

Reporting hospital performance—a balancing act between accountability and quality improvement

Mary E Seddon

In this issue of the *Journal* Chaudhry et al present the case for New Zealand to “join the ranks of health systems that embrace public reporting of quality data in the spirit of full and open transparency, benchmarking and continual improvement.”¹ A fine aim, but is it as simple as following the US and UK lead, and will it improve healthcare services?

An early report out of the RAND² made the point that the “US experience of public disclosure is presented in the context of its healthcare system and consumer orientated culture.” It is important to bear in mind some of the key differences in the US compared with New Zealand: patient and doctor autonomy is highly valued and there is at least theoretical choice of hospital (mostly controlled by employers as health insurers); hospitals exist in competitive markets; and due to their billing databases they have better quality and granularity of data (this comes at a cost with administration greater than 20% of the total spend on health, five times the OECD average).^{3,4}

The UK healthcare system is more similar to New Zealand’s, however with primary care commissioning there is also choice of hospital/services. In the New Zealand public health system, patients do not have a choice as to which hospital to attend, therefore the publication of hospital performance data may not be a competitive driver for improvement. So to answer the first question, it appears unwise to simply transfer performance indicators from other countries (tempting though it is).⁵

Public disclosure of healthcare performance data (predominantly hospital or provider performance) has been advocated for two main reasons:

- Accountability/transparency
- As a driver for quality improvement

To review these in turn. It seems that there is a policy appetite in developed countries for transparency and some form of accountability. Although it is stated in terms of accountability to the public, most studies show that the ‘public’ do not search out performance reports, often do not understand them if they do, and make little use of them in their decisions as to where to seek healthcare.^{6–8}

When there is a choice of hospital or doctor, the evidence suggests that the advice of friends and family,⁹ the long-term relationship with a doctor¹⁰ and the proximity of a hospital are more important than report cards of performance. It seems much more likely that the accountability touted is actually accountability to the funders of healthcare. Others have argued that this accountability function is about control including financial control.¹¹

Chaudhry et al appear confused as to the purpose of the Health Roundtable work. It is designed to initiate conversations around anonymous data so that organisations can

improve, it is not measurement for accountability—one of the main problems is the lack of validity and reliability in routinely coded data—and would not be useful to publicly report.

As Solberg et al said in their seminal article ‘The three faces of performance measurement: improvement, accountability and research’¹²: “We are increasingly realising how critical measurement is to the QI we seek, yet how counterproductive it can sometimes be to mix measurement for accountability or research with measurement for improvement.” Not only the purpose of the measurement differs, but also what and how it is measured.

For accountability, the purpose is comparison, and to be useful there must be precise and valid data, rigorously risk adjusted, a large sample size and collected over a long period of time. For QI, the measures need to be ‘good enough’ to learn about the process and assess whether improvement has occurred, with iterative learning cycles and it works best when they are confidential to the organisations involved. Without this confidentiality, the risk is a loss of trust in the process: “the problem with measurement is that it can be a loaded gun—dangerous if misused and at least threatening if pointed in the wrong direction.”¹³

So does the public release of this information lead to better quality of care?

Despite a rapidly expanding report card industry, there is little formal evaluation of the impact of publically releasing such data. A recent Cochrane review found only four high quality studies examining this issue and concluded that “the small body of evidence available provides no consistent evidence that the public release of performance data changes consumer behaviour or improves care.”¹⁴

In observational studies, the extent to which report cards promoted improvement in the quality of hospital care was variable at best with organisations often focussing on improving data collection systems rather than the systems of care.^{6,15}

Even the often cited New York State cardiac surgery reporting system noted in the Chaudhry article is not the clear cut success case it first appears. Most of the surgeons with high mortality rates were low volume operators, and following publication most either stopped doing bypass operations, or moved out of state. Secondly there was some data that surgeons stopped offering surgery to high risk patients, and finally cardiac surgery mortality rates were decreasing in other states that did not have report cards.^{16,17}

There are those who argue that performance data, especially with targets attached, actually work against improving quality. “Quality improvement is premised on the value to the patient (customer), local leadership and looking at systems as a whole. Targets do exactly the opposite: they devalue the customer by focussing on an arbitrary number, devalue local leadership by relying on central control and measure isolated silos of activity.”¹⁸ Whether public reporting of quality indicators is effective is not only an unanswered question, but in New Zealand it seems to be unasked.

In contrast to the paucity of evidence for the positive effect of public reporting, there is good evidence as to the predictable adverse effects¹⁰ with seven well recognised.⁷ These include tunnel vision (as routinely collected, quantitative data is the focus), myopia (focussing on short term objectives), ossification (unwilling to experiment with new and innovative approaches) and gaming.

