REVIEW OF EXISTING MODELS OF REPORTING TO CONSUMERS ON HEALTH SERVICE QUALITY

SUMMARY REPORT AND GUIDELINES

Prepared by the Division of Research and Education, Royal Women’s Hospital, Melbourne; Health Issues Centre; and Consumers in Health Consulting

A Consumer Focus Collaboration publication
The Commonwealth Department of Health and Aged Care has funded a range of projects to strengthen consumer participation in health through its Consumer Focus Strategy. These projects are overseen by the Consumer Focus Collaboration, which is made up of consumer organisations, professional organisations, Commonwealth, state and territory health departments, and private sector representatives. The Collaboration works to increase effective consumer participation at all levels within the Australian health care system.

Projects funded through the Strategy are intended to promote, integrate and disseminate information and increase consumer involvement in health service planning, delivery, monitoring and evaluation. The Consumer Focus Collaboration publication series documents these projects.

A wide range of organisations participate in the Consumer Focus Collaboration, representing a broad range of views and interests. Consumer Focus Collaboration publications do not attempt to reflect all of the views of the individual organisations and jurisdictions represented on the Collaboration. However they do demonstrate the shared perspective on strategies for building a strong consumer focus for national action on quality and safety.

For information on the availability of the publications, contact the Information Manager, National Resource Centre for Consumer Participation in Health, ph. (03) 9479 3614, free call 1800 625 619, web site http://nrccph.latrobe.edu.au

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FOREWORD

Building a safe, high quality health care system means that people managing and working in the system need to work together with consumers and the community to achieve sustainable improvements and maintain public confidence in the system.

The Consumer Focus Collaboration publication series provides practical tools to support consumers and health care providers to achieve this goal. These tools have been developed through projects funded by the Commonwealth Department of Health and Aged Care.

The Consumer Focus Collaboration, established in 1997, has played an important role in taking forward work on consumer participation at the national level. The Collaboration is a national body with representatives from consumer, professional and private sector organisations, and all health departments. Its aim is to strengthen the focus on consumers in health service planning, delivery, monitoring and evaluation in Australia.

The Collaboration is taking the lead in fostering an active partnership between consumers of health care and those who provide that care.

The resource guides, reports and issues papers that make up the publication series have been designed to provide health care consumers, service providers and managers with ideas and information about how to work together in partnerships.

Strengthening the voice of consumers in the health system requires a multi-pronged approach. This publication series reflects the commitment of the Consumer Focus Collaboration to provide strategic resources in a number of areas including education and training, building consumer capacity to participate, building provider capacity to respond to consumer need, and research into aspects of consumer involvement in health services.

Consumer Focus Collaboration
June 2000
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Introduction

The Review on Reporting on the Quality of Health Services to Consumers was conducted by a consortium led by the Royal Women’s Hospital in Melbourne on behalf of the Commonwealth Department of Health and Aged Care. Consortium partners were the Health Issues Centre and Consumers in Health Consulting.

The review was developed under the direction of the Consumer Focus Collaboration, a group of stakeholders working to increase effective consumer participation at all levels of the health care system. The Collaboration includes representatives of consumer organisations, Commonwealth, state and territory health departments, medical groups, hospital associations and other health industry groups. One of its four key goals is ‘to improve health service accountability and responsiveness to consumers’.

The Collaboration’s Strategic Plan identified that it would ‘facilitate the development of improved methods and formats for the provision of information to consumers about the quality and performance of health services at the local, regional, state and national levels. As a first step, an audit should be undertaken of current activity of health service reporting to the community’.

The primary objective of the review was to identify, from existing models of reporting on quality to consumers, the principles or strategies that contribute to their effectiveness in order to inform future initiatives in this area.

The review engaged a range of stakeholders in a process to identify and evaluate a variety of models for providing information to consumers on health services quality.

The key elements of the review were to:

- identify effective models of reporting on quality by health services to consumers, which would contribute to better informed consumer decision-making and assist consumers and health services to improve the quality of care;
- identify existing sources of information for consumers about service quality, and assess their reliability and accessibility;
- identify key incentives and disincentives for the collection and publication of such information;
- engage key stakeholders in the process of working towards effective reporting on quality to reach agreement on the types of quality information consumers wish to have; and
identify principles underpinning successful and effective reporting of reliable data on quality of health care, which might provide the basis for future public release guidelines.

The four phases of the review were:

1. The conduct of a literature review on reporting.
2. The identification and examination of examples of reporting under way in Australia and overseas, including a national stakeholder consultation.
3. The development of a set of principles and guidelines to assist health agencies and consumers in the design and implementation of a program of reporting to consumers.
4. A national targeted workshop to comment on the draft principles and guidelines.

The review was conducted between February and August 2000.

This booklet contains a summary of the findings of the review, and the principles and guidelines for reporting to consumers on health service quality which were developed as a result of the review.

A more detailed account of the review can be found on the web site of the National Resource Centre for Consumer Participation in Health at http://nrccph.latrobe.edu.au
PART 1: SUMMARY OF THE REVIEW

This review outlines the development of reporting to consumers on the quality of health care in the US, UK, Canada and Australia. On the basis of a study of the literature, a broad range of stakeholders were consulted to elicit opinion and identify perceptions of reporting, how health agencies might report to consumers and the scope of what could and should be reported. This consultation also examined the technical issues of data accessibility and reliability.

The review resulted in the development of a framework for reporting, which the review team termed Purposeful Reporting to Consumers. This framework arose from the findings of the literature review and the stakeholder consultation. Its distinguishing features are the intentional engagement of consumers in decision-making and performance improvement processes and the targeting of consumers as a primary audience for information on the quality of services. A framework of purposeful reporting to consumers has implications for the content of what is reported as well as the design and dissemination of reports.

With input from stakeholders, the review compiled a set of principles and guidelines to assist health agencies in the development of a purposeful report to consumers.

Key findings of the review

1. The identification of five reporting models drawn from the literature review, case studies and stakeholder consultation.

2. The identification of two frameworks for reporting on health service quality — public release of information and purposeful reporting to consumers.

3. Changes in the format and design of information on the performance of health agencies on the quality of health care.

4. Varying impact on consumers, purchasers, providers and health care agencies and quality improvement programs. At this stage, there is little evaluation or research on the impact of reports on consumer behaviour and health agency response to the findings of reports to consumers on the quality of health services.

5. Continued debate among key stakeholders as to the value of reporting.

6. The identification of few examples of reporting in Australia, that are either accessible or meaningful to consumers.
7. Shortcomings in the reliability and accessibility of data in Australia on the quality of health services that could be reported to consumers, particularly data enabling comparison between health agencies.

The experience of reporting — US, UK, Canada and Australia

Despite differing structural and policy influences, these countries have encountered similar challenges in the development of purposeful reporting to consumers.

