The Role for Information in Improving Quality and Performance

Sheila Leatherman
Professor of Health Policy and Management
School of Public Health, Univ. of North Carolina
Visiting Professor, London School of Economics

Remarks

- What are we trying to achieve?
- How does information contribute?
- Evidence; what works?
- Recommendations; how to move forward?

What are we trying to achieve? Better quality and performance

- Effectiveness
- Access
- Safety
- Equity
- Responsiveness
- Efficiency

Where does information fit?

Five pathways to improvement

- Public accountability/transparency
- Empowering patients and public
- Enhancing professionalism
- Market mechanisms
- Leveraging the “system-ness” of NHS

Where does information fit?
Five pathways to improvement in NHS

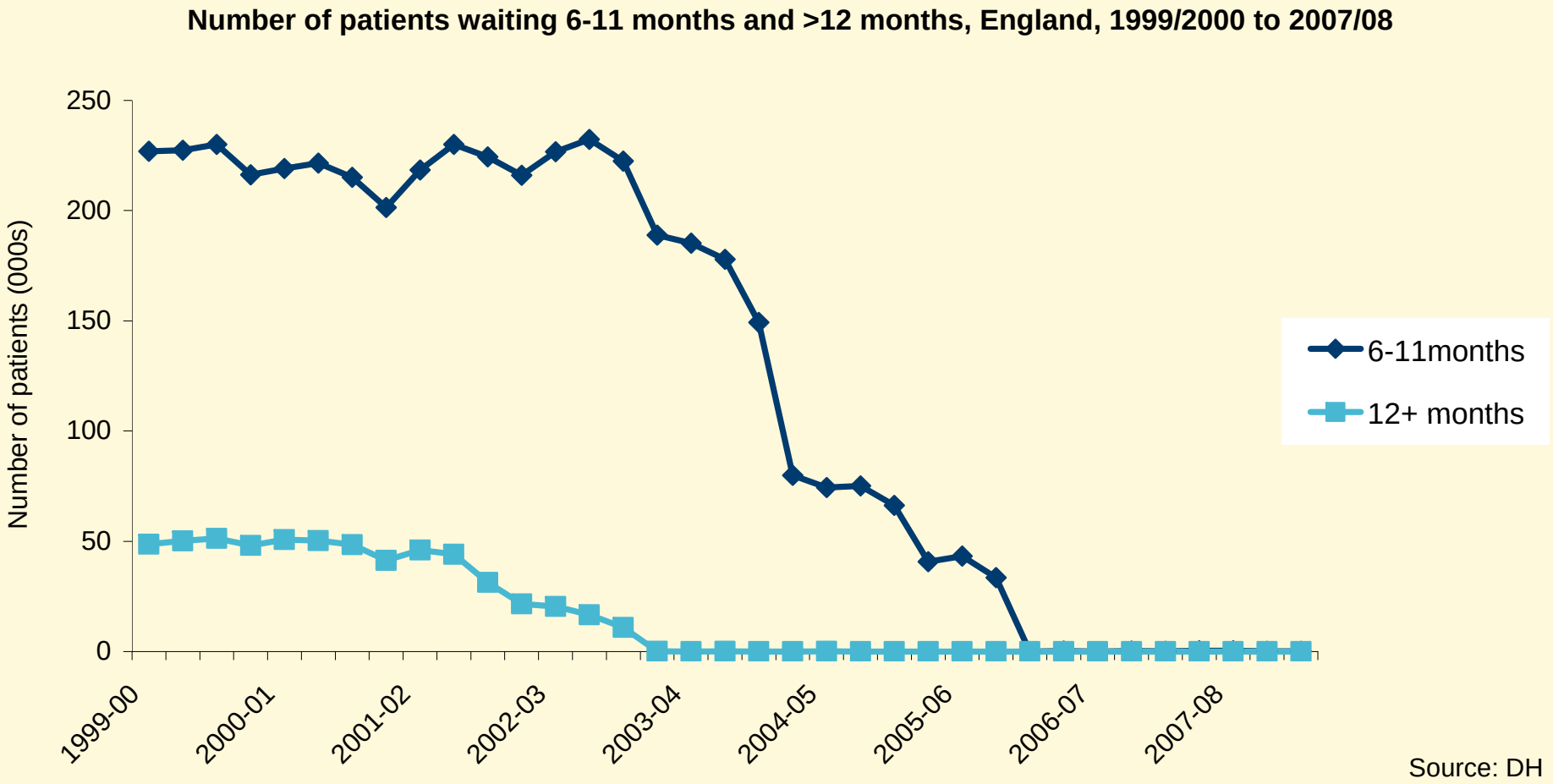
- What is that we think we are doing?
- What does the evidence say; what works?
- What should we be doing?

