The Public Disclosure of Performance Data

Policy Recommendations for the National Health Service

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The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Rt Hon Frank Dobson, PC, MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

Dear Secretary of State

Public Disclosure of Performance Data: Policy Recommendations for the NHS

The Nuffield Trust very much welcomes the initiative of the Department of Health in undertaking the public release of information on performance in hospitals in the United Kingdom, believing that this is likely to play a significant part in improving quality in health care. The Trust has a long standing interest in this area; while recent developments in the United Kingdom are welcome, the Trustees have for some time been aware that there is experience in the United States of the public disclosure of performance data which is likely to be of relevance to the UK. Accordingly the Trust has entered into a collaboration with RAND, one of the foremost US practitioners in the field, to explore US expertise and the potential benefits this may offer in developing the public release of information in this country.

To assist them in developing this programme, the Trustees invited a Steering Committee of UK experts to work with a select team from RAND to define and oversee a number of specific projects in areas such as the public release of performance data in cardiac surgery and quality assessment in primary care. Over the next two to three years a series of definitive reports of different aspects of the programme will appear. In the meantime the Steering Committee suggested that there were a number of key recommendations addressing major policy issues regarding the context, the implementation and ways of maximising the benefits and reducing the risks of the public. Accordingly the Trust commissioned a preliminary report on the public disclosure of performance data, which has been endorsed by the Steering Committee and which I now have pleasure in enclosing.

The Steering Committee was aware that the individual countries within the United Kingdom are proceeding at different rates, and with somewhat different approaches. Nonetheless we believe that the recommendations in this report are as applicable to Scotland, Wales and Northern Ireland as to England, and the attention of the respective Secretaries of State is being drawn to this report.

John Wyn Owen

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Secretary

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The Nuffield Trust
59 New Cavendish Street
London W1M 7RD

Authors
Martin N. Marshall*
Paul G. Shekelle**
Sheila Leatherman***
Robert H. Brook****

*Harkness Fellow, Senior Lecturer in General Practice, School of Postgraduate Medicine and Health Sciences, University of Exeter, U.K. **Senior Scientist, RAND Health Program, Santa Monica, CA, USA. *** Founder, Center for Health Care Policy and Evaluation, Executive Vice President, United Health Group, Minnetonka, MN ,USA, Senior Associate, Judge Institute of Management, University of Cambridge. ****Vice President, RAND Health Program, Professor of Medicine and Health Services, UCLA Centre for Health Services, RAND Health Program.

Introduction

Public disclosure of the performance of health care providers and purchasers is one mechanism of ensuring accountability, improving quality and reducing health care costs. The process requires the development and dissemination of standardised reports on quality of care and facilitates comparisons of performance over time and amongst providers and geographical areas.

The authors of this report believe that an increased level of public disclosure in the National Health Service is both inevitable and desirable, assuming that it is done rigorously. The purpose of the report is to present concise recommendations which we hope will contribute to current thinking, inform successful implementation of a policy on public disclosure and reduce the associated risks and unintended consequences. The recommendations will be expanded upon in a detailed technical report to be published by the Nuffield Trust in late 1999.

The recommendations are based on a critical appraisal of the twelve years of experience of public disclosure in the United States (US). This experience provides a useful insight to guide the expansion of the current low level of public disclosure in the United Kingdom (UK). The differences in culture and health care organisation need to be taken into account but much could be gained by studying examples of successful reporting systems and learning from the mistakes that have been made in the US. For the purpose of this paper an extensive review of published and unpublished reports and expert opinion was conducted between October 1998 and February 1999. Empirical evidence to guide policy is, however, sparse and is based largely on descriptive and a small number of quasi-experimental studies. The following tentative conclusions can be drawn from the available evidence.

- Consumers and purchasers of health services express wide ranging demands for comparative information about the performance of providers but only a small proportion search out or read the information and a significant proportion fail to understand the reports that are now available. Current evidence suggest that though performance reports have a small impact on the decision making of individual consumers and purchasers, the impact may be increasing.

- Doctors are sceptical about the publicly disclosed performance information and only a small proportion of them consider it to have any impact on their clinical practice or discuss it with their patients.

- Hospitals do appear to respond to the public release of performance data. In some instances a defensive response has been observed but in others the information was received positively and incorporated into the institution's quality improvement strategy, resulting in measurable improvements in the quality of patient care.

- At a community level there is evidence from the New York reports of mortality following coronary artery bypass surgery that publication of performance data contributes to an improvement in health outcomes.

The following recommendations address major policy issues regarding the context, the implementation and ways of maximising the benefits and reducing the risks of public disclosure. In each case, the term "stakeholders" includes consumers, patients and their representatives; individual health care professionals and professional organisations; health care organisations, including Trusts, Primary Care Groups, Health Authorities and general practices; the NHS Executive and the Department of Health.