Debate has centred on the views of various stakeholders on what information can and should be made available to consumers. To date, the US is well ahead of the UK, Canada and Australia in reporting to consumers, although these countries have recently begun to publicly release health performance data.

A ‘snapshot’ of the status of reporting in each country, as described in the literature, is outlined below.

United States

Reporting to consumers in the United States has been influenced by the imperative of private health insurance to identify cost efficiencies, the shift to managed care, and the dominance of a market-driven health care system.

Initially, reporting was intended to enable consumers to choose between competing health care plans. However, concern that price competition could ultimately cost consumers and purchasers in quality and adverse events provided a new focus to public disclosure of performance data. Reporting is seen to provide greater public accountability and regulation of the health system. The introduction of mandatory public reporting on adverse events is also intended to help reduce the consequences of medical errors.

Reporting measures in the US have shifted from a single clinical outcome indicator, such as risk-adjusted mortality rates after coronary artery bypass graft (CABG) surgery (New York and Pennsylvania), to include process and outcome measures such as the HEDIS data set. Most recently consumer reports such as the CAPHS indicators now include a range of indicators on ‘personhood’ or a range of functional measures such as in the Consumer Oriented Mental Health Report Card. There has also been a move to integrate cost and quality measures.
United Kingdom

Reporting in the United Kingdom has evolved from quality improvement initiatives and public accountability frameworks. The British Government’s main objective, at the health policy level, has been to maintain a cost-efficient and effective national health care system.

Reforms to the health care system in the late 1980s and early 1990s led to the separation of purchasers from providers of health services. The intention of this reform was to introduce internal market competition and to achieve greater performance and cost efficiencies. However, quality improvement still remained a largely internal, self-monitoring process.

The publication of comparative performance data on hospitals contained in league tables was an attempt to increase accountability for public service outcomes even though the data was not risk adjusted or audited. Consequently, the comparative ranking of health care agencies on performance received a negative response. This was partly due to the lack of statistical rigour of the data, and to the increase in perverse behaviours by providers attempting to achieve positive league table ratings.

More recently, the case at the Bristol Royal Infirmary has provided the impetus for a Government initiative to develop a set of quality performance indicators. The public release of risk-adjusted clinical and high-level performance indicators is intended to show unacceptable variations in health outcomes between different regions. The purpose of publishing this data was also to encourage the sharing of best practice through collaboration and partnership rather than competition. Clinical performance indicators will eventually be published for each major medical condition in every National Health Service (NHS) hospital. Reinforced by clinical governance regulations, local quality assurance programs are now being monitored by a Commission for Health Improvement (CHI), which aims to provide independent, external scrutiny of local efforts to improve quality and to address any serious review problems. Public reporting in the UK is supported by principles contained in the Patients’ Charter of Rights.

Canada

Canada, like the UK, has to date relied on voluntary, internal, self-monitoring quality improvement programs to set and safeguard health quality standards. In 1998, the Ontario Hospital Association (OHA) was the first health group to publish a report card that contained comparative performance data on all but two hospitals in the state of Ontario. This initiative, supported by a team at the University of Toronto, arose from a quality improvement framework. Aggregate measures of hospital system performance are included in the annual report card, rather than named hospitals. These yearly reports are primarily for the use of hospitals, which are members of the OHA and are used for peer review purposes.
Canada’s next initiative arose from a health information perspective. Entitled the Roadmaps Initiative, all stakeholders were consulted to develop an action plan to streamline health care information. The aim of Roadmaps is to resource purchasers — providers, policy makers and consumers — so that they are able to make more informed choices about health care decisions. Unlike other performance frameworks, this example includes the broadest definition of health and range of indicators found anywhere in the literature. The Roadmaps Health Indicators Framework seeks to integrate health status, non-medical determinants of health, health system performance indicators and lastly, community and health system characteristics to provide salient contextual information.

At this stage, information as to the accessibility or meaningfulness of reports to consumers on quality resulting from the Canadian Roadmaps initiatives is not yet available.

**Australia**

There has been considerable debate in the Australian health sector in the past decade over what information can and should be made available to consumers on the quality of health services.

To date, there has been little evidence of purposeful reporting to consumers, although the specific development of a health report card has been recommended at both national and state level. Some of the necessary development work needed for reporting has been addressed.

Australia has relied on various forms of voluntary internal and external (accreditation) quality review processes in a mixed public and private health care system. Like other countries, Australia has endeavoured to develop performance indicators and frameworks over the past 10 years. These efforts have also sought to develop standardised measures and national benchmarks across all states and territories.

In 1996, following a recommendation by the Taskforce on Quality in Australian Health Care that ‘accurate measurement of valid performance indicators should be made publicly available and be accompanied by appropriate explanation about their uses and limitations’, the Australian Health Ministers’ Advisory Council supported the exploration of the development of a Health Service Standards Report to inform consumers about the performance of hospitals against a range of quality measures. This form of national report was not pursued because of the need to further develop comparable data on issues in which consumers would be interested, and because of agreement by bodies such as the Consumer Focus Collaboration that the priority should be the development of improved methods and formats for providing information to consumers about quality at a local and regional level, which effectively led to the genesis of this project. (Consumer Focus Collaboration Strategic Plan, Consumer Focus Collaboration, 1998).
In the process of exploring the possibility of a Health Service Standards Report, the Consumers’ Health Forum was contracted to consult with a broad range of consumer population groups and interests about their views on the sort of quality information they would find useful in a ‘report card’ document from hospitals, and to explore their views on quality reporting. A prevailing view emerging from the consultation with consumers was that report card activity was seen as having little impact on choice, because choice was limited in Australia by so many other factors, including location and need for particular services. Most value was seen in terms of making hospitals available to the community and in clarifying what could be reasonably expected and dispelling myths and misunderstanding often promoted by anecdotal reports and media. The report from the consultations provided a rich source of data on the dimensions of quality of interest to consumers and the performance information which consumers sought against these dimensions. Table 1 summarises key performance issues identified during the consultations.
Table 1: Key performance issues for consumers

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>EFFECTIVENESS</th>
<th>COMMUNICATION AND PARTICIPATION</th>
<th>CARE</th>
<th>CONTINUITY OF CARE</th>
<th>HUMAN NEEDS</th>
<th>EFFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical access</td>
<td>Professional competence</td>
<td>Communication within hospitals</td>
<td>Physical environment</td>
<td>Admission</td>
<td>Respect for consumer rights</td>
<td>Targeting treatment to needs — avoiding overservicing and unnecessary or in appropriate treatment</td>
</tr>
<tr>
<td>Availability of services</td>
<td>Technical efficiency</td>
<td>Communication with patients, families and carers</td>
<td>Staffing</td>
<td>Co-ordination of inpatient services</td>
<td>Complaints and advocacy services</td>
<td>False economies — underservicing and premature discharges</td>
</tr>
<tr>
<td>Waiting times</td>
<td>Safety (adverse events)</td>
<td>Consumer participation</td>
<td>Nursing and clinical care</td>
<td>Discharge planning</td>
<td>Equitable treatment</td>
<td>Cost of services to consumers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involvement of consumer or support groups</td>
<td></td>
<td>Links to community services, general practitioners and other services</td>
<td>Provision for special needs</td>
<td></td>
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</tbody>
</table>

In Australia, various health round tables are in place for benchmarking but data is not publicly released. The Australian Council on Safety and Quality in Health Care and state health departments are undertaking development work to collect and report on the comparative performance of health agencies for a number of safety and quality measures.

