Measuring quality outcomes: the next frontier for competition?

Private health and care would be transformed if quality could be measured accurately in a way that patients could really understand. If measured, quality would then soar. And the sterile European private *versus* public debate would fade out as payers focused on quality outcomes and patient choice. Private operators could be compared on a level playing field with their public counterparts.

But this is the industry that has proved most resistant to quality measurements. So is talk of quality just so much pie in the sky?

Not necessarily. In the UK, the Private Health Information Network, mandated by the government, plans to enable all the above by 2017. And in other European countries, notably Sweden, the Netherlands and Germany, there are similar moves. ICHOM has been set up to create international standards of outcome measurements set quality, no just in acute but also in elderly care and psychiatry.

Yet, most providers and healthcare systems are still relatively new to systematically measuring quality. While European countries have apparently strict standards and auditing procedures in place, there is little emphasis on whether treatments result in tangible improvements for the patient.

From structure to outcomes

When measuring quality, you can differentiate between three key measures.

The first is structural, focusing on aspects such as staff numbers or medical equipment. The second is process-based, where hospitals or care homes concentrate on specific goals, often assessed through key performance indicators (KPIs) such as mortality, readmission or infection rates. The third focuses on outcomes, where clinical results and patient satisfaction are assessed over time.

It is the latter that gets the most attention. Dr. Tim Williams, CEO of MyClinicalOutcomes, a UK platform that asses outcomes as experienced by patients, explains: “The problem with process-based quality assessment is that it ultimately does not help the patient or the doctor to understand what works. Neither real-time data nor any long-term data are included. You have to remotely monitor developments after a treatment to improve quality.”

Beside physician-reported clinical results, the main methods to evaluate outcomes vary according to country. Examples include Consumer Quality Index, Net Promoter Score and Patient-Reported Outcome Measures (PROMs). PROMs look at whether the treatment has been effective in improving the patients’ quality of life, for example whether joint replacement surgery has reduced pain and increased mobility, or eye surgery has increased visual function.

This comes under the form of a questionnaire to be filled by patients before, immediately before and at a specific point after treatment (usually three or six months). Some services like MyClinicalOutcomes continue to survey on a regular basis. Patient Reported Experience Measures (on the care received at a facility) may also be used.

There are financial advantages in looking at outcomes. The benefits of measuring results are at the heart of ‘value-based healthcare’, the theory behind some of these initiatives. Pioneered by Michael Porter in the United States, and implemented in large groups like the Cleveland Clinic, the idea is that providers can achieve the best outcomes at the lowest possible costs, through the introduction of integrated care models and bundle payments.

Yet, the majority of countries in Europe do not really look at outcomes. Data on processes is easier and cheaper to

collect. KPIs on processes are the base for DRG reimbursements, allocated to providers by payers according to activity and risk, and widely implemented in Europe. As a result, it is processes, rather than outcomes, that are scrutinised by public authorities.

France is an example of a country with a strong focus on processes. Both public and private operators will be regularly inspected, with findings reported in Scope, a database that compiles information on KPIs. According to Stéphane Pichon, managing partner at Your Care Consult, France actually has the largest publicly available data in Europe.

Beside, there is disagreement on who benefits the most from quality measurements based on outcomes and a fear that they may be subjective. It makes patients more informed, doctors more effective and payers more selective. But while data is becoming accessible to everyone, this has not historically been the case.

Leonid Shapiro, managing partner at Candesic, says: “Healthcare is just becoming more consumerist. Patients are beginning to pay attention to both the hospital they go to and the reputation of the surgeon. In the past, patients have relied solely on doctors’ recommendations, after all, every hospital and doctor has to have a minimum level of quality to be certified/licensed. However now, increasingly, they are demanding higher quality and a higher chance at better outcomes, mainly due to the fact these things are now being measured and being made transparent to patients.”

A patient may choose to go to a specific hospital for the quality of facilities and ‘customer service’, although that might not make sense from a clinical point of view. But it has got to provide quality that is high enough for the patient to feel safe, and soft things like food and staff are all important.

