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TECHNICAL REPORT

How health systems make available information on service providers

Experience in seven countries

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Prepared for the Department of Health within the PRP project
"An 'On-call' Facility for International Healthcare Comparisons"

The research described in this report was prepared for the Department of Health within the PRP project "An 'On-call' Facility for International Healthcare Comparisons".

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Executive summary

There is growing interest in the public release of information on the performance of healthcare providers as a means to improve the quality of care and promote transparency and accountability. Countries have made considerable investments in creating systems to make available such information. However, there is lack of systematic comparative assessment of such systems. Thus, there is a need to better understand the drivers behind and leaders of initiatives and their aims and objectives; the nature, frequency and source of information provided; their availability to and usability by the public, and, finally, whether and how these systems might have an impact on the quality of care.

This report aims to contribute to filling these gaps by reviewing information systems reporting on the quality or performance of providers of healthcare ('quality information systems') in seven countries: Denmark, England, Germany, Italy, the Netherlands, Sweden and the United States. Data collection involved a review of the published and grey literature, complemented by information provided by key informants in the selected countries using a detailed questionnaire.

The review highlights that as the policy context for quality reporting in countries varies, so also does the nature and scope of quality information systems within and between countries. Systems often pursue multiple aims and objectives, which typically are:

- to support patient choice
- to influence provider behaviour to enhance the quality of care
- to strengthen transparency of the provider–commissioner relationship and the healthcare system as a whole
- to hold healthcare providers and commissioners to account for the quality of care they provide and the purchasing decisions they make.

However, system objectives are not always well defined and documented, which makes it difficult to assess whether, and how well, systems achieve their intended aims.

Similarly, quality information systems typically address a number of audiences, including patients (or respectively the general public before receiving services and becoming patients), commissioners, purchasers and regulators. Ultimately, however, the main users of information systems are the providers themselves as the publication of information provides an incentive for improving the quality of care. Most systems have the stated aim to make information on provider performance available to patients thus supporting choice of provider. Yet there are examples of systems that, in their present format, seem to be ill-

suit to meet patients' information needs as the nature of information collected and their presentation might require specialist knowledge in order to be usable and useful. This reflects, to a certain extent, the origins of several of the information systems reviewed here, which have developed gradually, often through a combination of some form of 'bottom up' initiatives and 'top down' regulation. In Sweden, for example, the national quality registries were initially developed by clinicians and professional networks, while requirements for quality reporting for hospitals in Germany were defined by the legislator. The *Weisse Liste* in Germany is developed by a private foundation in collaboration with associations of patient and consumer organisations.

As quality information systems vary in their objectives and target audiences, so does the nature and scope of data provided. In most countries, several systems co-exist, frequently, although not always, serving slightly different purposes. The scope ranges from those whose sole purpose it is to inform about one aspect of performance, typically waiting times (e.g. *Ventetider* in Denmark and *Väntetider i Vården* in Sweden), to systems that give users access to detailed information about the quality of care delivered by individual providers. Where detailed information on provider performance is available, it tends to focus on hospitals with only a minority of systems also providing information on the quality of primary and/or preventive care (e.g. NHS Choices in England, *Zichtbare Zorg* in the Netherlands, and *Öppna jämförelser* in Sweden). Furthermore, only a few systems provide patient ratings based on systematic surveys, including patients' experience (e.g. NHS Choices, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in the United States (US), and KiesBeter in the Netherlands), patient satisfaction (*Qualitätskliniken* in Germany) or provide an opportunity for direct feedback from patients (e.g. the ongoing pilot project by *AOK-Gesundheitsnavigator* in Germany).

Governments and health authorities play a key role in operating and funding quality information systems. Where healthcare governance has been devolved to regions or countries, quality reporting typically also involves regional governments. Furthermore, professional groups are involved, for example by operating the databases on clinical quality in Denmark or the national quality registries in Sweden. Dr Foster Intelligence in England has originated in the private for profit sector and is operated as a public-private partnership.

Although countries reviewed here have developed a variety of quality information systems for a range of different audiences, the evidence about the impact of these systems is fairly limited. Systematic evaluative work is mainly available for the US, suggesting that public reporting can improve the quality of care in some areas. However, the effects of information systems on quality of care are difficult to isolate as these frequently are part of broader quality initiatives. Also, the requirements for increased reporting necessitate improved documentation, which may explain some of the (initially) observed effects of quality reporting on improvements.

Quality improvement can result from selection and/or as a consequence of provider behaviour change. These mechanisms are however difficult to disentangle. Findings from six of the seven countries reviewed here suggest that patients rarely search out information about healthcare providers. Low uptake of published information suggests that the available data does not sufficiently meet patients' information needs, also highlighting lack

of systematic involvement of patients in the development of quality information systems (with NHS Choices in England being a notable exception). Growing evidence suggests that other user groups, such as managers and providers, indeed use comparative information to improve care where public reporting occurred. It is important to note that information systems can encourage changes in provider behaviour even if the public makes limited use of them. This supports the notion of an association between public reporting and quality improvement, which operates largely through provider behaviour change. More systematic research is needed, however, to understand the underlying mechanisms.

Based on the evidence reviewed here, we identify a number of considerations for the design of quality information systems. Thus, the purpose of publishing information on the quality of service providers needs to be well defined, as does the primary target groups that are supposed to be using the system. Where patients or the public are the main intended users, information systems must ensure access and usability so as to minimise the possibility of unequal access to web-based resources. Stakeholder involvement can improve acceptance of information systems and therefore potentially increase its use. It will therefore be necessary to decide early on which stakeholders to include and at what stage of the process.

Several findings highlighted the necessity to improve and ensure the high quality of data provided. Mechanisms for ensuring validity, reliability and consistency of reported data should go hand in hand with safeguarding the completeness of data. Mandatory approaches can be effective, but also incentive-driven schemes, for example ‘pay-for-reporting’ (Hospital Compare, US) can be successful in achieving high participation of healthcare providers. As there might be an incentive for some providers to manipulate data, control mechanisms are indicated. Finally, and perhaps most challenging, there is a need for systematic evaluation of information systems to assess the cost–benefit relation of information systems as well as their overall value for money. This includes rigorous measurement of potential impacts on provider behaviour and detailed understanding of the mechanisms at work. Further learning from international experience can be helpful in achieving these aims.