1. **The intended purpose or purposes of public disclosure should be made clear to all stakeholders**

Those who work in the NHS may feel threatened by public disclosure and may question the resources required to collect and report performance information. Making a clear statement about the expected benefits will help these people to understand the rationale for greater openness. In addition, the intended purpose will dictate the content and process of public disclosure. There is some evidence to suggest that disclosure can facilitate public accountability, improve the decision making of consumers and purchasers, inform decisions about resource allocation and regulation and promote quality improvement. An explicit definition of the goals and objectives will also help identify the evaluation criteria that are used to assess whether and how public disclosure is improving health care processes and outcomes.

2. **Public disclosure should be seen as an evolutionary process, becoming progressively more sophisticated and comprehensive over time**

Public disclosure represents a major culture challenge for health professionals and organisations who to date have had little obligation to demonstrate accountability for quality of care. There is a danger that public disclosure may be perceived as threatening professional autonomy and therefore work against the creation of an environment where systematic evaluation and improvement can flourish. Change will take time and the quality of the performance data will be an important determinant of the acceptability of the public information and its ability to promote change. The state of the art of performance indicators and the information technology to support them need to be continuously refined. Quality indicators do not have to be perfect but do need to be good enough to achieve "buy-in" from stakeholders. The National Performance Framework represents a good starting point in both the articulation of a long-term policy direction as well

as a classification of measures for development. Its credibility, however, will depend upon the demonstration of year-on-year improvements in the selection of indicators and their measurement and reporting. The framework will need to be responsive to constructive criticism. The Department of Health should work closely with academics, clinicians and other stakeholders to refine the framework.

3. Public disclosure should be seen as one component of clinical governance

The principles of clinical governance have been largely accepted by health professionals and managers. Accountability for continuous quality improvement is a defining feature of clinical governance and in the future should be based at least partially on publicly available information about performance. Providing evidence of deficiencies in quality, or evidence of best practice, for internal use alone does not appear to have produced the expected or desired level of improvement. Public disclosure may be seen as a way of focusing the attention of both clinicians and managers on specific areas. It will be most effective if integrated into other quality improvement strategies, for example educational initiatives, the use of professional and financial incentives, organisational change and regulation.

4. Provider organisations should be a key audience for information about performance

Assuming that the encouragement of quality improvement is one of the intended purposes of public disclosure, the reporting level of performance data needs to be carefully considered. Current evidence suggests that individual consumers are the least responsive to performance data, even in the consumer-orientated US. Therefore, whilst users should contribute to the process of public disclosure, they are not necessarily the prime audience for the data. Provider organisations

appear to be the most responsive of the stakeholders. This is because they are sensitive to their public image and because they have the authority to act on sub-optimal levels of performance and promote better standards of practice. Most of the evidence is based on hospitals in the US and it is likely that UK hospitals and Primary Care Groups will respond in a similar way. Reporting at the provider organisation level is consistent with the policy direction of clinical governance. Reporting at a higher level, for example at the level of Health Authorities, is also required and is an appropriate place to start for practical and statistical reasons. However, if information is only reported at this high level it is less likely to have a direct impact on the quality of patient care. Reporting at a lower level, such as Trust Directorates or Primary Care Groups is statistically more difficult but will be effective. Reporting at the lowest level of individual doctors may be possible in selected cases, such as high volume surgeons, but does not take into account or promote team work and is methodologically difficult.

5. The financial cost of implementing a national policy on public disclosure is likely to be significant and should be considered alongside the benefits

An accurate assessment of the financial cost of public disclosure has not been conducted in the US but the resources required to develop, measure, report and most importantly improve performance are likely to be significant. The opportunity costs of allocating resources to public disclosure in place of direct patient care need to be defended. If public disclosure is regarded as a necessity in a public service, irrespective of its potential to promote quality improvement, the costs may not be considered to be a significant factor. If however the principle aim is to improve quality, public disclosure will have to be judged alongside other quality improvement strategies and a full and formal cost-benefit analysis should be conducted.

6. Specific educational initiatives for target audiences should be implemented alongside public disclosure

There is evidence from the US of a defensive response or a lack of response to performance data from all of the stakeholder groups. The chances of a constructive response could be increased by informing and educating the target audiences through initiatives such as:

- Education of the public through the use of mass media.
- Education of all health professionals from the start of their basic training and as a component of a continuing professional education programme.
- Release of data as part of an educational package aimed at providers to promote quality improvement. This could include an explicit statement that the level of performance revealed by public disclosure should not only be seen as a function of the effectiveness of individual practitioners but also the team within which they function, the organisation within which they work and the resources available to them.
- Development of a strategy to promote greater collaboration and sharing of information amongst organisations.
- Proactive education of the media, which has proved to be an important component of successful public reporting programmes in the US.