Initiatives

Countries at the forefront of outcome-based quality measurements are Sweden, the Netherlands, the UK and Germany.

In the UK, the Private Healthcare Information Network (PHIN) looks at performance indicators in private hospitals. The information is to be released to the public in 2017. It should also enable care in private facilities to be compared to the public sector.

For this, PHIN uses a broad range of performance measures from simple activity counts through patient satisfaction measures and PROMs, to developing new ways of measuring the core safety measures of deaths in hospital following treatment, unplanned transfers of care between hospitals and unplanned readmission to hospita following discharge.

PHIN’s efforts toward standardisation of quality indicators have been praised by many British healthcare-related organisations. Williams says that the emergence of organisations like PHIN now allows MyClinicalOutcomes to offer additional value by allowing providers and clinicians to benchmark themselves against others, helping them understand not just the progression of individual patients, but variation in quality relative to their peers.

Before PHIN, measuring outcomes in the UK private sector was fragmented and focused at the specialty level, such as orthopaedics, rather than at entire healthcare systems.

PHIN is partnering with ICHOM, the largest international organisation looking at PROM quality measurements in healthcare. Run by doctors and backed by consultancy BCG, ICHOM is trying to set up a global quality standard for different medical conditions. It works with doctors, providers, payers and patients to implement value-based healthcare worldwide. Ambitiously, it is looking at conditions from acute through to elderly care and psychiatry.

Dr. Markus Hamm, managing director at Schoen Klinik, which uses a similar approach to ICHOM in measuring quality, says hospital initiatives in Germany differ from ICHOM in the importance they place on patients. “Many providers use process-oriented systems, which are not always relevant for the patient. Outcome-based systems used by ICHOM allow for the distinction between poor, good and very good hospitals, rather than just identifying

bad ones," he says.

In Sweden, several quality registries exist for providers to report data at the national and county levels. Those look at both clinical outcomes and patient satisfaction, and the findings are accessible for patients to consult.

Sweden's quality registries constitute one of the oldest initiatives to monitor quality. Most of them look at over 95% of all elective surgery. While Daniel Öhman, CEO of GHP Specialty Care, a healthcare provider trying to develop expertise in specific areas through quality measurements, says they had not been really used for anything else than publishing reports, he adds this is no longer the case: "Until a few years ago, quality registries were here mainly to submit data for DRGs. Now it is being used as a platform to introduce outcome-based payments and to help patients choose providers."

In the Netherlands, things have also changed. While most quality measures are still around structure and processes, interest in outcomes is growing, and the Minister of Health Edith Schippers announced that 2015 is 'the Year of Transparency' for the Dutch health care system.

Pieter de Bey, principal at BCG and former VP of Operations at ICHOM, explains that government-led initiatives such as ZiZo or 'Visible Care' largely failed: "ZiZo measured a lot of data, yet it was of little relevance for patients to choose providers and for providers to learn from each other and improve quality."

In 2006, the insurers' role shifted from being sick funds to actively finding the best providers at the best price, thus leading to more selective procurement. Dutch insurers also started looking at patient-reported outcomes. The Miletus Foundation, which groups several major insurance companies, does publish results based on PROMs, CQIs, NPSs and PREMs. Institutes like DICA, which originally looked at quality measures for colon cancer treatments, rapidly expanded to focus on other cancers. It is now the largest platform for monitoring quality for many sub-sectors, based both on outcomes and processes.

The interesting thing about DICA is that participation is based on peer-pressure, with virtually all hospitals now partnering. That is because providers are obliged to report quality indicators to the IGZ, a governmental body, one of which is participation in DICA. De Bey says a negative answer is not looked upon very well.

The Netherlands is trying to introduce Swedish-style registries, and DICA, which is already authoritative in most sectors, would be responsible for coming up with national benchmarks. But such a project is expensive. While insurers are partially financing DICA, the sheer amount of data crunching required to create a nation-wide database requires considerable funding. That could come from pharma and medtech companies who might want to access DICA's reports from a research perspective.