**Reporting models**

The assumption underlying all reporting initiatives reviewed to date is the expectation that reporting will improve the quality and effectiveness of individual health care services and of the wider health care system.

The public release of information has been used as a catalyst for change by a number of stakeholder groups and the most effective reporting systems have been integrated into existing quality improvement programs.

The review has identified five models for reporting. Each model is distinguished by:

- its rationale;
- the data reported on;
- the information design and dissemination; and
- the target audience.

Although there is overlap between the models (for example, a report based on the rationale of competition may also serve the purpose of accountability) a primary rationale and consequent content, design, dissemination and target audience can be identified.

The five models are:

1. Competition;
2. Accountability;
3. Quality and Safety;
4. Consumer empowerment; and
5. Health System and Health Status.
Competition

**Rationale:** It is argued that increased competition between health care providers can improve the quality of services while reducing or at least maintaining costs. Increasing information available to consumers — and purchasers in the case of the US — will facilitate more informed decision-making by consumers and purchasers in choosing their health care providers (individual providers, agencies, networks or managed care plans). Assuming purchasers make rational choices which maximise the value of services to them, services with better outcomes (cost, quality and other variables important to purchasers) will be rewarded with greater market share.

**Example of data reported:** Insurance and health care cover costs, benefits available.

**Information design and dissemination:** Print, internet, video.

**Primary target audience:** Purchasers of insurance funds, consumers, health agencies.

Accountability

**Rationale:** Improving the accountability of health services through the public reporting of performance information can provide a safeguard against poor quality health care and ensure that minimum industry and professional standards and patient rights are maintained. Increasing the external pressures on providers to meet minimum standards, be they related to qualifications, credentialling, accreditation, or outcomes related performance measures, recognises that self-regulatory practices in the health care system alone are inadequate to ensure quality.

Reporting for the purpose of accountability will provide external pressure to improve the level of quality through comparing, for example, a selected range clinical outcomes, patient perceptions and associated costs.

**Example of data reported:** Clinical indicators, accreditation status, licensing, certifying/credentialling, reporting on adverse events, complaints mechanisms and redress systems. The UK league table is an example of this model of reporting.

**Information design and dissemination:** Government reports, limited internet, limited inclusion in annual reports. Some data is in the public domain, but not readily available to consumers.

**Primary target audience:** Regulatory and funding bodies.
Quality and safety

**Rationale:** The publication of comparative quality data provides valuable feedback on performance and the identification of opportunities for improvements. In the US, health providers have been shown to be responsive to publicly released information on the quality of health services. Those involved in quality improvement systems are clearly a key audience, in addition to consumers, for publicly released performance data as they have opportunity to act on the data.

**Example of data reported:** Mortality data, infection rates, the achievements of continuous quality improvement, and benchmarking programs.

**Information design and dissemination:** Not publicly released or reported on.

**Primary target audience:** Government, regulatory bodies, associations, internal improvement mechanisms of individual health agencies. Consumers are not the primary target audience, although information has ‘found its way’ into the public domain.

Consumer Empowerment

**Rationale:** Providing consumers and the wider community with relevant information of health service quality and performance is seen as a fundamental right and of benefit to the health care system. More effective consumer participation in the planning, delivery, monitoring and evaluation of health services can enable providers to be more responsive and accountable to consumers and thereby improve the quality and outcomes of care.

**Example of data reported:** In the US, this includes report cards, hospital quality profiles, FACCT consumer reports and guides explaining how to interpret quality information, what questions to ask when choosing a provider, what questions to ask when deciding whether to use health services, and then which health services.

**Information design and dissemination:** Internet, print, video.

**Primary target audience:** Consumers.
Health system and health status

**Rationale:** Comparative performance measures are used as a tool in evaluating the quality of care and outcomes at local community and national level. Public dissemination of this information can be used as a basis for public debate and the development of health policy. Performance measures can form a useful part of public education campaigns, which may influence the behaviour of selected groups.

The availability of reliable, meaningful data that enable policy makers to track health outcome variations across regions is limited. This rationale for reporting has potential in helping achieve health system goals associated with equitable outcomes for different sectors of the population.

**Example of data reported:** Health status statistics, such as infant mortality or immunisation rates through different geographical areas.

**Information design and dissemination:** Government reports, internet sites.

**Primary target audience:** Epidemiologists, public policy, health departments.

In Australia, the National Health Performance Action Council will function within this type of reporting model.
Table 2: Reporting models and examples by country

<table>
<thead>
<tr>
<th>Reporting Model</th>
<th>Examples by country</th>
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</table>
| Competition             | NCQA accreditation and a report card called a "Report Card"  
 JCHO accreditation and report card called "Quality Check" (US)  
 Pennsylvania "Consumer Guide to Coronary Artery Bypass Graft Surgery" (US) |
| Accountability          | League tables (UK)  
 Accreditation status (all countries)  
 "The Patient's Charter" (UK)  
 The Bill of Patients' Rights (US)  
 "Clinical Indicators" and "High Level Performance Indicators" (UK) |
| Quality and safety      | New York Cardiac Surgery Reporting System (US)  
 Ontario Hospital Association Project (Canada)  
 Consumer Focus Collaboration. This project will report on how to report health quality and other information to consumers (Australia)  
 Australian Council on Safety and Quality |
| Consumer empowerment    | Consumer-Oriented Mental Health Report Card (US)  
 The Roadmaps Initiative (Canada) |
| Health system and health status | National Health Performance Committee (Australia)  
 WHO report on international comparisons on health status statistics |
Two frameworks for reporting

The review team identified two frameworks for reporting on health service quality.

Framework One – Public release of information

This refers to placing quality or performance information in the public domain often through web sites that can be accessed by a general audience. It is usually associated with public accountability at a state or national level, such as the UK league tables or the Hospital Services Report in Victoria. These initiatives are often introduced to monitor performance following a health system review, to support transparency or to boost public confidence.

The shortcoming of such reporting is that information has not been compiled for consumers as the target audience, nor do the measures reported on necessarily include those that consumers value as important. Although the information may be ‘in the public domain’, it is neither necessarily easily accessible nor promoted widely.