7. Health professionals and their representative bodies should be fully involved in the process of public disclosure

The experience in both the UK and US highlights the importance of involving health professionals and their professional bodies in the selection, implementation, monitoring and evaluation of the indicators. Specific mechanisms or processes for active participation should be defined. For example, allowing professionals and their provider organisations a period of time to both respond to performance data and to put mechanisms in place to improve performance prior to publication is one way of integrating them into the process

of public disclosure. Some reporting systems in the US gave providers a period of one year prior to the public release of the first data about a specific condition. Providers might be encouraged to send in written responses to the data, which are then published alongside the performance reports.

8. Both process and outcome measures of quality should be published

Health outcomes are intuitively appealing but have inherent problems when used to measure and compare quality of care. Outcomes are often the result of factors outside the control of the health system and focusing on outcomes gives no insight into how providers can improve the processes of care. Some outcomes, for example mortality, occur infrequently in comparison with the processes that prevent them and in health care there is often a long period of time between the action of a provider and the consequences of that action. The use of outcome measures is more applicable to some areas of practice than others but in general the use of process measures overcomes many of these problems. In particular the use of process measures can be justified when there is solid evidence that they are strongly linked to health outcomes. There is an increasing body of evidence that process measures are a more sensitive and more feasible measure of quality of care than outcome measures.

9. Outcome indicators must be risk adjusted

Meaningful comparisons of outcomes that are valid and credible can only be made if the sources of variation amongst providers that are not directly related to quality of care are removed by risk adjustment. The level of sophistication of the risk adjustment mechanisms currently being used is highly variable. A balance must be achieved between complex systems (with associated implications for cost and feasibility) and little or no risk adjustment which may penalise those providers who accept high risk patients, result in gaming of the system or reduce the credibility of the whole process of public disclosure. The level of risk

adjustment should evolve alongside other aspects of public disclosure. Current experience suggests that the proposed adjustment of indicators in the National Performance Framework could be significantly improved upon by incorporating additional important risk factors, for example adjusting for social deprivation as one factor that influences emergency hospital admissions for asthma. Process quality measures may not need to be adjusted if they are constructed so that the patients to whom they are applied are described with precise clinical detail.

10. Public disclosure should be accompanied by a strategy for monitoring the benefits and unintended consequences

Public disclosure has both risks and unintended consequences. Published evidence of deficiencies in the care provided by professionals who already feel over-burdened can be demoralising and may adversely effect public trust in the health service. Misinterpretation of information, manipulation of data and an inappropriate focus on what is being measured, to the detriment of other areas of activity, have all been described. Some of these effects are inevitable but virtually all can be prevented, predicted or managed to optimise the benefits of public disclosure. The Commission for Health Improvement should play an important role in the monitoring, evaluation and policy assessment of public disclosure.

11. Public disclosure should be accompanied by possible explanations for the variations reported

It is inevitable that performance data will be of great public interest and may be misinterpreted or over-interpreted by the public, the media, health professionals and managers. This will have adverse consequences for the credibility and potential impact of future data. The risks could be reduced by accompanying performance reports with expert analysis and interpretation of the data. This

commentary could then be used by providers as a catalyst for internal discussion and further action or could be used by government officials when addressing NHS resource allocation.

12. A research and development programme focusing on the generation and evaluation of public performance data should be supported by the NHS R&D Directorate

A policy on public disclosure is likely to be most effective if guided by empirical evidence of the associated merits and risks. The evidence is currently lacking, particularly in the UK and would benefit from a focused and adequately funded research and development programme. Information is needed about the content and presentation format of information most useful to consumers, providers and regulators, the impact of disclosure on professional morale and public trust in the NHS, the unintended consequences and the most appropriate risk adjustment mechanisms. The introduction of the National Performance Framework provides a unique opportunity to provide experimental or quasi-experimental evidence of the relative merits of public disclosure versus the use of the same data for internal quality improvement purposes.

NUFFIELD TRUST/RAND COLLABORATION

QUALITY STEERING COMMITTEE

Professor Nick Black	Department of Public Health and Policy, London School of Hygiene and Tropical Medicine
Dr Robert Brook	Vice President and Director, RAND Health
Professor Jessica Corner	Professor of Cancer Nursing, Institute of Cancer Research
Jan Filochowski	Project Director, NHS Breakthrough Service Collaboration
Professor Leon Fine	Professor of Medicine, Royal Free and University College Medical School
Sheila Leatherman	Executive Vice President, United Health Group, Minnetonka, US; Senior Associate, Judge Institute of Management Studies, University of Cambridge
Dr Martin Marshall	Senior Lecturer in General Practice, School of Postgraduate Medicine and Health Sciences, University of Exeter
Dr Fiona Moss	Associate Postgraduate Dean, NHS Executive London Region; Editor, *Quality in Health Care*
John Wyn Owen	Secretary, The Nuffield Trust
Professor Martin Roland	Director of Research and Development, National Primary Care R & D Centre
Dr Paul Shekelle	RAND Corporation
Sir Maurice Shock	Chairman, The Nuffield Trust
Jane Steele	Principal Research Fellow, Public Management Foundation

Observers

Mr Clive Smee	Department of Health
Mr David Skinner	General Medical Council