Transparency and Public accountability

- Two Pathways to improvement ;
  - Public reporting
    - Blame and shame
    - Publicly recognize the best
  - Benchmarking; peer comparisons
    - Peer pressure

UK: Transparency for national improvement

1999-2008 Waits for Hospital Admission in NHS



Source: DH

Transparency and Public accountability

- Evidence; what works to improve quality?
  - Public reporting works best for institutions
    - Hospitals/Trusts/Nursing homes
  - Benchmarking works best for doctors
    - Need comparative data to peers
    - Real issues;
      - -should doctor data be publicly released?
      - -better results when used for peer review?
      - -is it even fair at individual level to report?

Patients:
Information Needs and desires

- **Pathway to improvement;**

  What do patients want?

  - **Communication with their clinician**
  - **Information to make decisions about their treatment**
  - **More knowledge about their <u>current</u> illness**
  - **Info for treatment choice-not provider choice (usually)**

Patients;
Information Needs and desires

Evidence; What works?

Better clinical outcomes
Lower costs
Better patient satisfaction

- **Shared decision-making**
- **Basic patient education**

- **Provider choice only in specific populations,**
  - **ex .Maternity, Breast cancer, nursing homes**

Supporting Professionalism

- **Pathway to improvement;**
  - **Professionals motivated to do well for patients**
  - **Knowledge base beyond human capacity**
  - **Health systems complexity beyond individual**
  - **Professions need;**
    - **“ artificial intelligence”**
    - **“systems reliability”**

Information to Support Professionalism for Quality

- Evidence; what works?
  - Electronic record
    - Embedded clinical decision support
    - Improvements in appropriateness, continuity, safety
    - Reductions in waste
  - Performance data is KEY
    - Performance feedback with comparative data
    - Peer review
    - Reward??? If financial-linking payment to performance
      - Pay for improved performance
      - Pay for participation
      - Pay for top performance