Framework Two – Purposeful reporting to consumers

The literature review, stakeholder consultation and the identified case studies found few examples of what the review team has termed ‘purposeful reporting to consumers’, particularly examples that target a broad consumer audience. Such a framework of reporting on health service quality would:

- enhance consumer participation and feedback in the health care system;
- enable consumers to make informed choices about their health care with confidence as to the quality of the health service;
- improve the accountability of the health care system to citizens for performance over time;
- ensure the health care system and providers are focused on the interests of consumers; and
- establish a process that reports on and promotes continuous improvement.

Examples of this type of report are linked to a specific health condition, such as asthma, are guides to chronic conditions produced by FAACT, or to help consumers make a specific decision — between health plans, hospitals or individual providers. While consumer reports are still public documents and
distributed in the public domain, they are tailored to specific consumer stakeholders for their use in making health care decisions. It is important to note that some types of reporting that are ‘badged’ as consumer reports, such as The Pennsylvania Consumer Guide to CABG Surgery, are in practice targeted to hospitals and cardiac surgeons.

The principles and guidelines developed from this review are based on this ‘Purposeful Reporting to Consumers Framework’.

The format of reporting

The format of reporting documents has changed over time. These changes reflect the move from placing performance reports in the public domain, to one that is designed to facilitate consumer access.

Performance indicators have been presented using aggregated and disaggregated data, and protect the identity of particular organisations. The UK league tables and the New York CABG report hierarchically, and intentionally identify individual providers. Other reporting systems use aggregated data listed regionally or list organisations in alphabetical order. Debates centre on whether data on the performance of individual clinicians should be used for purposeful reporting to consumers.

Purposeful reporting to consumers to better inform and increase their health care decision-making requires presentation of quality information in an accessible format. Several organisations, such as the King’s Fund in London and the Australian National Health and Medical Research Council, have produced guidelines on how to report to consumers. These guidelines focus on the choice of medium, on literacy levels and on presentation formats.

In the US, the Agency for Health Care Policy and Research (AHCPR) has funded a project to help consumers identify the best health care plans and services for their particular needs. The Consumer Assessment of Health Plans (CAHPS) has produced materials that utilise photographs, flyers, videos and worksheets (in several community languages). The CABG project also uses a system of symbols such as asterisks and plus and minus signs to best convey information.
Table 3 presents an overview of some of the methods used to publicly report on performance data.

**Table 3: Overview of reporting formats**

<table>
<thead>
<tr>
<th>Report Document</th>
<th>Format</th>
<th>Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario Hospital Association Report Card</td>
<td>• Uses aggregate data</td>
<td>Voluntary</td>
</tr>
<tr>
<td></td>
<td>• Tabulates data by five numerically numbered and unidentifiable regions e.g. Region 1</td>
<td></td>
</tr>
<tr>
<td>UK league tables</td>
<td>• Ranks individual health care providers to identify “good” and “bad” performance</td>
<td>Government legislation</td>
</tr>
<tr>
<td></td>
<td>• Uses non-risk adjusted data</td>
<td></td>
</tr>
<tr>
<td>UK high-level performance indicators and clinical indicators</td>
<td>• Uses aggregate data</td>
<td>Government legislation</td>
</tr>
<tr>
<td></td>
<td>• Alphabetically orders and names NHS Hospital Trusts and Health Authorities (HA) by locality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Indicators adjusted for age not for socio-economic determinants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• “Like” HA graphed together to enable social economic and demographics information to be compared</td>
<td></td>
</tr>
<tr>
<td>New York Cardiac Surgery Report System</td>
<td>• The risk-adjusted mortality rates of high-volume surgeons who conduct over 200 CABG operations in a single hospital over three years are individually ranked and reported</td>
<td>Required</td>
</tr>
</tbody>
</table>

**The impact of reporting**

The literature, particularly for the US, emphasises the expected benefits of public reporting. As outlined earlier, reporting has been seen as a means of improving health care quality by enhancing competition, accountability, internal quality improvement systems, public health and policy making and consumer participation mechanisms. These expectations have driven the proliferation of reporting programs in the US and the more recent interest in UK, Canada and Australia.
Many studies suggest that the public disclosure of performance information can be instrumental in improving quality. Bodenheimer (1999) concludes that this is because reporting places pressure on health care providers, individuals and institutions in several ways. First, favourable scores on comparative ‘report cards’, particularly on issues salient to consumers, may steer these stakeholders towards those services that are highly ranked. Second, individual service providers and agencies that score poorly may be ‘embarrassed into doing better’. Third, public and private group purchasers may offer incentives or disincentives for selected performance outcomes, such as preventive services. Finally, government and professional regulatory agencies may impose sanctions, including financial penalties and reduced rights or deregistration, for poor or unsafe performance.

Despite calls for evaluation studies on the impact of public reporting and recommendations for ‘a report card on report cards’, the literature has not kept pace with the proliferation of reporting systems. Research undertaken has predominantly analysed the US experience. This is not surprising, given that the US introduced report cards in the health care system over a decade ago. Further, Marshall et al (2000) argue that because there has been minimal agreement among stakeholders on the expected gains of public reporting, it has been difficult to judge whether the benefits outweigh the disadvantages. Australia and Canada are still in the early stages of developing these initiatives, although several consumer consultations favour public reporting despite opposition of some stakeholders.

A brief review of the major studies on the impact on consumers, public and private purchasers, individual providers, and health care agencies is outlined below. It should also be noted that because these research studies are published in the peer reviewed literature, they reflect the interests and biases of academic and professionals engaged in health care improvement.

**Impact on consumers**

Marshall et al (2000) recently reviewed the US evidence, and claim that public disclosure has only had limited impact on consumers. Based on the Pennsylvania report card, they report that less than 10 per cent of CABG consumers surveyed in Pennsylvania were aware of *Pennsylvania’s Guide to Coronary Artery Bypass Graft Surgery* at the time of their surgery, and less than one quarter of these used it to influence their choice of surgeon. Thomas (1998) also reports that consumer access to performance information has clearly not changed their hospital choices. Other studies indicate that consumers continue to use hospitals with high mortality rates and that consumer choices were still more likely to be influenced by anecdotal press reports about untoward deaths than risk-adjusted mortality data (Marshall et al, 2000). Similarly, there is little evidence that the UK league tables have empowered consumers to make services more accountable (Shaw, 1999).
Only one study reviewed changes in consumer behaviour, (or referral patterns) to report cards. A study conducted by Mukamel and Mushlin showed that hospitals and physicians in New York with better than average CABG mortality rate outcomes experienced an increase in market share, and that these physicians increased their fees at a higher rates for this procedure than their peers, as measured before and after publication of the CABG consumer guide (Mukamel and Mushlin, 1998). In both New York and Pennsylvania, it is difficult to ascertain whether outcomes were consumer or provider-driven. Without more information on accessibility, comprehensibility and the relevance of these guides from a consumer perspective, it is impossible to gauge who is really responsible for referral decisions.

