Measuring performance is essential to patient-centred care

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A health care system should, first and foremost, be organized to meet the needs of patients rather than the needs of institutions and providers. More often than not, however, the needs of institutions and health providers come first. How often do we see patients repeatedly return to clinics on different days for poorly coordinated visits for diagnostic tests and follow-up with their physician?

A paradigm shift is needed in Canada toward a patient-centred health system. Change will only occur if patients have access to the necessary information to make their health care decisions. Without comparative measurements, decisions focused on the interests of institutions and health practitioners will continue to be made by administrators and bureaucrats because of limited public engagement.

Canadians should, for example, have access to standard hospital performance measures so public institutions can be held accountable. Before undergoing major procedures, patients need access to rates of surgical success and complication, since many health decisions are weighed against personal values or expectations. Canadians should also have access to the results of independent surveys and audits of practice that compare accessibility, timeliness of care, courteousness and overall satisfaction with health care interactions.

So why does measuring performance and health outcomes elude us?

Partly, it may be a lack of buy-in from top health decision-makers. The Canadian Institute for Health Information publishes standardized mortality ratios — the ratio of actual number of deaths to predicted number of deaths. It's a start. But the standardized mortality ratio, our only nationwide metric, can be misleading as an indicator of quality of care.[1]

Decision-makers need to agree on a common series of measurements that accurately represent quality of care at an institutional or individual level. But neither the federal government nor most health regions collect national institutional measures that reflect patients' experiences in the system, rates of medical error, hospital-acquired infections, surgical outcomes and complications. Even more complex measures are possible for institutional performance. For instance, balanced score cards could offer a picture of the quality of care among the services and providers offered by hospitals and clinics.[2]

Partly, it may be a lack of buy-in from individual practitioners. We do not track outcomes; nor do we even consider capturing patients' experiences of care received. For family physicians, eliciting patient feedback on the quality of their medical encounters seems key to delivering quality care. Timely feedback is critical because, as physicians, we are incapable of accurately judging patient satisfaction and other aspects of the encounter.[3]

We are, however, witnessing a growth in websites that offer ad hoc ratings of practitioners. Usually, such sites provide little more than a place for complaints. There is nothing systematic or reliable about such approaches. The existence of these sites reflects a measure of the public's appetite for more information about their health care system.

Some argue that more research is needed to develop better measurement tools and metrics, better statistical techniques to adjust for differences in the mix of patients going to different doctors and hospitals, and more uniform ways to capture accurate clinical information. I agree. But waiting until we have a perfect set of measurements is not an option. How can we effect any meaningful change without some way to measure institutional and practitioner performance?

In the United States, institutional and practitioner report cards have become common. Opponents point out that such public reporting allows the less scrupulous to play the system — providing care to low-risk patients so the numbers on complication and mortality look great. But the reports cards are beginning to drive change.[4]

In the long-term, we in Canada need to develop a system of standardized comparisons at all individual and system levels, so patients can judge quality of care. We need to select and follow process and outcome measures so the delivery of care improves health outcomes. Health authorities could then set and measure those targets and align funding with performance.

But if physicians want health systems and institutions to be patient-centred, physicians must lead the way. As a start, we could be asking patients about the perceived quality of their care: timeliness, availability, courteousness and overall satisfaction. Then we could report on quality publicly and improve or change things, if required.

When we have made ourselves more open to public scrutiny and feedback, we will have earned the right to demand more of our institutions and the health system.

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