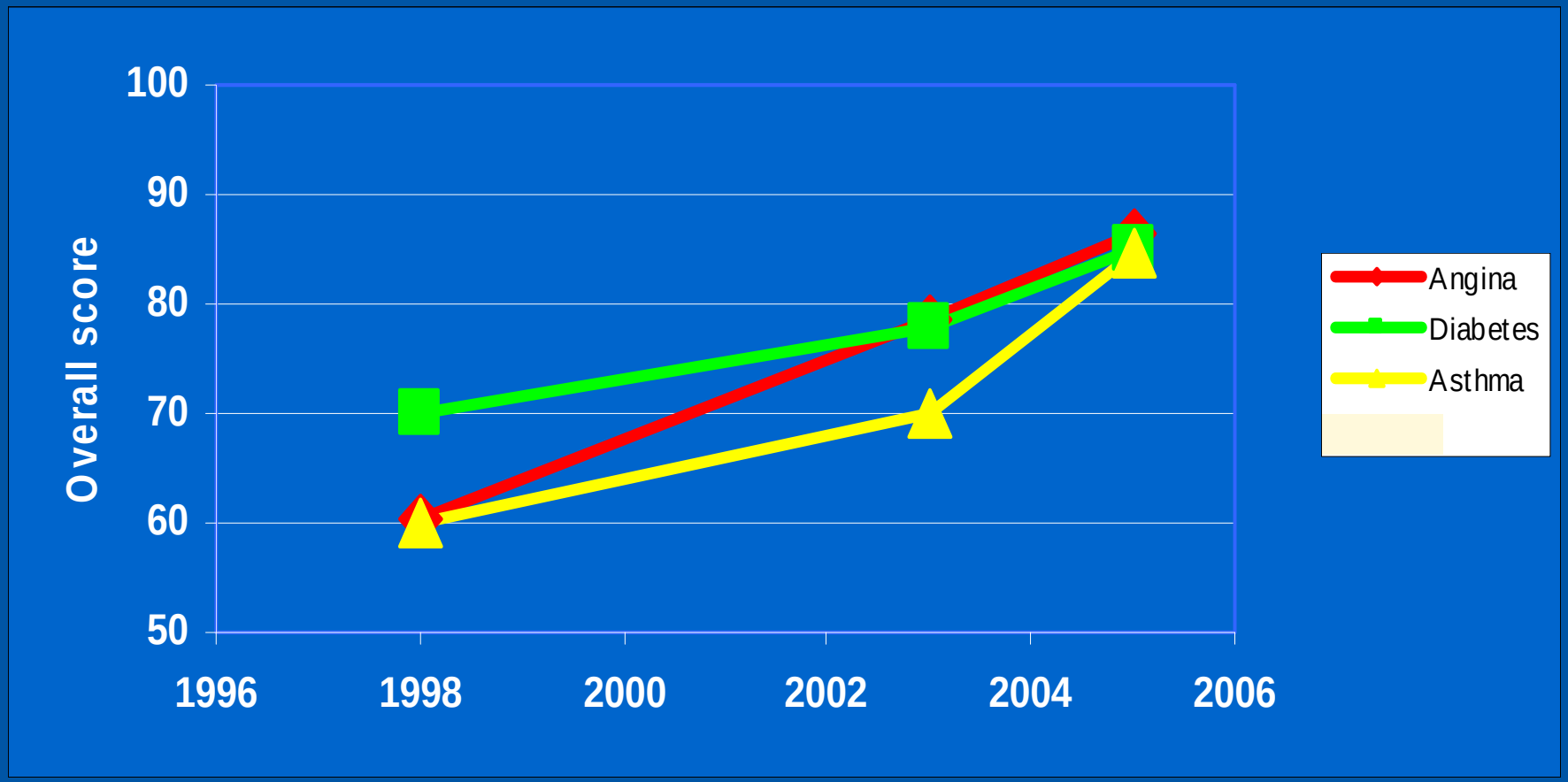
Use of market forces

- **Pathway to improvement**
  - **<u>Theory</u>; quality will be increased by;**
    - **competition for market share**
    - **public reporting**
    - **"informed consumers" select best providers**
    - **pay for performance**

Use of market forces

- Evidence; what works? (US)
  - Public reporting has driven up quality in target areas
  - Institutions (hosp and health plans) do respond to payment incentives
  - Informed consumerism using information to select providers is not a reliable strategy
  - Physician incentives less clear; insufficient reward level?