**Impact on purchasers**

Although an aim of US reporting has centred on increasing competition by influencing purchasing behaviour in public and private sectors, little evidence has been produced to either support or refute these aims. McLaughlin and Ginsberg (1998), contend that there is little evidence to suggest that there is a relationship between the notion of competition and the quality of medical care. Marshall et al (2000) report that public disclosure has only a small, although possibly increasing, effect on the purchasing behaviour of employers, the main purchasers of health care in the United States. Similarly, Nutley and Smith (1997) in the UK conclude that rankings in league tables have very little effect on purchasers.

**Impact on individual providers**

The acceptability and use of public performance data by individual providers will be an important factor in the successful implementation of a public disclosure policy. Clearly, doctors have a vital role in the use of performance data by their patients. They can make reports accessible or not and can interpret this information and make it relevant to the consumer’s individual situation. Individual providers can include this data in the decision-making process on treatment options with patients. They can follow up any further inquiries raised by the reports that are relevant to their patients.

Evidence suggests that doctors are interested but sceptical and consider reports of minimal use (Marshall et al, 2000). In practice, providers and their professional associations have been the most vocal and active stakeholder group in their opposition to the concept and practice of reporting in all four countries under review. While many reasons have been professed (see latter section), fundamental to their opposition has been the threat that public reporting represents to their professional autonomy. Again, this has been an under-reviewed area.
Impact on health care agencies and quality improvement programs

There is some evidence within the literature to suggest that health care organisations are more responsive to the reporting of performance data than other stakeholders. Marshall et al (2000), for example, observe that the way in which a given service provider responds depends on the kind of rating it receives. When an organisation was positively rated, this information was used internally to establish benchmarks, monitor performance and promote collaboration between departments. Those providers identified as poorer performers were more likely to criticise the validity of the data and the implication of using financial resources to rectify it. Other writers also note that performance ratings have had the most impact on the ‘best’ and ‘worst’ performers. Top-rating organisations use these results for marketing their services and those at the bottom compete with their peers to receive a higher ranking. Anecdotal evidence from experts in the field indicated that those providers in the middle range are largely unaffected by the disclosure of performance measurements (Robinson, 2000).

The finding that performance ranking largely affects providers is well illustrated by the Missouri example, where obstetric reports on 90 hospitals were published in 1995. In the following year two hospitals discontinued services and 50 per cent upgraded their programs to include follow-up care such as introducing baby car-seat hire and nurse educators for breast-feeding. It was noted that service improvements were more likely to occur in areas with more than one hospital than in hospitals without any competition. Improvements such as a reduction in caesarean rates, and an increase in vaginal delivery after a previous caesarean section, were also recorded. In particular, hospitals with the highest caesarean rates were most responsive to report card data. While it has been recognised that other variables can precept change, the consumer report was seen as a ‘primer’, a component of the change process, which increased attention and increased recognition that change was needed and clinical practice must be evaluated.

The New York Cardiac Surgery Reporting System remains one of the earliest and most studied examples of reporting in the literature. It has also had some of the most impressive achievements. Its primary aim was to reduce mortality rates after CABG surgery in New York hospitals, and its primary targets were the hospitals and their cardiac staff (both the objects and targets of the reports), who could use the performance data to improve procedures and outcomes. After four years of reporting, from 1989 to 1992, a 41 per cent decline in risk-adjusted operative mortality rates was recorded, compared with a national decline of about 18 per cent (Chassin et al, 1996).

Numerous reasons associated with reporting have been identified for this result. They include the withdrawal of some 27 surgeons with lower volumes and
higher mortality rates than their peers, the suspension of one poorly performing cardiac program until a new chief was appointed, and a conscious allocation of high-risk patients to surgeons with superior performance in some hospitals.

Evidence of system-wide analysis and problem-solving were also identified. Six of the 31 participating hospitals publicly admitted that their performance report prompted new quality improvement initiative. For example, with the help of New York Health Department, St Peter’s Hospital in Albany, one hospital with mortality rates significantly above the state average (27 per cent compared to 7 per cent), isolated the problem to its handling of emergency cases. A multidisciplinary team then worked through system changes and, without avoiding high-risk patients, the hospital improved from 11 out of 54 patients dying in 1992 to none out of 54 dying in 1993. (Chassin et al, 1996).

Reasons attributed to the success of the New York experience include:

- provision of data collection training to hospitals by the health department;
- collaboration with physicians on individual reporting;
- a history of strong oversight by physicians and the widespread publication of its methods and results in clinical journals;
- education of the media to ensure that they understand the purpose of the program and can better interpret results;
- provision of follow-up support to hospitals seeking to identify the cause of problems and improve procedures; and
- provision of external audits of hospital data to ensure accuracy.

Numerous criticisms have also been aired by opponents of the New York public reporting system. As many of these are generic, they may be viewed in the next section.

Significant and sustained reductions in risk-adjusted mortality were also found in an evaluation of the Cleveland Halt Quality Choice project. Improved outcomes were found for six common medical conditions and two surgical conditions following the publication of mortality data (Marshall et al, 2000).
Barriers to reporting

Although cost is seen to be one of the major disincentives towards purposeful reporting to consumers, the literature presents several other challenges. Cohen (2000: 728) contends that the main barriers to reporting fall into three categories: ‘fear of individual or organisational repercussions; false belief that medical error can be used as a measure of practitioners’ competence; and potential legal discovery of error reports’. In particular, the fear of repercussions has, at times, led organisations or individuals to engage in ‘perverse behaviours’ as a way of improving the performance ranking (Coles, 1999).

One form of perverse behaviour is commonly known as ‘gaming’. This occurs when health care services, intent on achieving good performance scores, manipulate these measures. If, for example, waiting times are given prominence, GPs may under-refer to improve their performance (Sheldon, 1999). In addition, measures may be manipulated when doctors and providers are unwilling to treat high-risk patients or under-report adverse events (Coles, 1998; Chassin, Hannan and De Buono, 1996). There have also been concerns that physicians in New York have moved potential high risk CABG patients to the outer-regional hospital of Cleveland to improve their ranking. However, a study by Chassin et al (1996) refutes this claim.

Sheldon (1999) and Nutley and Smith (1998) have also noted that reporting tends to focus on measurable outputs like non-acute surgery and waiting lists. Sheldon says that this can lead to falls in less-scrutinised areas leading to overall reduction in performance. These practices can impede the need for openness and transparency that are essential to any form of public or purposeful and effective reporting.

