Editorial

Being strategic with public reports

Evaluations indicate that comparative reports of health care organization performance have had only minimal impacts on consumer behavior [1,2]. While the ultimate goal of public reports is to improve the quality of care, it is important to note that there are different possible pathways and supporting strategies to achieve this end. For example, some report card developers have as their priority informed individual decision making. Their concern is helping individuals to make effective use of performance data in choosing providers and provider organizations, so that they are more likely to receive high quality care. Although there may also be the hope that reports will generate delivery system improvements, it is not their primary objective. Some employers disseminate reports to employees with the primary purpose of helping their employees secure better care.

Other report card developers are concerned about stimulating improvements in the delivery of care. This approach relies on changing market dynamics and encouraging widespread use of comparative data for making health selections. The assumption here is that if many consumers make decisions on the basis of performance, high performing provider organizations will gain market share. The theory is that a shift in market share will motivate improvement among competing organizations and ultimately there will be improvements in care in the broader delivery system. That is, care would be improved for all consumers, not just those using comparative data to make selections. In the USA, coalitions of large purchasers of health care tend to pursue this ‘collective choice’ strategy. For example, the goal of Leapfrog, a group of large Fortune 500 companies, is to utilize their role as health care purchasers to initiate breakthrough improvements in the safety and overall value and quality of health care to American consumers.

There is also a third possible pathway for public reports to result in improved care, the ‘reputation protection’ pathway. It does not rely on consumer selection, but assumes that providers are motivated to improve in order to protect or enhance their professional/institutional reputations. When performance is made public, and the public pays attention, institutional and provider reputations and public images could be affected. This benefit or threat may be sufficient to motivate improvements.

It is not clear which, if any, of these pathways will eventually be effective in stimulating improved care. Most attention has been on the collective and individual choice pathways, even though there is minimal evidence that these approaches are influencing consumers [1,2]. It may be that it will take more time for consumers to adopt the innovation of using comparative reports. Furthermore, it is possible that poorly designed and difficult to use reports have slowed their adoption. There is, however, some evidence to support the efficacy of a ‘reputation protection’ approach [3].

Although many report card developers hope that their efforts will operate through all three pathways, they do not necessarily use reporting strategies that support all three.

What strategies are likely to support all three pathways?

Improving communications about quality

All three pathways rely on consumers to pay attention to quality data and understand their import. Regrettably, it is in this most basic area of getting consumers’ attention that we have been least successful [4]. This failure may be due to some key ‘disconnects’ in the way we have communicated about quality.

Firstly, we have not given consumers a compelling reason to pay attention. The public needs to be told that there is a quality problem. Consumers assume a high and consistent level of clinical quality across providers and provider organizations. They have not been told otherwise, and report card disseminators have been reluctant to do so. Consumers will pay attention if they understand that they are at risk and could be harmed by poor quality care. To assume that the public is not interested in quality when they have not been given the full story is a serious mistake.

Secondly, there is a major disconnect between what consumers think quality is and what we are attempting to convey in quality reports. We need to communicate what quality of care is and what it is not. Surveys show that consumers think that quality is: doctor qualifications, ability to choose their own doctor, costs, benefits, access [4]. While the professional community has several frameworks for understanding quality (e.g., evidence-based, underserve, overuse, misuse, etc.), the public does not. Providing a framework will help consumers understand what they should be looking for and help them to understand the meaning of comparative performance data. In focus groups with consumers, the concept of evidence-based care was explained [5]. Participants understood the concept and thought it was a highly valuable way to understand what good care should be. Furthermore, once participants understood the concept, comparative data on evidence-based care were much more meaningful to them. Communicating a framework that helps consumers understand quality does not have to be complex or elaborate. For example, indicating that health care should be safe, effective, and responsive to patient’s needs is easily understandable and communicates what is meant by quality.

Thirdly, if we want consumers to pay attention, then
comparative reports need to address consumer concerns. Consumers do have real concerns about health care. They have worries that their health plan will put financial concerns above considerations of good care, and that should they become seriously ill, their health plan will not deliver the needed care [6]. Yet most comparative reports do not directly address these concerns. When comparative reports do carry messages that speak directly to these types of concerns, they are attended to by consumers to a greater degree, are better understood, and the information more highly valued than reports that fail to address these concerns [7].

Finally, while most comparative reports focus on health plans, consumers are most interested in provider level data [8]. There is broad recognition of this need, and while there are measurement challenges, comparative reports are beginning to move in this direction with physician group performance reports.

To summarize, if consumers understood the scope and the nature of the problem and the risks they face from poor quality care, if they understood what was meant by quality of care, and if reports spoke directly to consumer concerns and interests, then it is highly likely we would see more consumer attention to quality reports. Of course wide dissemination and promotion of the reports are also needed to boost exposure to the information.

Making quality reports easier to use

Once we have consumers’ attention there is still the problem that the reports are complex and burdensome to use. They have too much data and conflicting information (e.g. a health plan that is good on one measure and poor on another), leaving the viewer confused and unsure of what to do with the information.

Is there a way to make it easier to use the reports? Our findings from recent laboratory studies begin to answer this question. Our experiments were designed to determine how presentation approach, including presentation approaches designed to be ‘evaluable’, affects the interpretation and use of data [9]. ‘Evaluable’ refers to presenting information in a way that makes it easier to discern better and worse options. The findings show that using evaluable presentation approaches (e.g. ordering by performance or using visual cues that help identify high performers) resulted in making the information easier to interpret and more likely to actually be used in choice. Thus, the findings suggest that using ‘evaluable’ presentation approaches would enhance the ‘choice’ pathways. Moreover, because they highlight better and worse options, they would likely boost the effect of the ‘reputation’ pathway as well.

Institutions spend substantial resources and effort in building a public image of trust, safety, and quality. Through a coordinated communication and advertising strategy, referred to as ‘branding’, institutions try to create a generalized positive impression. A public report that is easy to digest and one where it is easy to discern high and poor performers (using evaluable presentation formats) could threaten or support an institution’s public image.

If, for example, people form a generalized impression about the quality and/or safety of a hospital, based on an evaluable comparative report, this can be a powerful threat or benefit to that hospital. A generalized impression would likely be communicated to family and friends over time (just as impressions of restaurants and schools are communicated), creating a wider net of those holding this impression. Furthermore, we know that when people must make choices of hospitals or plans they ask a friend or family member. Thus, an evaluable report might eventually indirectly influence consumer choice as well.

Thus, using evaluable reporting approaches, or ones that highlight for the viewer better and worse performers, could boost the impact of all three pathways.

On the other hand, if we wanted to boost just the ‘choice pathways’, providing comparative information along with decision-support tools would help consumers use the data in decision making. Decision-support tools can help consumers individually weight and bring together all the relevant factors (costs, benefits, quality) into a choice. Use of these tools could enhance the likelihood that quality data would be included in choice. The tools would likely not affect institutional reputation, however, and would not motivate providers to improve as a way of protecting their image. Thus, designing effective public reports needs to begin with a clear understanding of which pathways are being pursued.

In summary, evaluations are needed that illuminate which pathways are most effective in achieving improvements in care. Furthermore, we are just beginning to understand how the reputation protection pathway works and what factors boost the impact of that pathway. Although we have laboratory research indicating which reporting strategies are likely to increase the use of comparative performance data in choice, we need to see how well these findings hold up in real life decisions. Until there is more empirical evidence about which pathways are more effective in stimulating quality improvement, using reporting strategies that have been tested in the laboratory and are likely to boost the impact of all three pathways may be the safest approach.

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References