Quality of care improved between 2003 and 2005; following the introduction of financial incentives



Campbell et al. Improvements in clinical quality in English primary care before and after the introduction of a pay for performance scheme. (BMJ)

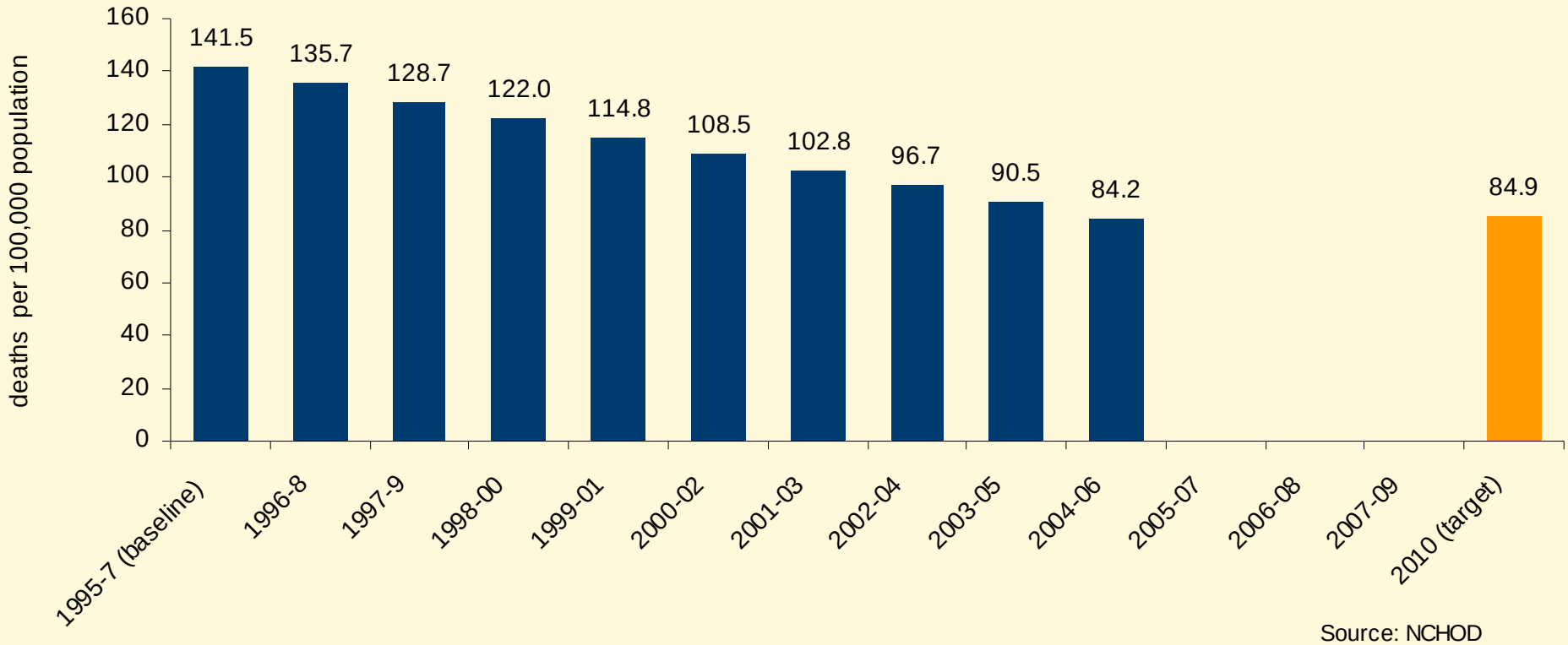
Using the power of system-ness

- Pathway to improvement
  - Setting priorities, standards and targets to maximise impact on population health
  - Using information to establish ;
    - Baseline burden of disease
    - Evidence based standards
    - Targets for attainment and track progress
- Evidence

Editorial Comment -While England has the luxury to reject; other countries covet the opportunity