Proponents and opponents

The incentives and challenges to reporting often depend on different stakeholder perceptions and definitions of quality, and the impact it has on them collectively or as individually. Table 4 presents an overview of some of the arguments used by proponents and opponents of reporting.
### Table 4: Proponent and opponent arguments for public reporting

<table>
<thead>
<tr>
<th>Opponents</th>
<th>Proponents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Destroys trust in health professionals and providers</td>
<td>• Participation in reporting can increase trust by creating a culture of openness and transparency</td>
</tr>
<tr>
<td>• Creates a culture of blame</td>
<td>• Can create a culture of collaborative partnerships and a sharing of best practice</td>
</tr>
<tr>
<td>• Providers may avoid high-risk patients to lower their risk-adjusted mortality rates</td>
<td>• US studies have shown no movement away from hospitals with high mortality rates</td>
</tr>
<tr>
<td>• Performance measures can be manipulated through “gaming” — manipulating the data</td>
<td>• Millensen (1997:198) believes that gaming is often a “distortion of stories”. In New York, he suggests that at most gaming accounts for only 4 per cent of that state’s reduction in cardiac deaths</td>
</tr>
<tr>
<td>• Data is “retrospective” and doesn’t accurately predict the future</td>
<td>• Performance data is designed to improve performance and to avoid repeating problems encountered in the past</td>
</tr>
<tr>
<td>• Public reporting has little impact on improving performance</td>
<td>• Risk adjustment models do have predictive functions, for example, for mortality rates</td>
</tr>
<tr>
<td>• Consumer reporting is too expensive</td>
<td>• Studies have shown that public reporting in US did improve mortality rates after CABG surgery and for a number of other surgical and medical procedures</td>
</tr>
<tr>
<td></td>
<td>• If the main aim is to improve quality, reporting should be judged alongside other quality improvement strategies and formal cost/benefit analysis conducted (Marshall et al, 1999)</td>
</tr>
<tr>
<td></td>
<td>• High quality is associated with cost efficiencies and effectiveness; low quality may be more expensive</td>
</tr>
<tr>
<td></td>
<td>• Much of the data for public reporting is already available, or should be routinely gathered</td>
</tr>
</tbody>
</table>
Reasons consumers are not using reports/changing behaviour

Given the majority of report cards in the US say the main aim of reporting is to change consumer behaviour by providing quality information, the findings of these studies are surprising.

Many reasons have been identified. Lack of actual consumer choice is an obvious barrier. Large numbers of consumers are unable to exercise any choice at entry level to the health care system, choice of health insurance or health plan provider, or in their selection of individual providers or health care agency. Further, consumers are often unable to make choices about a range of services because health plans and doctors may automatically select these for them. Many providers clearly do not share available reports with their patients. For example, CABG patients surveyed showed a low rate of awareness of Pennsylvania’s CABG guide, which would have ‘encouraged them to discuss the information in the guide with their physicians’, had they been able to access a copy (Pennsylvania’s Health Care Cost Containment Council, 1998).

In addition, there has been a well-documented non-alignment between consumer definitions of quality and the quality measures used by health plans and hospitals reports when consumers have not been involved in developing the quality reporting system.

Other reasons for consumers’ apparent lack of interest include their difficulty in understanding of technical quality measures/information, lack of trust, lack of timely access, preference for information received from family and friends (Marshall et al, 2000). The majority of users also face formidable educational, cultural, or socio-economic barriers to being able to access and use quality data and are perhaps too ill anyway.

Evidence from the decision-making literature suggests that consumers can only process a limited number of variables, they prefer performance indicators and outcome measures, which relate to people like them, and that consumer decision-making priorities change over time and in different situations (Hibbert and Jewett, 1996 and 1997). The literature calls for more research on what consumers want, how best to present and package information and how to support consumers in the decision-making process. Hibbert and Jewett (1997) acknowledge that some consumers will always need help from some form of intermediary if they are to access the quality information in report cards.
Examples of reporting in Australia

Through the stakeholder consultation and a study of the grey literature, the review team identified a number of case studies that illustrate the status in Australia of reporting to consumers on the quality of health services. These included:

- the public release of Victorian public hospital mortality data, 1993;
- individual health agency clinical reports;
- individual health agency annual reports;
- Victorian hospital services report;
- New South Wales Mothers and Babies Report;
- the New South Wales health survey;
- the NSW public hospitals comparison data book;
- waiting times information; and
- Western Australia’s health sector performance indicators report by the Auditor-General, June 1999.

These are all examples of the public release of information rather than of purposeful reporting to consumers. With the exception of waiting list data, none of these reports has been designed primarily for consumers.

They are a starting point, however. Individual health agency clinical reports, such as that produced by the Royal Women’s Hospital in Melbourne, are uncommon yet provide performance data monitored over time on clinical procedures, incorporating descriptive and tabular information and identifying areas of improvement.

The 1993 release of mortality data in Victoria provides several salutary lessons as to what not to do in reporting on the quality of health services to consumers.

The Victorian Department of Human Services (DHS) now requires within its funding guidelines for acute health, the annual production of a quality report. The format and audience for this report are yet to be determined, however it would appear this is evidence of the government’s intention to encourage the release of information that until now has not been publicly available.
The Victorian Hospital Report provides an account to the public of a limited range of indicators related to quality, particularly those that attract considerable media attention. Hospitals are required through their service agreements with DHS to report on these indicators and achievement of the associated targets can attract bonus payments.

However, publication of the report is not accompanied by any particular strategy for its dissemination to consumers. It is a public document and attracts attention in the lay media and is available through organisations such as Health Issues Centre as well as the DHS itself.

Other examples considered include the Mothers and Babies Report published by the NSW Health Department. It combines the annual reports of the NSW Midwives Data Collection (MDC), the Neonatal Intensive Care Units Data Collection and the NSW Birth Defects register. Part 7 of the report details data on the onset or augmentation of labour for individual hospitals. This is a good example of data in the public domain for the purpose of accountability, public health surveillance and possibly quality improvement. The report is not specifically designed to help consumers make decisions about their health care and in particular not all the information is current. Nonetheless, it has attracted media attention for its potential utility in this regard (Bill Birnbauer, Journalist, The Age, 2000).

**Limitations of the data**

**The burden of collection**

One of the difficulties associated with purposeful reporting to consumers on quality relates to the collection, presentation and dissemination of statistically presented performance indicators. Apart from concerns that the selection of performance indicators is restricted to the reporting of quantifiable outcomes (Nutley and Smith, 1997; Sheldon, 1999), there are also issues related to the validity, reliability and credibility of outcome measures. These measures are often more influenced by factors extrinsic to an institution but for which it is held accountable (Goldstein and Spiegelhalter, 1995). This is because most performance indicators are insensitive to differences based on culture, ethnicity, age, class, geographic location and gender, which are necessary for comparison (Campbell, 2000). The use of health status indicators to compare different regions can say more about differences in social and economic characteristics underlying ill-health than the quality of local health services. Research into British league table ratings between Oxfordshire and Manchester exemplifies this and highlights the need for risk-adjusted data.
There are also patient confidentiality issues that need to be resolved. At an agency level, some quality measures can be gathered from existing data collection systems in place, while in other cases new information systems may be required. The comparative cost/benefit ratio of different collection methods, therefore, is a major factor in choice of quality measures.

**Risk adjustment**

Debate about the validity of outcome-based information invariably focuses on the need for risk adjustment to compensate for differences in health status among patients that affect their treatment outcomes. However, risk adjustment is not a simple endeavour. The purpose of risk adjustment is to account for differences in the severity of patients’ illness at presentation. Differences in the severity of illness that arise later during treatment or complications may reflect the quality of care.