Germany is another country to focus on quality, with providers and payers both playing a strong role. Yet, existing initiatives are very fragmented.

Large German private hospital chains have been very proactive at evaluating quality. Helios founded the IQM project, which includes over 250 quality indicators, and now covers over 350 hospitals in Germany and Switzerland. Another provider-led initiative is 4qd, comprising Ameos, Asklepios and Rhon Klinikum. This contains 400 quality indicators for acute, psychiatry and rehab. Some operators like Schoen Klinik or Martini Klinik pride themselves on having very high levels of patient satisfaction and outcomes for all stages of care, based on the systematic use of PROMs.

But major public payers like AOK and Techniker have their own institute for quality, which assess data and DRG-related data delivered by hospitals. However, there is no cooperation between acute and primary care. This is a big issue for insurers, as they need to be able to have a comprehensive picture to guide patients.

According to Hamm, private medical insurers like Axa are trying to create 'case managers' to look at the whole patient journey. This is not only seen in Germany. A similar initiative is being put in place by the Danish government. Denmark is currently introducing a 'patient manager', who could be a GP or a nurse, who will be in charge of collecting data on the patient journey. This will be available to any healthcare professional the patient might consult.

There are other countries where the government is very involved. In the Czech Republic, ophthalmology chain Optegra says local government inspections into quality outcomes are comparable or higher than in any other country where it operates. “The level of scrutiny is extremely high and there are many unannounced controls. I often hear that Eastern European countries like the Czech Republic or Poland are not transparent enough. This is not true, in fact it’s the other way round,” says Roberto Cirillo, CEO of Optegra.

While all these measures do involve the clinician at some stage, some web-based platforms only rely on the patient. Through website and apps, patients can report and share their experiences, often ranking providers.

Here there has been an explosion in online content. In Germany, the web-based platform Jameda claims to be visited by around 5m patients every month. Another example is iWantGreatCare, a Tripadvisor-like website where patients rate their experiences of doctors and hospitals, which exist in parallel to the NHS own service.

Issues in measuring outcomes

Findings from quality measurements can lead providers to change their business model and service offerings.

According to Optegra, using PROMs had two major positive impacts on its business model. Firstly, it got a long-term and holistic perspective over the progress of patients and became more aware of potential shortcomings in the level of care offered. Secondly, it allowed it to maintain a relationship with the patient and offer more bespoke treatment plans.

Cirillo says feedback from patient satisfaction has had direct impacts on the way Optegra actually runs its facilities: “we insist our staff know who each patient is and we have redesigned waiting spaces to be more private. On the medical side, we now give surgeons feedback in the hope of generating continuous improvements of practices.”

Martini Klinik, a German prostate cancer centre, has been using PROMs extensively and conducts over 2,000 surgical procedures a year. Its CEO Detlef Loppow said that findings from PROMs suggested each doctor needed to perform 350 surgeries before 90% of their patients did not have increased PSA after 5 years. He adds that, in comparison, the UK’s largest prostate cancer provider only performs 280 surgeries per group of surgeons. Findings at the surgeon-level led other consultants to spend a longer time conducting certain procedures.

In the Netherlands, the clinics of Equipe Zorgbedrijven, use Pulse, an outcome-centred registration system that allows doctors to evaluate the success of their treatments. Patients provide feedback on experienced levels of pain and their satisfaction with the treatment result. Doctors are notified automatically, up to one year after treatment, whenever values on these outcomes are unusual. Through Pulse, Equipe Zorgbedrijven says it has reduced complaints associated with pain.

But there are major issues related to the accuracy of data and the lack of standardisation in quality indicators.

Providers need to be aware of the patient background and the likely presence of co-morbidities to determine not only which treatment to follow, but also to assess whether this treatment is successful in the long-term. In the case of chronic diseases in particular, quality cannot be assessed through single visits and outcomes must take into account the patient journey and background.