National Goal in UK;
Reduce Mortality in circulatory disease

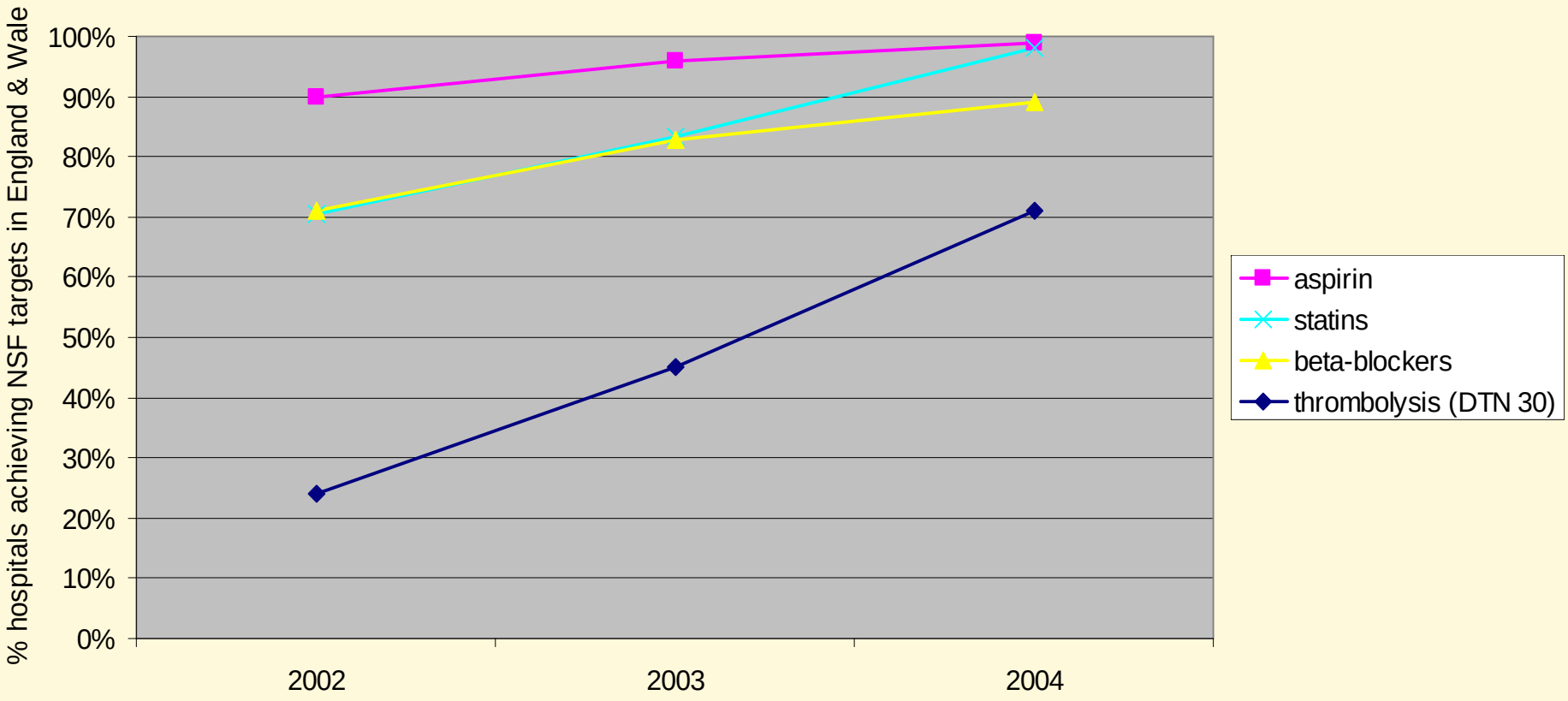
Mortality rates from circulatory disease (people <75 years), England, 1995/7 - 2004/6