Risk adjustment may also require adjustment for differences associated with institutions or particular units or to allow for pressures associated with a particular geographic catchment.

Marshall, Skekelle, Leatherman and Brook (1999) recommend that the ‘level of risk adjustment should evolve alongside other aspects of public disclosure’. An evaluation of the UK National Performance Framework by these researchers suggests that social determinant risk factors of health need to be incorporated into the proposed adjustment of the framework’s indicators. They cite social deprivation as a factor influencing emergency hospital admissions for asthma.

The experience in both the United Kingdom with league tables and in Victoria with the release of mortality data confirms that it is essential that information be risk-adjusted and verified prior to release.

**Benchmarks**

Apart from variations in the selection of performance measurements and the use of risk-adjusted data, there are also differences in the choice of benchmarks used for comparison. Comparisons can be made against best practice and an objective standard, the best example of practice, average peer practice, an industry norm, or against an organisation’s own previous performance over time. This data may also be compared against local or national standards.

Quality improvement initiatives undertaken by health care services now require organisations to become more accountable by verifying organisational actions against benchmarks or industry standards (Sheldon, 1999). Further, the use of benchmarks has moved from internal confidential monitoring, to improving service quality, to the requirement to externally verifiable standards.
To ensure benchmark data reported to consumers are both meaningful and useful, data on performance against benchmarks will require accompanying explanation and interpretation.

**The absence of the right data**

While health services and government departments have access to voluminous amounts of data, for the purpose of improving the quality of services and health outcomes, the data are often:

- not available;
- focused on financial dimensions of care; or
- not collected.

The introduction of performance reporting may require health agencies to collect ‘new’ data or to report publicly on data that are not yet publicly available.

**Conclusion**

From overseas experience, the objectives of reporting to consumers have been to increase accountability, competition and compliance requirements; to complement consumer participation strategies and consumer protection provisions; and to improve the safety and quality of services, and in particular reduce medical errors.

Concern about medical errors has proved to be one of most influential factors in promoting reporting reforms. A strong case has been made for the need for purposeful reporting to consumers as a complement to self-regulatory systems such as peer review.

The literature suggests that reporting to consumers is vital to the emergence of a more open and accountable Australian health care system. The principles and guidelines, developed through this review, are intended to as a resource to health agencies in establishing a program of purposeful reporting to consumers. Over time this will enable comparison between health agencies as to the quality of health services.

It is emphasised that initiatives in reporting need to be accompanied by further research and evaluation on the impact, take-up by consumers and effectiveness as a catalyst for bringing about improvements to the quality of health services.
PART 2: PRINCIPLES AND GUIDELINES FOR PURPOSEFUL REPORTING TO CONSUMERS

This section of the summary sets out the Principles underpinning purposeful reporting to consumers. It includes detailed implementation guidelines to assist health agencies intending to develop reports to consumers on the quality of services and on performance over time. These principles and guidelines have been informed by the literature review and by the consultation with a range of stakeholders, including consumers, providers and administrators.

The concept of purposeful reporting to consumers on the quality of a health agency will require health agencies to incorporate what consumers want to know into the data that is collected, monitored and reported on.

This form of reporting is intended to enable consumers to participate in health care decision-making at an individual level and contribute to quality improvement of the health care system. It is also recognised that purposeful reporting to consumers will be of benefit to health agencies and providers interested in implementing improvements to services based on the measurement of performance.

Why report to consumers?

The overall aim of reporting to consumers is to improve the quality, performance and outcomes of health care. Specific objectives supporting this aim are to:

- enhance consumer participation and feedback in the health care system;
- enable consumers to make informed choices about their health care with confidence as to the quality of the health service;
- improve the accountability of the health care system to citizens for performance over time;
- ensure the health care system and providers are focused on the interests of consumers; and
- establish a process that reports on and promotes continuous improvement.
The introduction of reporting to consumers

The introduction of reporting to consumers recognises:

- the dual interests of consumers, individually and collectively, and their various and overlapping roles as customers, citizens and payers;

- the choices available to consumers may be limited, which reinforces the need for health agencies to demonstrate how they maintain standards;

- the complex organisational and cultural change processes inherent in the move to increased public accountability and consumer participation in the health care system;

- that reporting is an integral component of the existing quality improvement, consumer participation and evidence based practice of health agencies;

- that while consumers are the primary target audience, multiple stakeholders, in particular practitioners, will have an interest in what is reported and have a contribution to make to the compilation, interpretation and use of data;

- the quality of a health care agency and the health care system can be improved through a partnership between consumers and health service providers at both individual and collective levels; and

- the potential for reporting to serve as an educational tool for consumers to inform public debate on the equitable distribution of health resources.

Principles underpinning reporting to consumers

The development of purposeful reporting to consumers on the quality and performance of a health agency and the broader health care system is based on the following key principles.

Principle One

Reporting on the quality of health services to consumers values open, honest and transparent dialogue between consumers and providers.
**Principle Two**

Health agencies have a duty to comment on, interpret and share information on the quality of care with consumers and the wider community.

**Principle Three**

Consumers need to be informed as to what they can expect of individual health agencies and the health care system.

**Principle Four**

The contribution of consumers to defining the measurement of quality is essential to improving the quality of health services.

**Principle Five**

Consumers are entitled to information about how health resources are being allocated and whether the health system is delivering equitable outcomes.

**Principle Six**

Reports to consumers on the quality of health services should integrate definitions of quality of value to consumers as well as those of value to providers.

The following ‘Implementation Guidelines’ have been developed to assist health agencies in the design and establishment of a purposeful reporting program to consumers — one element in the cycle of performance and improvement and consumer feedback.
Implementation guidelines

1 Purpose and planning

**Guideline**

Before a report is developed, the target audience, scope, purpose and intended benefits are identified in a clear statement of intent.

**Strategies**

To develop a statement of intent on reporting to consumers, health agencies may find it useful to adopt the following strategies.

- Identify how consumer reporting is linked to existing quality improvement and quality monitoring initiatives.
- Engage stakeholders including those likely to support and those critical of reporting.
- Engage staff, consumers and other stakeholders in developing the statement of intent on reporting to consumers.
- Prepare a program proposal and implementation plan, which includes resources and costs.
- Identify the breadth of information to be reported on and whether the report is intended to be agency-wide or target more specific audiences. Different measures may need to be reported on and different strategies adopted to report to different populations such as older people, people from a non-English speaking background, or parents of sick children.

2 Partnerships with communities of interest

**Guideline**

Specific communities of interest relevant to the consumer reporting system are identified and involved in all phases of its development and implementation.