The lack of standardisation of quality indicators is a hindrance. While ICHOM is working on this, providers face difficulty in collecting exactly the same sort of data, from all staff and patients, all of the time. Getting a meaningful result can only happen if as many as stakeholders as possible cooperate. While that might be easy within facilities, it becomes harder once patients are at home, especially for follow up care. Patients are likely to participate, but they might need encouraging, reminding and guiding.

Matt James, CEO of PHIN, says that is vital for providers to compare themselves to their peers in a transparent and independent manner, but that without standardisation, each operator could come up with its own set of quality indicators that cannot be compared.

In the UK, the lack of collaboration between the public and the private sectors is problematic, despite PHIN's efforts to work with the NHS. "All patients are ultimately public patients, even those who choose to receive some episodes of care privately. In most cases, they will have consulted an NHS primary care doctor. Collaboration is virtually non-existent when it comes to patient history," says James.

Sometimes, quality assessments can lead to a push back from doctors, especially in cases where procedures have yet to be standardised and where risk-adjustments are not properly in place. For doctors, outcome measurements can become very technical and lead to a fear of selection bias from providers. The fact that organisations like ICHOM are run by doctors can be a reassurance, especially when clearer standards become available.

Elmar Willebrand, chairman of hospital and investment group AccuMeda, explains one of the biggest issue in improving quality is the lack of innovation in many hospitals: "Many hospitals only do what is strictly required by law, they comply with standards only to get the necessary authorisation to keep their licenses up-to-date. They shouldn't stop there, because quality measurement is this most powerful tool for innovation, if applied with enthusiasm. Although it is very difficult to measure the quality of a hospital, it is worth trying to do so."

Monitoring quality for mental health and elderly care require particularly complex risk-adjustments and coding. Due to the nature of patients' conditions, it can be impossible to actually measure patient outcomes, although ICHOM has set up a working group on Older Persons to set up quality standards for this sector. This comes at a time when elderly care is under scrutiny –and for good reason. Existing assessments of quality standards in nursing homes have failed to prevent abuse, including in those countries most focused on quality of care.

For example, the German care home rating system came under fire in 2014, after several residents died in various facilities despite 'excellent' ratings. It came out that care homes were only inspected once a year and the presence of a garden was considered as important as how medication was administered and staff numbers.

In psychiatry, medical outcomes are related to patient's recovery from diagnoses and patient being able to live a normal life, but the success of a treatment is difficult to assess. Like other sectors, favourable outcomes depend on the patient being able to live a normal life. Henrik Brehmer, head of corporate communications at Capio, says: "it is easy to measure, for example, the blood pressure of a patient, but we need to assess whether they are satisfied as well. This can only be done through patient involvement and feedback."

Measuring quality, although potentially leading to lower costs if errors are reduced, will require capital to implement the necessary coding and potentially restructure care delivery. That means small operators might have a harder time assessing performance. Besides, a solo facility cannot compare itself easily to peers.

But according to Willem Koelewijn, CEO of Koelewijn Zorg Holding, the most important issue for small hospitals is their limited volume of activity. As the success of Martini-Klinik shows, volumes are key to improving quality. "The driving factor in reporting quality is not size, but the number of procedures you carry out for a specific condition. If you don't do a lot, it can be difficult to measure quality," says Koelewijn.

Can quality be rewarded?

There are only a few examples of payers rewarding quality outcomes. Switching from DRGs is expensive, and the lack of standards in most countries makes it impossible for now. However, this is starting to change. Sweden and Germany, in particular, have introduced quality payments for DRGs.

For Thomas Kelley, European director at ICHOM, creating financial incentives is a tricky issue: "For quality outcomes to be linked to payments, it is crucial to have standardisation across the board. It makes sense for payers to reward quality, as they want to contract providers with the highest value -that is not only a good outcome but also cost minimisation. But measuring quality is still in its infancy, and remuneration is risky because it can distort behaviour."