Source: NCHOD

Managing Heart Attack : National reporting by all hospitals

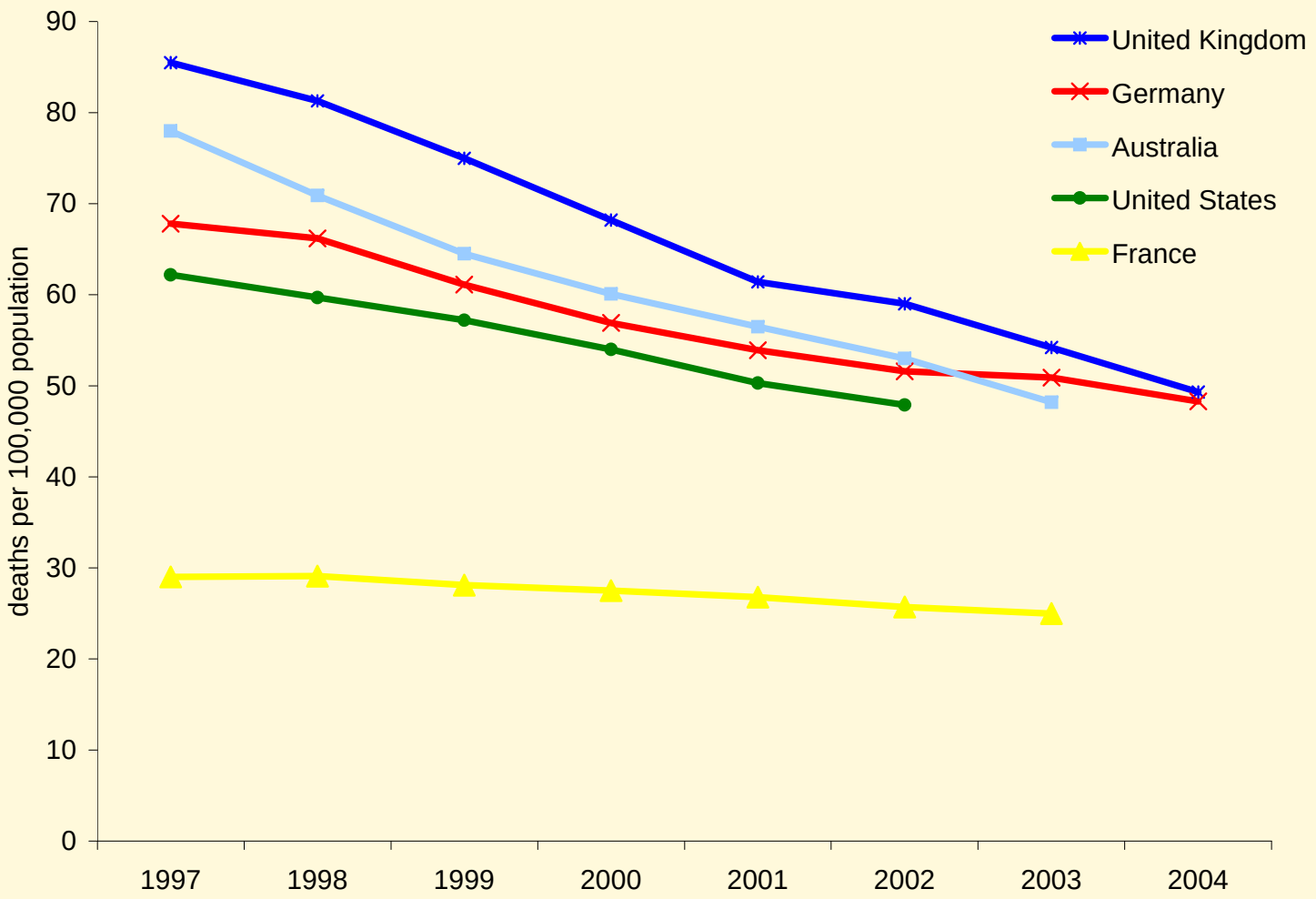
1.17a Managing acute myocardial infarctions, England and Wales 2002-04



Source: Royal College of Physicians

International comparisons; Mortality from AMI

Mortality from AMI, international comparison, 1997 - 2004



	% decrease 1997 - 2004
United Kingdom	42.3%
Germany	28.8%
Australia	38.2%
United States	23.0%
France	13.8%

Aus & Fr 2003, US 2002

Source: OECD

"Quality is never an accident;

it is always the result of intelligent effort."

(and information)

John Ruskin (1819-1900)