Reply to Letter to the Editor

Public Reporting of Cost and Quality Information in Orthopaedics

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Dr. Ali raises important and valid points. The medical profession should lead quality improvement efforts in health care, and the primary vehicles for change in our healthcare delivery system will be healthcare professionals. Expecting the dissemination of cost and quality reports to correct the information asymmetry in healthcare markets in a manner that equips patients to independently make informed value-conscious medical decisions is unrealistic and overly simplified. However, this was not the premise underlying our recommendation for public reporting of cost and quality information [4]. In the text of our article, we state that “The policy goals of reporting quality and cost information in orthopaedic surgery are to equip stakeholders, including healthcare purchasers, payers, and patients, with information to evaluate the relative value of musculoskeletal care. Correlating surgical outcomes with the costs associated with the delivery of surgical care holds

the potential of yielding the measure of value desired” [4]. The underlying assumption is that the availability of cost and quality information will equip a multitude of actors to make more informed decisions, to increase provider accountability, and to incentivize performance improvement, more effectively than they can in the absence of such information. If appropriately implemented and applied, the provision and use of publicly available cost and quality information should gradually make it impossible for “failing providers” to provide care, and should equip patients to recognize what substandard care would be.

Thus to the point raised concerning the possibility that “failing providers are left for those unable to exercise choice, for example, those in lower socioeconomic classes or the elderly”, the goal of public reporting in health care is to not allow such providers to practice without accountability and reprimand for delivery of substandard care. However to stimulate change in the medical profession requires the development of a standard of care that patients must learn to expect and evaluate through access to information and provision of feedback. This is reportedly the preference of patients particularly in the case of elective procedures, where studies [1] including that of the Dartmouth Center for Informed Choice [6] have shown that patients facing elective procedures—such as elective orthopaedic procedures—benefit greatly from understanding their options, risks, and benefits. In the current evolution toward a patient-centered care model, patients’ personal preferences and values, lifestyles, and family and social circumstances are considered in the decision-making regarding individual options for treatment. This has been identified as one of the important factors constituting high-quality health care [1]. Patients prefer participation in the decision-making process, and when informed often make different choices than patients who are not fully

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informed [3]. Thus the goal of access to healthcare information is not to oblige patient choice without appropriate support, but rather to involve and educate patients toward exercising a choice that reflects their preferences and values.

Regarding the responsibilities of the patient consumer and the healthcare professional, it is overly simplistic to designate public reporting and the practice of quality control as the exclusive responsibility of one or the other. As was alluded to in the text of our article [4], the list of actors certainly includes patients, approximately 55% of whom are younger than 65 years with benefits through employment-based insurance, 30% of whom receive Medicare and Medicaid, and the remainder who represent a segment of the uninsured in the United States [2]. A large segment of these patients would benefit from access to information, and have been active users of existing online vehicles of health information. A 2009 Pew Research study [5] showed that 61% of all US adults sought web-based health information. Approximately 59% of this population were in the 50- to 64-year-old age group, 27% were 65 years old or older, and approximately 44% of this population were in a household annual income bracket of less than \$30,000. Furthermore for patients either not capable or not interested in engaging in shared, value-conscious healthcare decisions, the proposed concept of accountability under public reporting would incentivize physicians, health plans, and purchasers to consider this information and guide patients accordingly, as their value-based reimbursement rates become driven by public reports of patient satisfaction.

However in addition to patients, the list of stakeholders also includes payers, who will use this information to derive provider payment rates and allocations. It includes purchasers who will consider the information in designing new benefit plans (eg, tiered provider networks, consumer-directed health plans, and global payment models, etc). It also includes healthcare professionals ranging from physicians, nurses, and case managers to hospital administrators and management support staff, who will need this information to perform effective monitoring and evaluation, accurate benchmarking, and continuous quality improvement. Thus, rather than dividing the “professional provider” and the “patient consumer” into two separate groups, this interdependent group of actors requires shared participation of all entities to achieve the intended goals.

Finally, regarding the final statement “quality control (being) the responsibility of the medical profession, not of patients”, one could argue that the indication for public reporting and greater patient involvement arose in response to the historical lack of professional oversight in health care. This has been revealed through an extensive body of evidence that highlighted inconsistent and unexplained variations in practice, overuse and underuse of services, insufficient monitoring of safety, outcomes, and the management of healthcare finances and resources. It would be unreasonable to assume that a surge of effective self-regulation will spontaneously arise without an organized shift in the paradigm of healthcare delivery for patients, providers, and purchasers.

We believe that public reporting is a necessary building block for value-based health care. Alone, it is not sufficient to provoke the transformational changes we seek to promote in our healthcare system. Bending the cost curve and achieving meaningful quality improvement, we believe, is not obtainable without this critical information.

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