

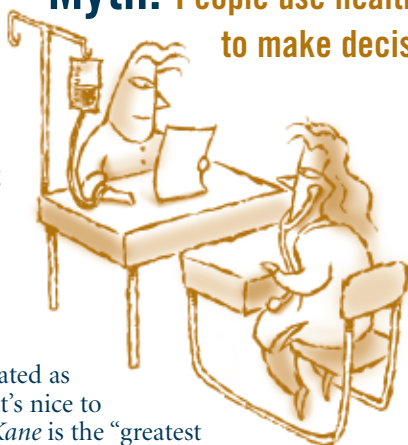
Mythbusters

A series of essays giving the research evidence
behind Canadian healthcare debates

Myth Busted December 2003

Busted Again September 2006

Myth: People use health system report cards to make decisions about their healthcare



In a culture obsessed with ranking the Top 10 everything, it seems logical patients would want their hospitals and doctors to be rated as well. After all, it's nice to know *Citizen Kane* is the "greatest American movie," but it won't change your life. On the other hand, knowing your local hospital is a world leader in heart surgery just might.

This is the thinking behind healthcare report cards for the public. Providers and hospitals are ranked, giving patients the ability to choose between superior, average, and poor performers. As well, those being ranked can focus their quality improvement efforts where they will do the most good.

Unfortunately, research indicates that, while most Canadians want comparative information,ⁱ they are not using it when making healthcare decisions. In addition, evidence of improved quality and accountability is somewhat tempered by potential gaming of the system.

If you build it, will they come?

In the province of Ontario, hospital-specific report cards have been used since the early 1990s to rate cardiac care.ⁱⁱ However, people are not consulting these reports before going to the hospital. For example, follow-up of a one-time atlas on heart attack care showed none of the patients at 81 percent of hospitals asked about the findings within a year of its release.ⁱⁱⁱ

The situation is similar south of the border. Pennsylvania produces an annual report on bypass surgery; in its fourth year, only 12 percent of patients had even heard of it before they had surgery. And less than one percent of people going into surgery knew the rating of their surgeon or hospital and said the rating had a moderate or higher effect on their decisions.^{iv}

In addition, a large study of Wisconsin hospitals that were included in a public report card showed no change in the number of people using each hospital after the report's release. Further, only 10 percent of people who were exposed to the report used it to recommend or choose a hospital within two years, and almost no one spoke with their doctors about it.^v

Finally, report cards on bypass surgery, heart attack care, and spinal surgery in New York and California produced almost no sustained change in hospital volumes after they came out—there was some patient movement towards high-ranked hospitals and away from low-ranked ones in the first few months, but these effects were only temporary.^{vi}

Of course, it's possible the reports aren't reaching the public—people aren't using them simply because they don't know they exist. Most reports are available on web sites and may be reported on only once in the newspapers, requiring people to actively seek them out in the first case and read a particular article on a particular day in the second. However, in Wisconsin, the reports were also sent directly to people's homes and distributed by community groups and libraries yet still had very limited uptake by the public.^{vii}

A further complication is patients' ability to make choices based on these reports. In Canada, care for many serious conditions—such as cardiac care—is often centralized in hospitals within health regions, so patients don't have many options that wouldn't involve significant travel.^{viii} In the United States, report cards have some effect on what health plans people opt for.^{viii, ix} But after choosing a health plan, patients are often locked into a specific network of hospitals, meaning they may have very few realistic choices to make based on the report cards.^x

So what *are* patients consulting? Surveys show people prefer health services somewhere close to home,^{xi} they listen to what family and friends say about the hospital, and they feel comfortable if they were referred to the same place by their doctor in the past.^{xii}

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But can they still be useful?

While the public may not use report cards in decision-making, facilities may use them to improve quality and accountability. In Ontario, 54 percent of hospitals said they made changes in response to the heart attack atlas.ⁱⁱⁱ Another study said 77 percent of Pennsylvania hospitals and 88 percent of New Jersey hospitals set up ways to monitor quality, and 38 percent of Pennsylvania hospitals and 56 percent of New York hospitals put more money into quality improvement for heart surgery patients.^{xii} A survey of Missouri hospitals that were publicly evaluated on their obstetrics services found improvements in nearly half the hospitals one year later.^x England, which rated its NHS trusts annually between 2001 and 2005, found remarkable improvements in the amount of time people spent waiting in emergency rooms, ambulance responses to life-threatening calls, and waiting times for elective hospital admissions.^{xiii}

Finally, studies suggest it is indeed the public aspect of report cards that spurs quality improvement efforts. In the Wisconsin hospital study, 33 percent of hospitals that were included in the public report card improved their performance two years later and only five percent had worse performance; among hospitals that received confidential feedback at the same time, only 25 percent of hospitals improved, and the performance of 14 percent declined.^v This mirrors a large study of Quebec hospitals that studied immediate versus delayed feedback and determined “feedback based on one-time, confidential report cards... is not an effective strategy for quality improvement regarding care of patients with [heart attacks.]”^{xiv}

Caution required

Several concerns remain about public report cards. Ontario hospitals worry the reports don't do enough risk-adjustment—factoring in things like the patient's age or other ailments.ⁱⁱⁱ And it can be years between the time the data are collected and when they are published—issues that brought down ratings may no longer be problems.^{xv, xvi}

In addition, the reports may have some unintended negative effects. In 1996, almost two-thirds of New York heart surgeons said they refused to do a bypass on at least one high-risk patient, mostly because of public reporting.^{xvii} Cardiologists in Pennsylvania also said they were having trouble finding surgeons to operate on high-risk patients.^x And “gaming” has been alleged in England; as one example, patients had to wait in ambulances outside the emergency room until staff was confident of meeting the four-hour waiting time target for treatment (the clock didn't start until patients left the ambulance).^{xiii}

Despite these concerns, public report cards are likely here to stay.^x The best bang for our buck may come by focusing on where the research says we're already making the most headway—making report cards multidimensional and useful for health professionals, institutions, and decision makers.^{xviii}

Mythbusters are prepared by knowledge transfer and exchange staff at the Canadian Health Services Research Foundation and published only after review by researcher experts on the topic.
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