Counterpoint

‘Counterpoint’ is an occasional feature presenting discussion of a topic that is currently under debate in quality of care circles. We invite readers to submit Letters to the Editor adding their opinion to the topic.

Integrating health status into the quality equation

Over the last 10 years we have seen the coming of age of performance measurement and data base analysis to study the effectiveness of our health care system. Unfortunately, while administrative databases have become easier to analyze, their limitations, too, have become apparent. Hybrid methods of performance measurement remain the norm as process indicators have greater discriminatory power than outcome measures that reflect infrequent events or require years of observation to be meaningful.

Much of performance measurement focuses on behavior of health professionals individually or as a part of a complex organization. Structured surveys of beneficiary perceptions of their experiences with the health care system have also matured through instruments such as the Consumer Assessment of Health Plan Survey (CAHPS) which is now a staple of managed care in the USA. This rather lengthy survey tool generates a remarkable return rate from its randomly assigned recipients and thus demonstrates the interest and willingness of consumers to critique their health care and have a voice in its assessment and evolution.

Now comes a more intimate survey tool, the Health Outcomes Survey (HOS) described in this issue of the Journal [1]. Researchers have long demonstrated that patient perceptions of their own well being and health can be measured consistently and reliably through relatively brief structured instruments. The current effort by the Health Care Financing Administration in the USA represents an application of this technology on a mass scale to understand the health perceptions of a population over time in a community rather than a research setting. It represents a new era in quality measurement whose impact and utility have yet to be defined.

The paper by Cooper et al. [1] contains the descriptive cumulative data of an enormous number of surveys of Medicare beneficiaries describing perceptions of their health. Not surprisingly, perceived physical health declines with age and co-morbidities. Distribution of patients with perceived poor health did not follow the economic structure of insurance plans. HCFA is currently resurveying this population to compare the health status of this population over time.

This second dataset will be of great interest to health care practitioners, researchers, and quality experts. Will it demonstrate changes in perceived health status reflective of an aging population or of the care delivered by the health care system? Will such change be sufficiently substantial to warrant such conclusions with confidence?

I remain somewhat skeptical that unfocused use of the HOS instrument will generate gross distinctions between health plans and the perceived health of their beneficiaries. It will be hard to tease apart the effects of age and new or chronic conditions that tend to naturally alter the physical and mental status of an aging population at greater risk for such change.

Nevertheless, there is a variety of applications for this data that could prove enormously helpful for policy makers and public advocates over the next decade.

Linking this data to specific diagnostic codes, DRG or procedural codes could have enormous implications for providers and service plans. Managed care has yet to address fully the economic and delivery issues associated with chronic conditions. While the health insurance risk model performs reasonably well for acute care conditions, there exist substantial conflicts of interest in the delivery of services to covered individuals requiring chronic maintenance or ongoing rehabilitative therapy. For example, patients with a stroke or a debilitating neurological condition such as multiple sclerosis can require years of physical therapy, outpatient reassessments, and durable medical equipment that represent a persistent fixed cost to an insurance entity that thrives on managing variable events. The differences in perceived health across plans by patients with such chronic conditions are potentially reflective of benefit management strategies as much as the delivery of care itself. One could imagine that comparisons of health status reports 4 to 6 months after a stroke could differ widely among different health plans based on the use of rehabilitation and other supportive services.

Likewise, health providers, too, could be profiled on outcomes of high volume services such as total joint arthroplasty, carotid surgery or perhaps diabetes. Given enough patients with similar socioeconomic backgrounds, differences between providers over time could well reflect superior or inferior application of medical knowledge and technology on behalf of an individual beneficiary.

Unfortunately, there is also a darker side to the collection of such data. HOS surveys require an individual beneficiary to reveal considerable personal information about themselves and their health. The linking of an individual’s health perceptions to an administrative database could provide a powerful window on the effectiveness of the health care system.
It also provides a striking profile regarding the individual that could be used to assist insurance entities in selecting a population whose medical risks make future expenditures more predictable. As the internet era has matured into a world of interlocking data bases and personal profiles that have chilled privacy experts [2–4], will fewer individuals fill out such surveys and to what extent will privacy policies be promulgated and honored in the years ahead? These issues will only grow larger as we better understand effective application of this rich source of information.

Thus, the perceptions of health by patients should prove to be a powerful tool for quality experts in the future. Effective applications will probably require linkage to specific conditions and the tracking of outcomes over time. Widespread population surveys such as those described in this issue of the *Journal* will provide the raw material for sophisticated reflection upon best uses of this data in targeted and cost effective ways. We may be pleasantly surprised that this current effort results in specific statements on health outcomes across plans but such discriminatory power is uncertain at best when this tool is used as a population wide assessment. Nevertheless, the health outcomes survey (HOS) effort is an enormous and important first step towards the sophisticated integration of patient health perceptions into the portfolio of techniques for quality assessment and improvement.

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References