Health Policy 120 (2016) 377–383

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Public reporting on quality, waiting times and patient experience in 11 high-income countries☆

Bernd Rechel[a,*], Martin McKee[a], Marion Haas[b], Gregory P. Marchildon[c], Frederic Bousquet[d], Miriam Blümel[e], Alexander Geissler[e], Ewout van Ginneken[e], Toni Ashton[f], Ingrid Sperre Saunes[g], Anders Anell[h], Wilm Quentin[e], Richard Saltman[i], Steven Culler[i], Andrew Barnes[j], Willy Palm[k], Ellen Nolte[l]

[a] European Observatory on Health Systems and Policies, London School of Hygiene & Tropical Medicine, 15-17 Tavistock Place, London WC1H9SH, United Kingdom
[b] University of Technology Sydney, Australia
[c] Institute of Health Policy, Management and Evaluation, University of Toronto, Canada
[d] Caisse nationale de l'assurance maladie des travailleurs salaries (CNAMTS), France
[e] Berlin University of Technology, Germany
[f] School of Population Health, University of Auckland, New Zealand
[g] Norwegian Knowledge Centre for the Health Services (NOKC), Norway
[h] Lund University School of Economics and Management, Sweden
[i] Emory University, Atlanta, United States
[j] Virginia Commonwealth University, United States
[k] European Observatory on Health Systems and Policies, Brussels, Belgium
[l] European Observatory on Health Systems and Policies, London School of Economics and Political Science, London, United Kingdom

ARTICLE INFO

Article history:
Received 27 November 2015
Received in revised form 24 January 2016
Accepted 12 February 2016

Keywords:
Patient satisfaction
Quality of health care
Benchmarking

ABSTRACT

This article maps current approaches to public reporting on waiting times, patient experience and aggregate measures of quality and safety in 11 high-income countries (Australia, Canada, England, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the United States). Using a questionnaire-based survey of key national informants, we found that the data most commonly made available to the public are on waiting times for hospital treatment, being reported for major hospitals in seven countries. Information on patient experience at hospital level is also made available in many countries, but it is not generally available in respect of primary care services. Only one of the 11 countries (England) publishes composite measures of overall quality and safety of care that allow the ranking of providers of hospital care. Similarly, the publication of information on outcomes of individual physicians remains rare. We conclude that public reporting of

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

* Corresponding author. Tel.: +44 20 7927 2106; fax: +44 2079272701.
E-mail addresses: Bernd.Rechel@lshtm.ac.uk (B. Rechel), Marion.Haas@chere.uts.edu.au (M. Haas), greg.marchildon@utoronto.ca (G.P. Marchildon), Frederic.Bousquet@cnamts.fr (F. Bousquet), miriam.bluemel@tu-berlin.de (M. Blümel), a.geissler@tu-berlin.de (A. Geissler), ewout.vanginneken@tu-berlin.de (E. van Ginneken), toni.ashton@auckland.ac.nz (T. Ashton), Ingrid.Sperre.Saunes@kunnskapssenteret.no (I.S. Saunes), anders.anell@fek.lu.se (A. Anell), wilm.quentin@tu-berlin.de (W. Quentin), rsaltma@sph.emory.edu (R. Saltman), sculler@sph.emory.edu (S. Culler), andrew.barnes@vcuhealth.org (A. Barnes), wpa@obs.euro.who.int (W. Palm), E.Nolte@lse.ac.uk (E. Nolte).

http://dx.doi.org/10.1016/j.healthpol.2016.02.008

aggregate measures of quality and safety, as well as of outcomes of individual physicians, remain relatively uncommon. This is likely to be due to both unresolved methodological and ethical problems and concerns that public reporting may lead to unintended consequences.

1. Introduction

The public reporting of the quality of health care and the performance of health care providers has expanded in recent years, often using dedicated websites targeted at the general population. A wide range of measures is available. Three broad types of information can be distinguished, relating to:

- health care outcomes (such as mortality rates or rates of complication);
- provider performance (such as waiting times, length of stay or other care processes);
- patient experience and satisfaction (as elicited through patient surveys).

Advocates of public reporting believe that it helps to improve transparency and accountability, empowers patients to make informed choices, and provides policymakers and third-party payers with the knowledge to inform decisions on payment, including rewarding high or penalising low performers [1,2]. Public reporting of performance data is thought to improve the quality of care through two principal pathways: the first ('improvement through selection') believes that information on quality provides users with knowledge that will enable them to select providers according to quality criteria, while in the second ('improvement through change'), quality improvement is achieved through changes in provider behaviour. In this latter pathway, information is seen as helping providers to identify areas of underperformance and reporting can act as a stimulus for improvement, motivating providers to compete on quality [3,4].

Public reporting does, however, face several challenges. First, publication can have unintended consequences, creating perverse incentives that could ultimately damage quality and public trust. For example, providers may become more reluctant to take on high-risk patients, clinical priorities might become distorted, and staff morale may be reduced [3].

Another concern relates to the accuracy of the information used and the extent to which it reliably reflects provider performance [5–7]. The selection of meaningful indicators is a particular problem [2]. The experience of the United States is of particular relevance here, as indicators of provider performance have been published for over two decades. By 2012, the United States National Quality Forum (a non-profit organisation) had endorsed more than 750 measures [2]. However, there is little overlap between the indicators used in various programmes [8] and a study of 29 private insurance plans identified 550 indicators, few coinciding with those used in public programmes [9]. A study comparing four national rating systems of hospitals in the United States found different systems producing different results, with only 10% of the 844 hospitals that were ranked as top performers in one system designated as high achievers in any of the other systems [10]. Although these systems were intended to inform patient choice, the study found that they tended to confuse rather than guide informed decision-making [10]. Indeed, despite 20 years of comparisons of hospital quality in the United States, consumers take such information into account only to a small extent in their choice of provider [11].

A number of other countries have also invested considerable efforts to collect and publish data on outcomes, provider performance and patient experience. Examples in Europe include Sweden, the Netherlands, Germany and England. However, countries differ in the extent to which they make such data publicly available. England appears to have gone further than most in providing single composite ratings of provider performance, in addition to measures of performance in specific areas, or using multi-dimensional profiles. For example, its Care Quality Commission, the regulator of health and adult social care, generates a composite rating of each provider based on whether they are safe, effective, caring, responsive to people's needs and well-led [12–14].

There is, however, little explicitly comparative information so far on the current state-of-the-art of public reporting in high-income countries. Our study sought to provide a comparative analysis of public sector approaches in 11 high-income countries towards the collection and publication of provider performance data. Such a comparative analysis is useful for two reasons: First, publication of information on provider performance is often viewed as promoting transparency on the performance of health systems. Second, an analysis of how approaches differ may reveal their strengths and weaknesses.

The study was undertaken by the European Observatory on Health Systems and Policies in response to a request of the English Department of Health. A summary overview of key findings was published by the Department of Health [13].

2. Materials and methods

Data were collected by means of a questionnaire (see supplementary web appendix) for self-completion by key informants in Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the United States, exploring the following areas of public reporting (i) overall ratings for quality and safety of care (for every major hospital, general practice, residential care provider and domiciliary care provider); (ii) outcomes of individual health care professionals on indicators, such as mortality or other measures of performance; (iii) waiting times between referral and treatment for every