Gaming is especially likely if large incentives are attached to the performance targets. This can be seen in the analysis of the 4-hour Emergency Care target in the UK where 98% of units achieved this target. According to mathematicians and queuing experts this result could only be obtained through gaming: making patients wait in ambulances, moving patients (and occasional temporary walls) so the patient was no longer in EC and admitting patients too early.¹⁸

At present the momentum towards the use and public reporting of performance data is increasing more rapidly than our understanding of the consequences of this. New Zealand should be cautious and evaluate the effects of any proposed system.

There are other ways to encourage healthcare improvement and transparency. One of these are the proposed Quality Accounts, which each DHB will produce next year. These are designed to balance the emphasis on financial accounts with a review of quality of care gaps, quality improvement programmes and progress in these areas. These are the place to address the organisation's performance in patient-centred care (so much more than the patient satisfaction surveys mentioned in the Chaudhry article) with patient stories of their care, and examples of experience-based design. With time these may mature into very useful windows on the good work going on in many of our DHBs.

Competing interests: Nil.

Author information: Mary E Seddon, Clinical Director of the Centre for Quality Improvement, Ko Awatea, Counties Manukau District Health Board (DHB), Otahuhu, Auckland

Correspondence: Dr M Seddon, Clinical Director, Quality Improvement Unit, Counties-Manukau DHB, Private Bag 93311, Auckland, New Zealand. Fax: +64 (0)9 2593865; email: Mary.Seddon@middlemore.co.nz

References:

1. Chaudhry M, Gauld R, Horsburgh S. Hospital quality-of-care performance measurement and reporting: what New Zealand can learn from the United States and United Kingdom. *N Z Med J*. 2012;125(1366). <http://journal.nzma.org.nz/journal/125-1366/5445>
2. Marshall M, Shekelle P, Brook R, Leatherman S. Dying to know. Public release of information about quality of health care: RAND and Nuffield Trust; 2000.
3. Farrell D, Jensen E, Kocher R, et al. Accounting for the cost of US health care: A new look at why Americans spend more: McKinsey and Company; December 2008.
4. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *The New England Journal of medicine*. 2003 Aug 21;349(8):768-75.
5. Marshall MN, Shekelle PG, McGlynn EA, Campbell S, Brook RH, Roland MO. Can health care quality indicators be transferred between countries? *Quality & Safety in Health Care*. 2003 Feb;12(1):8-12.
6. Davies HT, Marshall MN. Public disclosure of performance data: does the public get what the public wants? *Lancet*. 1999 May 15;353(9165):1639-40.
7. Marshall MN, Romano PS, Davies HT. How do we maximize the impact of the public reporting of quality of care? *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care / ISQUA*. 2004 Apr;16 Suppl 1:i57-63.
8. Hibbard JH, Greene J, Daniel D. What is quality anyway? Performance reports that clearly communicate to consumers the meaning of quality of care. *Medical care research and review: MCRR*. 2010 Jun;67(3):275-93.

9. Harris KM, Beeuwkes Buntin M. Choosing a health care provider. The Synthesis project research synthesis report. 2008 May(14). <http://www.ncbi.nlm.nih.gov/pubmed/22051936>
10. Schwartz LM, Woloshin S, Birkmeyer JD. How do elderly patients decide where to go for major surgery? Telephone interview survey. *BMJ*. 2005 Oct 8;331(7520):821.
11. Smith P. On the unintended consequences of publishing performance data in the public sector. *International Journal of Public Administration*. 1995;18(2-3):277-310.
12. Solberg LI, Mosser G, McDonald S. The three faces of performance measurement: improvement, accountability and research. *The Joint Commission Journal on Quality Improvement*. 1997;23(3):135-47
13. O'Leary DS. Measurement and accountability: taking careful aim. *Joint Commission Journal of Quality Improvement*. 1995;21:354-7
14. Ketelaar NABM, Faber MJ, Flottorp S, et al. Public release of performance data in changing the behaviour of healthcare consumers, professionals or organisations; 2011.
15. Schauffler HH, Mordavsky JK. Consumer reports in health care: do they make a difference? *Annual review of public health*. 2001;22:69-89.
16. Ghali WA, Ash AS, Hall RE, Moskowitz MA. Statewide quality improvement initiatives and mortality after cardiac surgery. *JAMA: the Journal of the American Medical Association*. 1997 Feb 5;277(5):379-82.
17. Epstein AJ. Do cardiac surgery report cards reduce mortality? Assessing the evidence. *Medical care research and review: MCRR*. 2006 Aug;63(4):403-26.
18. Gubb J. Have targets done more harm than good in the English NHS? Yes. *BMJ*. 2009;338(a3130).