**Strategies**

- Identify and engage all stakeholders, particularly consumers and providers.
- Create a multi-disciplinary working party, with representatives of relevant stakeholders and technical expertise, to oversee the program.
- Undertake appropriate research to identify the information requirements of various stakeholders, their definitions of quality and their preferred reporting format and potential dissemination strategies.
3 Deciding what to report on

**Guideline**

Information reported on is valid, credible, meaningful, set in context and has the endorsement of consumers and providers prior to publication.

**Strategies**

- Identify consumers’ definitions of quality and priorities and incorporate them in the reporting program, along with those considered important by practitioners and providers.

- Ensure all information is based on evidence, whether they relate to clinical process or outcome indicators, consumer ratings or cost/resource utilisation measures. It is noted that evidence may not always meet the ‘gold standard’ and that both quantitative and qualitative evidence may be required.

- Ensure the measures address a range of domains, including organisation-wide outcome measures, outcomes of key activities and outcomes of the process of care.

- Ensure clinical outcomes are risk-adjusted and set in context, and that reference is made to independent benchmarks of good practice outcomes. It is helpful to explain normal variation and highlight material findings in plain language.

- Where possible, align reports to national and state performance indicator measures but also tailor content to local conditions and priorities.

- In reporting on the quality of health services, a range of domains should be reported on. These should include domains of importance to consumers: access; effectiveness; communication and participation; physical care; continuity of care and human needs (Consumers’ Health Forum Consultations on a Health Service Standards Report, a report to the Department of Health and Family Services on consumer and community consultations conducted by the Consumers’ Health Forum of Australia, 1996).

- Explain the plans of a health agency to improve in areas of under-performance and describe how the health service regularly reviews and acts on data on adverse events.

- Explain the outcomes and resultant improvement initiatives of the health services’ accreditation processes.

- Provide information on the ongoing credentialling of all staff involved in clinical practice and other health professionals delivering health services.
In selecting process measures it is recognised that:

- no single measure is valid to represent consumer experiences of the structure, process and outcomes of care;

- the data reported on may need to address a range of domains across the continuum of care from measures relevant to staying healthy to living with illness as well as inpatient care; and

- domains addressing the responsiveness of the service to consumers may need to be developed, including categories such as ‘sensitivity to patients’, ‘public and patient education’, and ‘ethical consultation and complaints handling’.

4 Selecting the data

**Guideline**

To maximise compliance and completeness, data collection needs to be integrated into existing information systems and avoid being overly burdensome in terms of time, cost and difficulty.

**Strategies**

- Agencies identify a feasible scope of information and find a balance between the aim of reporting and the availability and cost of collecting data.

- There is recognition of the need for clear procedures, training, incentives for completeness and accuracy.

- The data reported is timely and meaningful for consumer decision-making.

- Maximum use is made of data from existing and compatible information systems to avoid duplication and to track changes in measures over time.

5 Ensuring accuracy

**Guideline**

To maximise their credibility, reports are rigorous and capable of independent verification or audit.

**Strategies**

- Evaluate all measures periodically for their validity and usefulness to stakeholders.

- Update all measures and reports regularly and include date of publication and date of next publication.
• Build mechanisms into the reporting process to protect against the release of inaccurate statistical data. This includes verification, time for review and correction.

• A program of what is to be reported on may be usefully announced prior to the analysis and release of data to protect against selectivity or avoidance of poor performing areas.

• To ensure the rigour of data, all data are submitted in a consistent manner.

• Use a transparent process of reporting and submitting data with clear processes for data capture and independent audit or verification and independent commentary.

6 System Linkages

Guideline

Consumer reporting will be most effective when it is part of a quality system, and where the agency adopts consumer participation strategies in all aspects of the system.

Strategies

• Effective reporting systems are embedded in and support a range of quality improvement strategies, for example, complaints handling, quality improvement processes, credentialling and accreditation processes.

• Performance reports are used at individual, departmental, agency and health system levels to set goals for change and improvement over time.

7 Communicating the data

Guideline

Data reported to consumers on health care quality requires explanation, interpretation and consideration of how it is best communication to key target groups.

Strategies

• Ensure the format for reporting to consumers assists decision-making and is relevant to the target group’s health needs.

• Reporting that presents information in both tabular and descriptive formats is likely to be more accessible than information produced in a single format. Pilot testing with the relevant audience will be important to ensure maximum accessibility and comprehension.
• Explanation and interpretation of normal variation is provided and an independent commentary included.

• Consider tailoring resources and methods of communication to the key target groups. For example, web sites may be popular with young people and advertising on radio may be a good way to reach this group. Posters may be a good way of communicating report highlights to outpatient users.

• Opportunities for collaboration between health agencies and funding bodies to produce appropriate educational and support materials for such groups may be important. Video information in relation to common procedures may be worthwhile but expensive for individual agencies to produce. This also applies to production of materials for high need but small population groups (such as refugees, who may not be literate either in English or their first language).

• The National Health and Medical Research Council document How to present the evidence for consumers: preparation of consumer publications, (National Health and Medical Research Council, 1999) is used as a guide on how to explain the evidence, format and present consumer reports.

8 Dissemination, communication and feedback strategies

Guideline

Dissemination and communication strategies are integral to the success of reporting.

Strategies

• Ensure sufficient resources are allocated to enable effective dissemination. To minimise the burden of dissemination, be creative in relation to existing communication systems that can be utilised. This may include incorporating references to consumer reports in patient information literature, links to the target audience through support groups, and placing the data on an internet site.

• Consider highlighting issues in the report for consumer intermediaries, including referring general practitioners, consumer advocacy networks and target dissemination to specific groups such as maternal and child health nurses, migrant resource centres or Aboriginal health workers.

• Consider the contribution and role of ‘intermediaries’ in assisting consumers to read and understand the information reported.

• Provide mechanisms for consumer feedback on the usefulness of the report.
• Provide information on ways in which consumers can give feedback on the quality of a health service and ways in which services could be improved.

• Provide consumers with opportunity to make recommendations on the data to be provided.

9 Evaluation

Guideline

Rigorous evaluation of the process, impact and outcomes of reporting programs is essential.

Strategies

• Incorporate in the report itself opportunity for consumer feedback; for example, tear-off response sheet enquiring as to whether the information met consumers needs and how the format and content could improve.

• Build in resources for comprehensive ongoing evaluation from the outset. This should include identification of data availability issues.

• Include all stakeholders in evaluation processes.

• Evaluation may consider stakeholder experience in regard to:
  – awareness of reporting program;
  – uptake and use of the report;
  – influence on decision making;
  – influence on other behaviours/practices.

• Actual changes resulting from reporting may be important to assess, including:
  – impact on the perceived quality of services;
  – impact on the clinical and cost outcomes of services;
  – impact on the quality improvement process itself etc.

• Evaluation findings will be most credible if they are also publicly available, the findings have been reviewed by the provider’s board of governance with senior staff, a commitment made to relevant quality improvement strategies, and progress in relation to such initiatives built into the next stage of the reporting cycle.
References