In the UK, the NHS is using a system called the Commissioning for Quality and Innovation (CQUIN). This pays an

extra 2.5% if targets are met. Several consultants said this was not a good idea. One said: “2.5% is a huge slice for a hospital CEO and one that he or she can not afford to lose so they will game the system.” Rewarding quality can therefore distort measurements. James says that his concern about CQUIN is that it forces hospitals to focus on what commissioners deem important, and can actually reduce the attention that they give to improving quality from the patients’ perspective.

Sweden has introduced ground-breaking PROMs-based measures by partially substituting DRGs with bundle payments. The data sent to quality registers is used to calculate what the outcomes of elective surgery should be, based on patient feedback. If a provider exceeds these standards, they get extra payment. If they don’t meet them, they have to reimburse part of the payment. They also have to bear the financial costs of readmission into a public hospital and any rehabilitation costs.

“We are now totally in charge of how to deliver care, as DRGs are replaced by a single payment. This is a major step towards value-based healthcare, and it makes our job much more interesting. This is a big opportunity to be more aware of costs and improve outcomes for the patient,” says Öhman.

In the Netherlands, there are talks about whether to reward volume, as this often means higher quality. Insurers already tend to select providers on their volume of procedures.

In Germany, hospitals get a score every year, reflecting how they compare to the average, as well as a score from 0 to 5. The GBA, a body that combines and oversees insurers, doctors, dentists, psychotherapists and specialists, is mandated to produce quality guidelines.

Payers and pension funds do force rehab providers to follow strict quality controls through audits measuring their performance. Based on inspections of facilities and patient satisfaction, rehab providers with very good or very bad quality receive more or less referrals. In some extreme cases, the insurer will stop all referrals, forcing providers to close and restructure whole departments.

Willebrand says: “I remember a case where patients systematically complained about one particular physician. Eventually, the insurance just refused to send out patients to this doctor, leading to a 35-bed department being close. They only started to refer patients once the provider employed a new doctor, which took at least six months. These measures sound very robust, but this is the best way to get rid of low quality care.”

Interestingly, the process also works the other way round. If a provider shows particularly good practice and scores high, referrals will increase. In fact, Willebrand says insurance groups all have ‘competition centres’ that patients can visit for advice on which facility to visit or even how to get a second opinion. Contrary to healthcare providers, which are prohibited from advertising in Germany, these centres promote certain operators over others based on quality.

While the power of insurers is limited to controlling patient influx, the German government is trying to introduce pay-for-performance reimbursement schemes, as a partial substitute for DRGs that are purely based on activity. This is part of the Hospital Structure Act, which will be introduced from 2020.

The new reimbursement system means insurers will be able to reward providers that show evidence of good quality care. Quality is to be included in hospital licensing from 2017 and remuneration to incentivise operators from 2020. Payments will be adjusted to reflect excellent and poor quality, although it is not clear whether changes will be based on processes or outcomes.

Our Analysis: Quality measurement is coming but progress is painfully slow. It is very complex and doctors often resist such moves. However it would be wrong to pillory the profession. In general, professional bodies increasingly say they are in favour of such measurements.

Bureaucracy and siloes will also slow things down.

But in general, the move to quality is coming. It will be interesting to see if PHIN hits its 2017 deadline, or whether

Germany will change its payment system by 2020.

How accessible and transparent the data will be is another matter. But again there are many expressions of good intention.

So far, the standardisation of quality indicators exist within national boundaries and it will be interesting to see if pan-European initiatives will emerge. ICHOM is certainly going toward that direction, but at the moment it is depending on partnerships with individual providers in a handful of countries, which are also responsible for reporting data to other organisations.

Hence the question: are there too many initiatives? Health is not an EU matter so setting up a European authority to measure quality is probably a non-starter. But we might see a scenario where a supranational body mandates an entity like ICHOM. This is, however, highly unrealistic for now.

We are still at the stage where outcome-based measurements are experimental. Quality remains an essential part of healthcare innovation, competition and, increasingly, financing.