phase I trials, and today there are 150 200. The use of catheterisation to treat elderly heart attack patients in the U.S. Medicare population increased from 11 percent in 1984 to 41 percent in 1991.

New drugs, devices, and procedures are easily recognized as change. A less well recognized form is the learning that physicians, especially surgeons, acquire as they employ new procedures. Proficiency rises with familiarity, and physicians become more willing to perform the procedure on clinically riskier patients. Discovering effective off-label uses of drugs represents analogous learning.

Rapid change makes knowledge quickly obsolete and places heavy burden on mechanisms that enable physicians and other health professionals to keep up. The profession's main formal instrument for keeping current is continuing medical education (CME). However, the usual CME conference has little effect, and more-promising strategies are seldom used. The IOM *Quality Chasm* report, which also emphasizes the rate of change in knowledge as cause of poor performance, points toward more systems-oriented approach and greater use of information technology to help practitioners cope and to make knowledge diffusion more rapid and more uniform.

Although rapid rate of technological change surely has something to do with the poor performance of medical care, it cannot be the entire story. Other industries with rapid technical change exhibit much different performance. As everyone knows, technological change in the semiconductor and computer industries has been rapid; between 1971 and 1999 the number of transistors per chip increased 10,000 times. Between 1974 and 1996 the price of memory chips, adjusted for this phenomenal change in capabilities, decreased by factor of 27,270 times, a staggering 41% per year. Prices of logic chips, the data for which have been available only since 1985, fell an even greater 54% per year in the 1985-1996 period. Although these figures do not directly show that high-defect – implying high-cost – producers have not survived, that seems likely. Furthermore, over this period dynamic random access memory (DRAM) and metal-oxide-silicon (MOS) logic chips became commodities, implying that quality was nearly uniform. Why do these two industries have performance that is so different from medical care?

Many manufacturers can readily compute defect rates from alternative suppliers because they typically purchase large quantities of supply made to given specifications. Health plans, however, face the constraint that the sample of pa-

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Up coming Seminars

October 16th

@ Gillies Hospital
160 Gillies Ave, Epsom
5.30m. for 6 p.m.

Management Careers in Health

Graham Ewing, Principal, EQI Global

Non Members Welcome
Cost

Members \$20
Non Members \$30

Light refreshments supplied

Nov 5th

Venue to be confirmed

Ann Hall, Principal ITLaw

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tients of any provider is often too small to draw reliable inferences about that provider's performance for particular disease. Plans could, of course, measure the performance of an organized delivery system or aggregation of providers instead, using Health Plan Employer Data and Information Set (HEDIS) or Consumer Assessment of Health Plans (CAHPS)-type measures, but this leaves the possibility of within-system variation in performance.

Implicit in the *Quality Chasm* report's call for greater use of organized systems is that management of these systems could reduce within-system variance in performance to minimal levels. To do so requires that managers not only be able to measure the performance of providers but also have the incentive to reward the better performers. Both requirements are problematic for reasons already described. It is not obvious that the organized delivery system is much better placed than the plan is to overcome the problems of small samples and difficulty of risk adjustment. Nor is it clear that the marketplace, whether economic or political, will reward plans that restrict choice to better-performing organized systems.

The health care financing systems of all developed countries have an important public-sector component. Because efficiency is not the only goal of such systems, one should not expect the same performance as in standard markets. Viewed from the local community, health care financed with taxes is an export good, as is care financed by premiums if premium payers are geographically dispersed. Local legislators will therefore seek to maximize funds coming to providers in their districts. In rural and inner city areas health care spending may also serve community development purposes; the hospital may be among the largest employers in the local area. Although it may be possible to reduce costs and improve the quality of medical services by closing a hospital, they are notoriously difficult to close.

Furthermore, all developed countries regulate entry into the health care professions. The regulations necessarily specify who may perform certain tasks. Such regulations probably inhibit delegating tasks to allied health personnel in cases where delegation would improve performance. Needless to say, the regulations are vigorously defended by those advantaged by them.

The barriers to improvement suggest that medical care quality chasm will always be with us. Nonetheless, the chasm does not have to be as large as it is now. Greater use of information technology can help; if patient's medical history and all available test and medication data were available online at the time physician was making diagnostic or treatment decision, quality would surely improve. Greater use of computerized decision support systems also would improve quality.

Health services research can also help. Most of the evidence of inefficiency comes from health services research. When the scope of the problem is not known, better performance is improbable. In some cases, simply disseminating the findings can improve matters through the goodwill, altruism, or professionalism of health care providers. Research on financial incentives could play an important role. Physicians want to practice good medicine. But there are costs to keeping up, and in many cases the rewards for using the best technique are weak or even negative. The design of better incentives thus should be high priority.

Graham Ewing, our October Seminar speaker, has been involved in high profile executive search and recruitment for more than 18 years. Assignments have involved appointments of Company Directors, Executive Directors, Chief Executives, Senior and Executive Management. In the public health sector Graham has been involved in the appointment of Chief Executives to most of the District Health Boards nationally.

No Risk AGM

Our Branch AGM will be held at the conclusion of Graham Ewing's presentation at our October Seminar.

Do not be dissuaded from attending the Seminar by concern that you might be nominated for the Branch Committee. We have sufficient Committee nominees for the upcoming year.